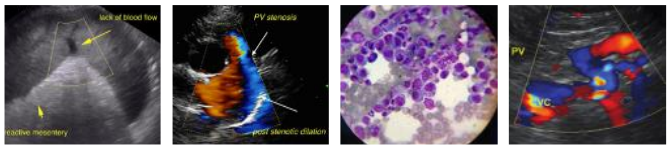


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Basil Hollomon

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

4 years, 1 month

WEIGHT

Not Provided

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Amanda Crook – SDEP Certified Clinical Sonographer

HOSPITAL NAME

Rivers Edge Pet Medical Center

REFERRING VET

Dr. Cora Hollomon

INVOICE

10527

DATE

3/9/22

PRESENTING CLINICAL SIGNS

History: About 1.5 months ago was noted to be vomiting more (hairballs and bile) and displayed an eating behavior that he performs when he is stressed (chews up food and drops it out of his mouth) and was eating less. A full work up was performed including AUS which showed prominent mesenteric lymph node. Blood work showed mild anemia, mild leukocytosis with neutrophilia, globulins 7.4. Mesenteric lymph node aspirate was inconclusive (mixed, mainly lymphoid inflammation with spindle cell proliferation). Prior to his consult at OSU, pt did have one episode of vomiting that was noted to be unusual - vomitus was thicker, a dark greenish-khaki color, and had coffee ground-like material in it. There was nothing noted that the pt had gotten in to, though he has a history of eating things off the ground and chewing string. He has not had to be treated for it. A repeat full work up was performed at OSU Teaching Hospital, repeat blood work showed anemia progressing at 19%. A UA was performed that demonstrated hematuria and fat, no protein, USG >1.050. A repeat AUS @ OSU was performed which demonstrated: 1) Large mesenteric mass is most likely lymph node in origin but a primary mesenteric mass is possible; malignancy is common (e.g. sarcoma, lymphoma) but benign etiology (e.g. granuloma) is possible 2) Mild, mesenteric lymphadenopathy could be multicentric neoplasia, metastasis or reactive 3) Mild typhlitis 4) Bilateral renal cortical hyperechogenicity and moderate lipiduria are reported normal variations in cats 5) Bilobed gallbladder, normal variant; gallbladder sludge could be incidental or due to cholecystitis A repeat FNA of the mesenteric lymph node showed: Consistent with reactive lymphoid tissue Comments: Findings are most suggestive of aspiration a reactive mesenteric lymph node. Mild suppurative inflammation may also be present. Evidence of neoplasia or infection is not seen in this sample, but these processes cannot be ruled out elsewhere in the abdomen. A Texas GI panel was sent out and all findings were normal. Pt was started on a hydrolyzed diet (Hill's z/d) and has been on the diet strictly for one week. Pt still eats small amounts, eats only a handful in the AM, seems to eat more when prompted in the afternoon and evening times (pt is meal fed, twice per day but has been getting his morning food in the afternoon if he does not finish it). Pt still has a decreased appetite but has not been noted to chew up pieces and spit them out like he was before. Still vomiting occasionally, vomitus is mostly bile, sometimes small hair balls. Has not had any more episodes of the unusual vomiting that he had once before earlier in the month. Pt is still drinking well and seems to have normal to mildly decreased energy. No current medications. pt was premedicated with gabapentin today and was sedated on alfaxalone, butorphanol, midazolam for the recheck ultrasound

Abnormal PE/Chem/CBC/UA Results: See above for previous abnormalities CBC repeated today showed HCT 22.1% (RBC 5.85, HGB 7.6), WBC 21,000 (23,000 one month ago) with neutrophils 17,000 (19,300 one month ago) X-rays performed one month ago showed no obvious abnormalities of thoracic or abdominal cavity. These have not been repeated

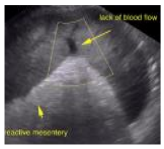
ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

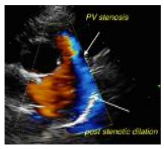
Urinary System

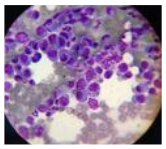
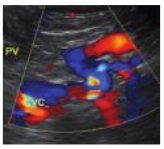
The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A moderate to large amount of suspended echogenic debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal size (4.52 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. The cortex is hyperechoic. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (4.43 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. The cortex is hyperechoic. There is no evidence of pyelectasia, nephroliths, infarcts or





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hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.36 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.40 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is subjectively prominent in size (1.11 cm in width at the level of the hilus) with slightly swollen peripheral contours. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. 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 bilobed conformation is present. A small amount of aggregated, echogenic, mostly gravity dependent debris is observed within the lumen. The cystic and common bile ducts are normal.

Gastrointestinal

The gastric lumen is mildly to moderately distended with ingesta. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is segmentally dilated with chyme. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The pancreas is diffusely visible/prominent, with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and homogenous in appearance. No distinct focal lesions are observed. The pancreatic duct is visible, but not overtly dilated (0.18 cm in diameter).

Free Abdomen

There is no evidence of free fluid. Several enlarged irregular, hypoechoic to heterogenous mesenteric lymph nodes are visualized, the largest measuring 3.55 x 1.20 cm. Surrounding mesentery is mildly hyperechoic. A prominent gastric lymph node (0.82 cm in length) is also seen.

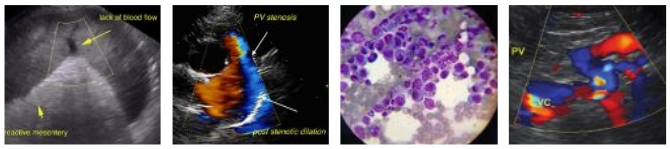
Other

A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Abdominal lymphadenopathy. Changes are similar to the previous sonogram. Differentials include lymphoma, lymphadenitis (i.e., reactive, pyogranulomatous), lymphoid hyperplasia, other.



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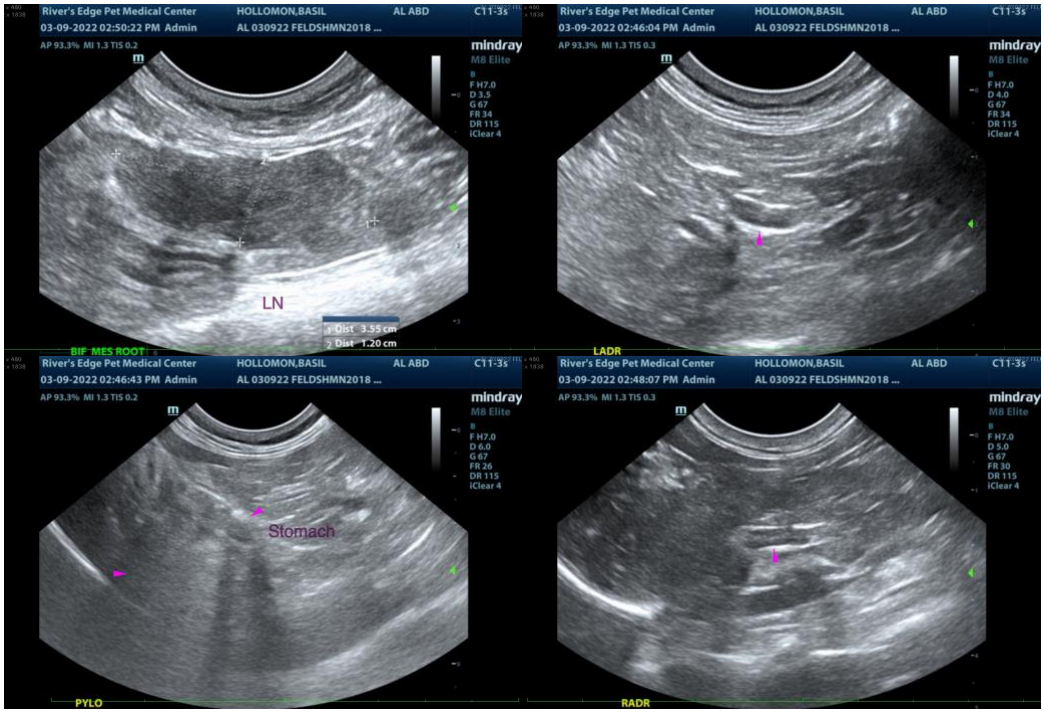
Secondary Findings

- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.
- Mild splenomegaly. This is a persistent finding. Differentials include antigenic stimulation, lymphoid hyperplasia, extramedullary hematopoiesis, splenitis, or emerging neoplasia.
- Urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the patient's clinical signs have not resolved, consider surgical biopsies of the abdominal lymph nodes and gastrointestinal tract, as sometimes cytology results are not representative of a diffuse process.
- Given the patient's anemia, a reticulocyte count is recommended to determine if it is regenerative versus nonregenerative. If regenerative, infectious disease testing (i.e., mycoplasma, tick-borne disease), should be considered. If nonregenerative, a bone-marrow aspirate along with a feline leukemia IFA on the marrow sample may be warranted.



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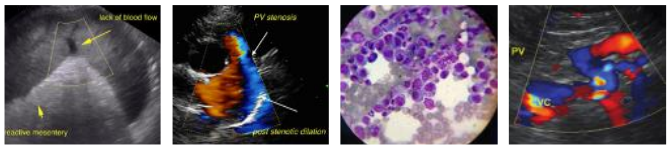

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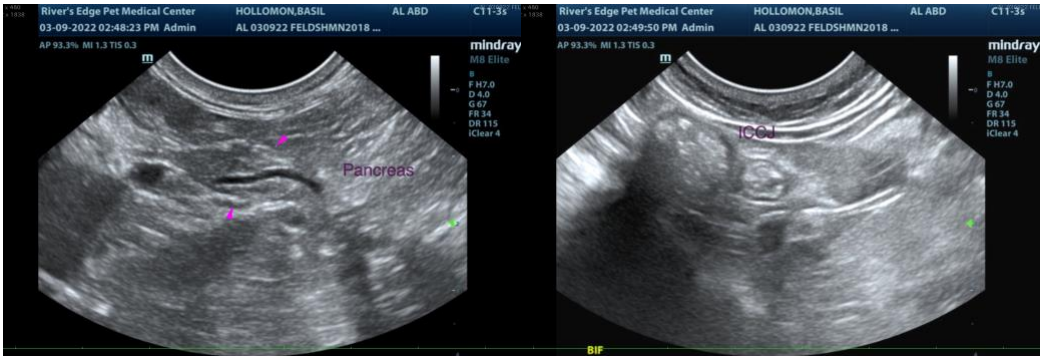

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com