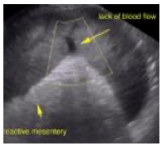
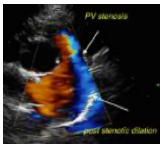
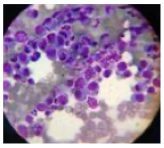
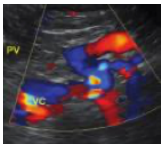

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1-800-838-4268 info@sonopath.com

**PATIENT**

Jason Hannold

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

15 years

**WEIGHT**

7.8 lbs

**INTERPRETED BY**

Tam Mengine, DVM, DABVP (canine/feline practice)

**IMAGING PERFORMED BY**

Dr. Tam Mengine

**HOSPITAL NAME**

Stoney Creek VH

**REFERRING VET**

Dr. Keely Zhang

**INVOICE**

13994

**DATE**

8.8.23

## PRESENTING CLINICAL SIGNS

History: Presented 7/28 for weight loss, vomiting and inappetence.
CBC / Chem / T4 / U/A - Alb 2.2, SpGr 1.019 - else wnl.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is moderately distended with anechoic urine, and no luminal sediment is present. The ureteral papillae, trigone and pelvic urethra are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted. Urethra visualized to 3.0 cm.

Both kidneys are hyperechoic and exhibit moderately decreased cortico-medullary differentiation. There are small cortical cysts present within the right kidney. There is no evidence of nephrolithiasis, mineralization, pyelectasia or hydronephrosis. The proximal ureters are not visible (normal). The left kidney is 4.0 cm in length. The right kidney is 4.1 cm in length.

### *Adrenal Glands*

The adrenal glands are both identified in their normal locations. They are normal in size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. The left adrenal gland height is 3.2 mm at the caudal pole. The right adrenal gland height 4.3 mm at the caudal pole.

### *Spleen*

The spleen is of appropriate size and has a normal, homogenous parenchyma with a smooth, continuous capsular surface. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal. Thickness at the splenic hilus is normal at 5.5 mm.

### *Liver*

The liver is of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

### *Gastrointestinal*

The stomach is empty. The gastric wall is 2.4 mm with normal deviations due to rugal folds and exhibits appropriate wall layering. The pylorus is of normal appearance.

The small bowel has diffuse changes to the normal 1:3 muscularis to mucosa ratio. Wall measurements are normal up to 2.2 mm for duodenum and 2.1 mm for jejunum. Overall wall layering is preserved. Intestinal motility appears normal.

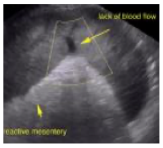
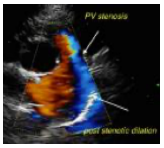
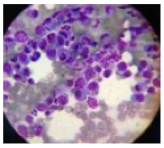
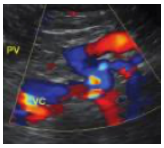
There is a 2.5 cm x 1.9 cm inhomogeneous mass arising from the wall of the wall of the ileocolic junction. The surrounding omental fat is hyperechoic. There is not evidence of obstruction.

### *Pancreas*

The left limb of the pancreas is hypoechoic, but of normal size and with no changes to the surrounding mesenteric fat. There is no evidence of peripancreatic inflammation. The pancreatic duct appears normal.

### *Free Abdomen*

There is no evidence of free fluid within the peritoneal cavity. The omentum and intra-abdominal fat are of hyperechoic. The mesenteric and colic lymph nodes were moderately enlarged and hypoechoic with a

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rounded shape, measuring up to 1.3 cm. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

- Stricturing mass of the ileocolic junction with lymph node involvement

### Secondary Findings

- Chronic renal changes
- Small intestinal changes typical of infiltrative bowel disease

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although the mass noted in the large bowel is not currently obstructing the GI tract, it is stricturing and likely will soon be obstructive. Recommendations would include fine-needle aspirate for definitive diagnosis. Resection and anastomosis could be attempted, but would likely be difficult in this region, and given the likely spread to the regional lymph nodes, would be unlikely to be curative.





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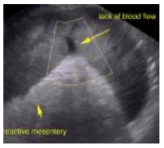
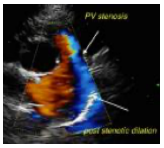
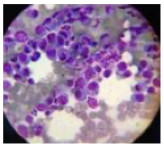
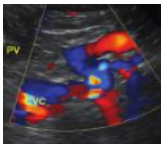

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**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

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