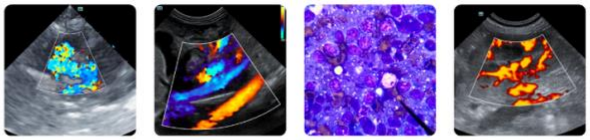

PATIENT

Leo Mendoza

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

10 Years

WEIGHT

11.3 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Renee Ziegler-Post

HOSPITAL NAME

For Cats Only Veterinary Clinic

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PRESENTING CLINICAL SIGNS

Not eating and vomiting

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is moderately turbid with abundant suspended echogenic debris. Normal appearance of the bladder neck and proximal urethra. No cystoliths or convincing ultrasonographic evidence of cystitis or urinary bladder neoplasia are identified.

The left kidney is normal in shape and size, measuring 3.95×2.15 cm, with cortical thickness measuring 0.34 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 4.16×1.91 cm, with cortical thickness measuring 0.32 cm. In both kidneys, the renal cortex is mildly hyperechoic relative to the liver parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is identified. Color Doppler demonstrates an overall preserved vascular pattern.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.24 cm at the cranial pole and 0.23 cm at the caudal pole. The right adrenal gland measures 0.27 cm at the cranial pole and 0.27 cm at the caudal pole.

Spleen

Multiple heterogeneous splenic nodules measuring approximately 1 cm in diameter are present and result in multifocal capsular contour deformity.

Liver

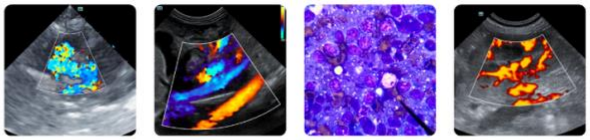
The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma looks uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The wall is thin and the contents are primarily anechoic with a small amount of biliary sludge. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal tract

The stomach is empty and contains a small amount of fluid. Gastric wall thickness measures approximately 1.36 mm with preserved wall layering. The pylorus measures 3.32 mm. The duodenum measures approximately 3.92 mm.

The jejunum measures approximately 1.77 mm in total thickness, with mucosa measuring 0.71 mm and submucosa 0.37 mm. Portions of the ileum appear within normal limits, measuring approximately 1.87 mm in thickness. However, additional ileal segments are moderately thickened, measuring up to approximately 3.27 mm, with mucosa measuring 1.00 mm, submucosa 1.06 mm, and muscularis propria 1.07 mm. The ileocecal junction measures approximately 4.54 mm, with marked muscularis



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propria thickening measuring up to approximately 2.39 mm. Intestinal wall layering remains preserved throughout the evaluated segments.

Most intestinal loops are mildly fluid distended, and several segments demonstrate subtle corrugation and mild “to-and-fro” luminal motility compatible with functional ileus/dysmotility. No discrete obstructive foreign material or focal obstructive lesion is identified ultrasonographically. The colon measures approximately 0.89–1.14 mm and contains formed fecal material within the descending colon.

Pancreas

The pancreas measures approximately 5.36 mm in thickness. The pancreatic parenchyma is overall isoechoic relative to the adjacent omental fat. The pancreatic duct is not dilated. No convincing ultrasonographic evidence of active pancreatitis or pancreatic mass lesion is identified.

Free Abdomen

No abdominal effusion or sonographic evidence of peritonitis is identified. Cranial mesenteric and ileocecal lymph nodes are not confidently visualized, although the surrounding mesentery appears unremarkable. A pancreaticoduodenal lymph node measures approximately 4.19 mm in thickness and maintains normal shape and echogenicity. The region of the iliac trifurcation appears normal

PRIMARY FINDINGS

- Duodenum thickening and segmental ileal thickening with marked muscularis propria involvement.
- Marked muscularis propria thickening at the ileocecal junction.
- Mild diffuse intestinal fluid distension with subtle corrugation and functional ileus/dysmotility pattern.
- Multiple splenic nodules.

SECONDARY FINDINGS

- Mild bilateral renal cortical hyperechogenicity.
- Small amount of biliary sludge.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Moderate segmental ileal thickening and marked muscularis propria thickening involving the ileocecal junction are present with preserved wall layering. In combination with the presence of multiple large heterogeneous splenic nodules/masses causing capsular contour deformity, chronic vomiting, anorexia, and functional ileus pattern, infiltrative neoplastic disease is considered highly concerning. Alimentary lymphoma with splenic involvement/metastatic splenic infiltration is considered the primary differential diagnosis.

Additional differential considerations include severe chronic inflammatory enteropathy with reactive splenic change, multicentric lymphoid neoplasia, or less likely other infiltrative splenic neoplastic processes. However, the splenic appearance is considered markedly abnormal and not typical of mild incidental age-related nodular change alone.

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The mild diffuse intestinal fluid distension, subtle corrugation, and “to-and-fro” luminal motility pattern support associated functional ileus/dysmotility.

No convincing ultrasonographic evidence of active pancreatitis or biliary obstruction is identified currently.

Recommendations

- Correlation with CBC/chemistry, Spec fPL, GI panel, and cobalamin status is recommended if not already performed.
- Ultrasound-guided cytology of the splenic nodules.
- Intestinal biopsy should be considered if splenic cytology is nondiagnostic or if clinical signs persist/progress.
- In the meantime, empiric supportive medical management directed toward chronic gastrointestinal disease may be reasonable, including antiemetic therapy, gastrointestinal support, dietary management, cobalamin supplementation, and probiotics. If clinically feasible, empiric corticosteroid/anti-inflammatory enteropathy-directed therapy is ideally deferred until diagnostic sampling has been pursued, as steroid administration may reduce the diagnostic yield of subsequent intestinal biopsy/cytology interpretation.
- Close clinical monitoring for worsening vomiting, abdominal pain, inability to tolerate food/water, progressive lethargy, or decreased fecal output is recommended given the functional ileus/dysmotility pattern identified ultrasonographically.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient’s clinical status.

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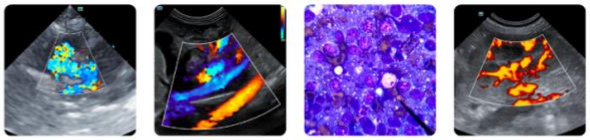

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

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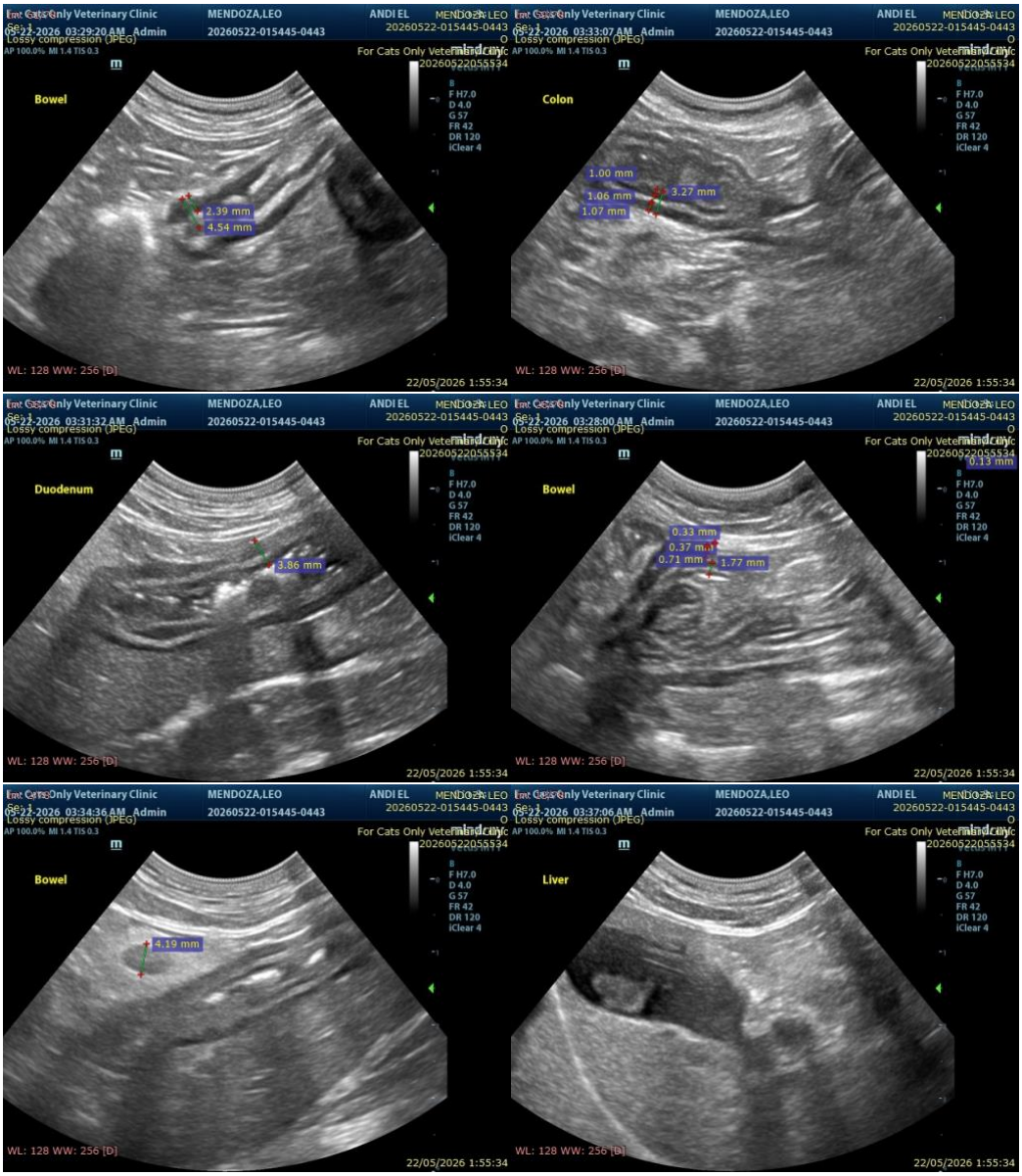

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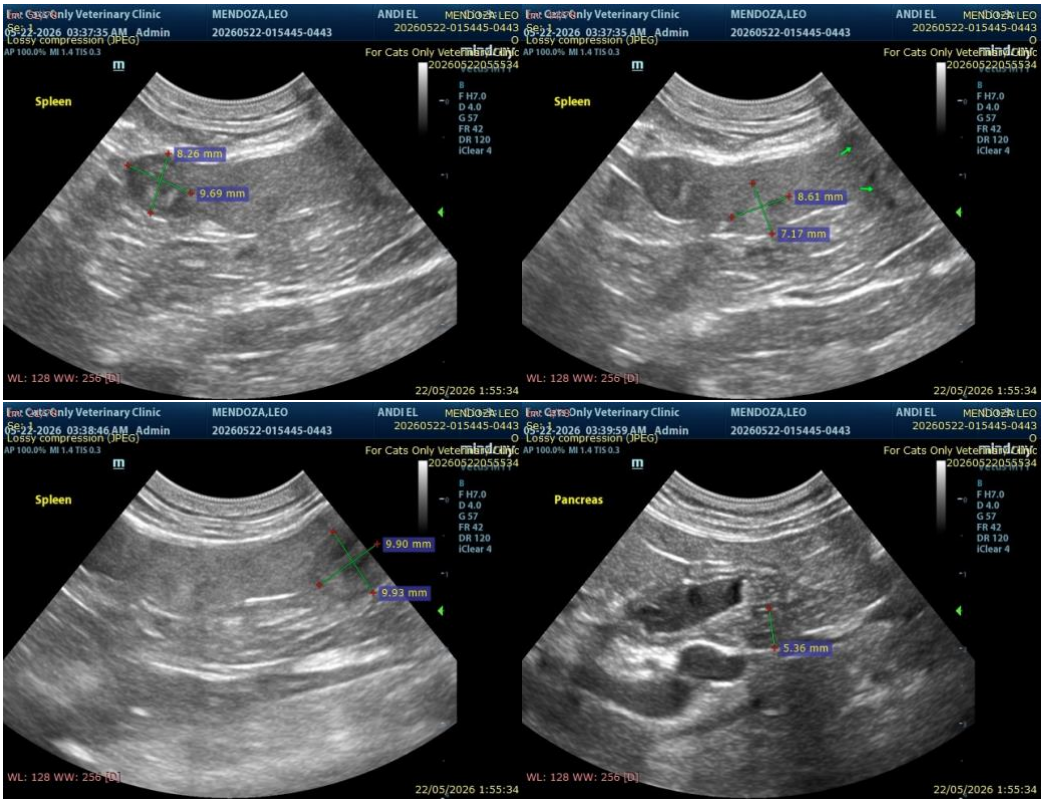

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

info@SonoPath.com