



**PATIENT**

Robin Sammies Friends

**SPECIES**

Feline

**BREED**

Domestic Shorthair

**SEX**

Spayed Female

**AGE**

Geriatric

**WEIGHT**

5.6 Pounds

**INTERPRETED BY**

Andrea Nicastro, DVM,  
Diplomate ACVIM  
(Small Animal Internal

**IMAGING PERFORMED BY**

Loetitia Saint-Jacques, RVT

**HOSPITAL NAME**

Brighton Greens VH

**REFERRING VET**

Dr. Robin Janeway

**INVOICE**

13964

**DATE**

2/16/22

**PRESENTING CLINICAL SIGNS**

History: Species: Feline Gender(altered?) FS Age: geriatric Weight in #: 5.6 Breed: DSH History: Continued weight loss. Patient had dental and brief abdominal ultrasound performed here on 12/20/21. Abdominal mass or enlarged LN was aspirated and demonstrated reactive lymphadenopathy. Patient has been eating Blue Buffalo duck canned food exclusively for several months. Patient has good appetite but is continuing to lose weight. Physical exam findings: Emaciation; diffusely thickened and fluid filled intestinal loops; MM pale pink Abnormal CBC/Chemistry/UA values: ALP low @ 5 IU/L, Na/K ratio decreased @ 31, mild elevation of serum amylase @ 1248 IU/L, increased Precision PSL @ 48 U/L, N,N,N anemia with HCT @ 24%, mild thrombocytosis @ 540,000/uL, mild lymphopenia @ 1068/uL, T4 low @ 0.6 ug/dL (euthyroid sick), 2+ proteinuria, 1+ bilirubinuria, 2-3 Calcium Oxalate Monohydrate crystals phpf Reason for Ultrasound: evaluation for causes of weight loss; re-evaluate lymphadenopathy

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is mildly distended with anechoic urine. The wall is normal in thickness with a smooth mucosal surface. No cystic calculi are observed. The region of the trigone is normal.

The left kidney is normal size (4.04 cm in length); with a slightly irregular shape. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. The cortex is hyperechoic. A nonobstructive nephrolith is visualized. Trace pyelectasia is present. There is no evidence of hydroureter.

The right kidney is normal size (4.11 cm in length); with a slightly irregular shape. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. The cortex is hyperechoic. A few nonobstructive nephroliths are visualized. There is no evidence of pyelectasia or hydroureter.

**Adrenal Glands**

The region of the adrenal glands is evaluated. No obvious pathology is observed.

**Spleen**

The spleen is normal in size (0.63 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

**Liver**

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1:1.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of suspended echogenic debris is observed within the lumen. The cystic and common bile ducts are normal.



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The gastric lumen is not distended. The gastric wall is suspected to be thickened. However, the gastric wall thickness is difficult to determine due to excessive rugal folds. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is diffusely thickened (up to 0.30 cm) with apparent retention of the normal layering pattern. There is disruption in the normal 1:3 muscularis to mucosa ratio with >1:1 ratio in most segments. Discreet masses are not identified. The ileocecolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

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**Pancreas**

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The base and limbs of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated (0.16 cm in diameter). There is no evidence of peripancreatic inflammation or effusion.

**AGE**

**Free Abdomen**

Geriatric

Trace free fluid is observed. Several mesenteric lymph nodes are enlarged and irregular. Some of the nodes have small cystic areas. The largest node measures 4.11 cm in length.

**WEIGHT**

**Other**

5.6 Pounds

A brief echocardiogram reveals questionable trace pericardial effusion.

**ULTRASONOGRAPHIC FINDINGS**

**INTERPRETED BY**

Andrea Nicastro, DVM,  
Diplomate ACVIM  
(Small Animal Internal

**Primary Findings**

- The bowel and lymph node changes are concerning for lymphoma. However, severe inflammatory bowel disease cannot be excluded.
- The trace ascites is likely secondary to bowel pathology.
- Questionable trace pericardial effusion. Rule out systemic inflammation, primary cardiac disease, infiltrative neoplasia of the myocardium, other.

**IMAGING PERFORMED BY**

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**Secondary Findings**

- Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- Bilateral, chronic nonspecific nephropathy with nonobstructive nephrolithiasis
- Age-related pancreatic remodeling with suspected fibrosis. Concurrent low-grade inflammation is also possible, particularly if the patient exhibits pain on cranial abdominal palpation.

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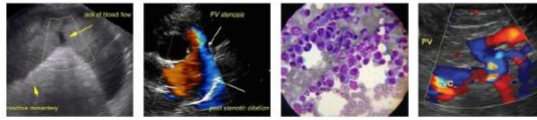
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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

- Three-view thoracic radiographs are recommended to assess for lymphadenopathy in the chest



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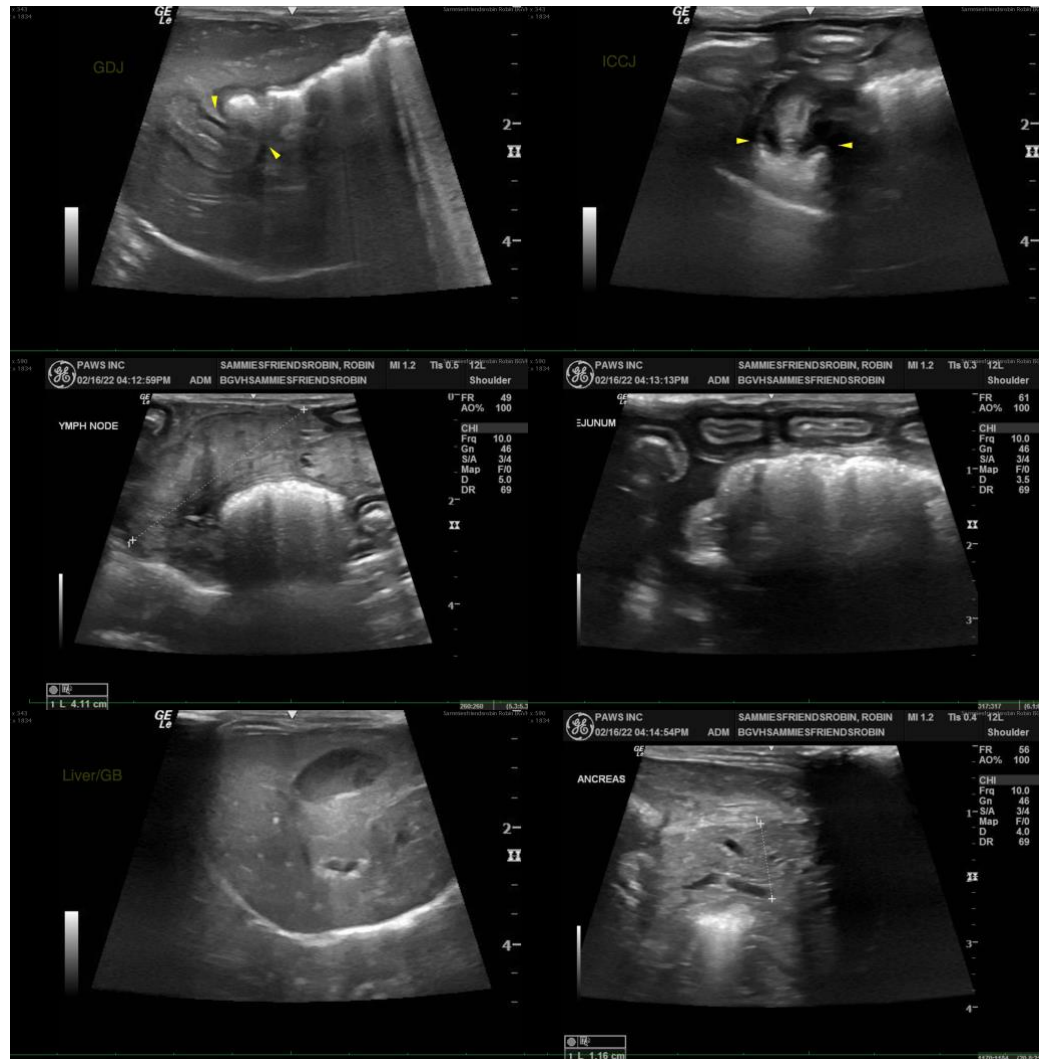
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- Consider a repeat aspirate of an enlarged mesenteric lymph node. If results are inconclusive, an abdominal exploratory with gastrointestinal and lymph node biopsies may be necessary to get a definitive diagnosis.
- A GI panel (send to Texas A & M) is also recommended.
- If biopsies are not pursued, consider empirical treatment for inflammatory bowel disease with corticosteroids and a hypoallergenic diet.



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Portable Animal Veterinary Sonography, Inc.

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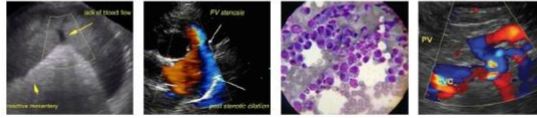
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I



**PATIENT**

Robin Sammies Friends can be of any further assistance please contact me.

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