



PATIENT

Boo Baumgarth

SPECIES

Feline

BREED

DLH

SEX

Spayed Female

AGE

12 years

WEIGHT

9.5 lbs

INTERPRETED BY

Andrea Nicastro, DVM,
Diplomate ACVIM
(Small Animal Internal
Medicine)

**IMAGING
PERFORMED BY**

Dr. Goodman

HOSPITAL NAME

Evandale-Blue Ash PH

REFERRING VET

Dr. Goodman

INVOICE

10797

DATE

4/21/22

PRESENTING CLINICAL SIGNS

History: Recheck ultrasound from 1/28/22. Since her last ultrasound we have performing aspirates of her lymph nodes and a Texas GI Panel. Lymph node cytology results attached. GI panel showed cobalamin deficiency and we started B-12 once a week for 6 weeks, the one dose a month later. Planning to recheck on 6/1/22. Started b-12 inj on 2/16/22 and administered depo-medrol inj. Patient has been eating well at home but still lost weight per owner's scale. Performed CBC/Chem/UA/Fecal/T4 with PLI on 4/19/22- results attached with bloodwork from Feb 2022 for comparison.

Abnormal PE/Chem/CBC/UA Results: Weight: 1/28/22 - 9.8lbs 2/9/22 - 9.3lbs 2/16/22 - 8.7lbs 2/21/22 - 9.1lbs 2/23/22 - 9.3lbs 3/2/22 - 9.8lbs 3/8/22 - 9.7lbs 3/16/22 - 9.9lbs 3/23/22 - 10.1lbs 4/19/22 - 9.5lbs Cytology Report: "MICROSCOPIC DESCRIPTION: The smears are moderately hemodiluted and highly cellular. Nucleated cells are comprised of a majority of lymphocytes, with fewer leukocytes and mast cells. The lymphocyte population is heterogenous and left shifted and consists of a majority (~80%) of small lymphocytes, and fewer but slightly increased proportions of intermediate and large lymphocytes. Lymphocytes have normal morphology. Neutrophils are proportional to the degree of hemodilution present. Mast cells are well granulated and are seen sporadically individually. No infectious agents, significant inflammation, or overtly neoplastic cells are noted.

MICROSCOPIC INTERPRETATION: Mild reactive lymphoid hyperplasia; mild mastocytosis; please see comments

COMMENTS: Lymphocyte heterogeneity and predominance of small cells are supportive of reactive lymphoid hyperplasia; please correlate with clinical and imaging findings. Of note, small cell lymphoma variants can never be entirely ruled out cytologically, but this disease is less consistent with the observed heterogeneity (small cell lymphoma typically requires histopathology, PCR, or flow cytometry for confirmation, and therefore if neoplasia is clinically suspected, one of these ancillary tests is recommended; also, flow cytometry can be performed on whole blood if the lymphocyte mass is greater than 5,000/uL). The other pertinent finding is a low-density population of mast cells which are seen individually. The cells may be inflammatory, but are also concerning for drainage or incipient colonization from a primary mast cell tumor (i.e. feline systemic mastocytosis; typically presents in the liver, spleen, and/or gastrointestinal tract). If there is any other detected organomegaly, cytologic or histopathologic sampling would be recommended."

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 lumen is moderately distended with anechoic urine. 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 (3.51 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal size (3.57 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.



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Adrenal Glands

The left adrenal gland is normal size (0.31 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.29 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.58 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 normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen. A 0.87 cm hyperechoic nodule is observed deep on the right side, adjacent to the diaphragm. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is not distended. The gastric wall is normal in thickness with a normal layering pattern. The small intestines are not visualized in their entirety. In the visualized portions, the lumen is not dilated. The wall is normal in thickness with a normal layering pattern and appropriate mural detail. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The left limb 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. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

There is no evidence of free fluid. A few prominent mesenteric lymph nodes are visualized, the largest measuring 1.51 cm in length. Surrounding mesentery is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Small intestinal wall pattern most consistent with inflammatory bowel disease with some potential for emerging lymphoma. However, neoplasia is considered less likely at this time. Changes are similar to the previous sonogram.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely. Regional peritonitis is present. Changes are similar to the previous sonogram.



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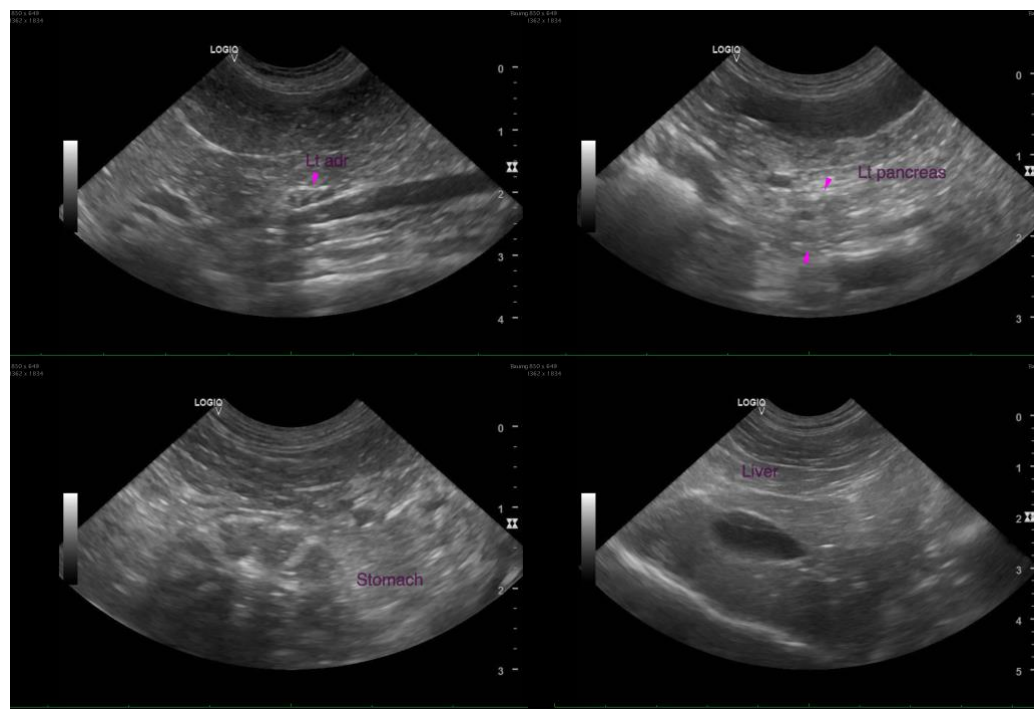
4/21/22

Secondary Findings

- The bilateral age-related renal changes
- Age-related pancreatic remodeling
- The hyperechoic hepatic nodule trends toward the benign (i.e., lipogranuloma, focus of lymphoid hyperplasia). However, emerging neoplasia cannot be completely excluded.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider initiation of a hypoallergenic diet if the patient will tolerate it. Also consider using a daily or twice-daily corticosteroid (i.e., prednisolone (in lieu of Depo-Medrol injections)), as the systemic effects may be more consistent.
- Given the continued weight loss, three-view thoracic radiographs are recommended to assess for occult neoplasia in the chest.
- A neurological examination is also recommended as some patients with primary brain tumors will present with weight loss as the sole clinical sign.
- Ultimately, to obtain a definitive diagnosis, GI biopsies (endoscopic or surgical) would be necessary. If biopsies are pursued, the patient should be weaned off corticosteroids due to the potential for masking of underlying GI pathology.





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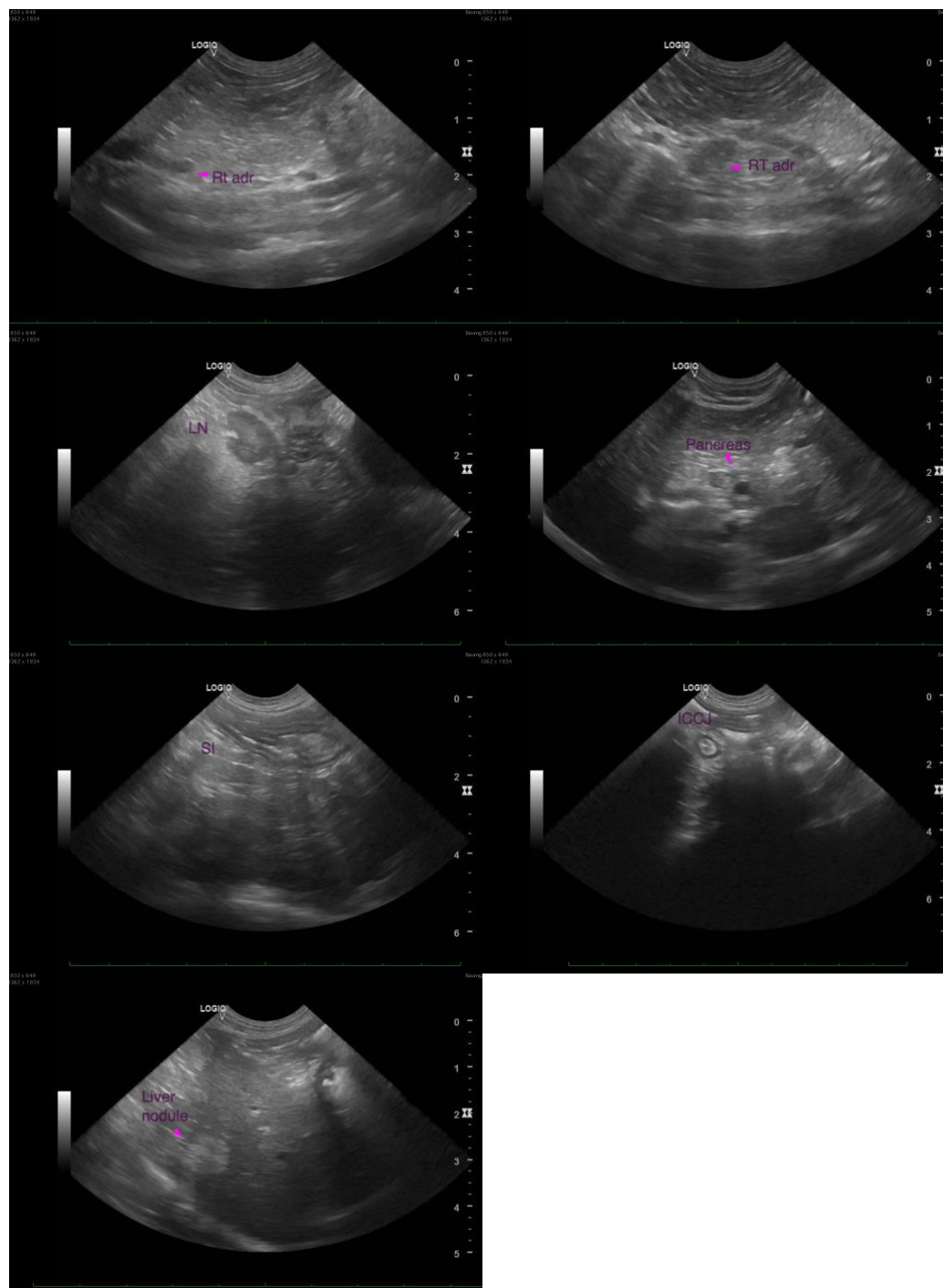
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.



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info@SonoPath.com

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