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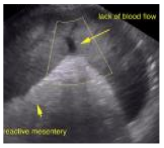
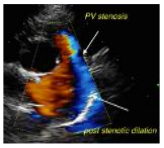
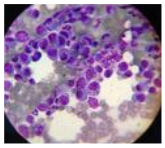
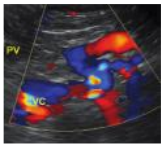
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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**PATIENT**

Fozzy Williamson

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

10 years

**WEIGHT**

7.13 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Laura Field

**HOSPITAL NAME**

Westview VH

**REFERRING VET**

Dr. Laura Field

**INVOICE**

10845

**DATE**

5/4/22

## PRESENTING CLINICAL SIGNS

History: Long history of chronic vomiting. Became acutely worse a week ago, now cat is not eating and vomiting more. CBC, Chemistry and fpli normal. Xray report did not find any evidence of obstruction. Still nauseous despite 24 hrs on ivft and supportive care. Is on ampicillin, cerenia, buprenorphine. Has had an enema due to mild constipation but still has not produced stool.

Abnormal PE/Chem/CBC/UA Results: No abnormalities on CBC, CHEM, TT4, SDMA, fPli normal. X-ray report Conclusion 1. Unremarkable thorax. 2. Unremarkable abdomen. Recommendations A definitive surgical lesion is not seen at this time. The patient could be treated symptomatically, and if there is any clinical evidence of pancreatitis an abdominal ultrasound could be done. If clinical signs persist and ultrasonographic findings are equivocal, ultimately an upper GI may be beneficial both for diagnostic and therapeutic purposes. The possibility of a proximal duodenal obstruction cannot be ruled out as due to the frequency of vomiting these patient's, radiographic changes associated with an obstruction typically are not produced. An ultrasound and upper GI could help to further assess this possibility as well.

## 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 1-2 cm, are normal.

The left kidney is normal in size (4.43 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney presented normal size (4.61 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

### *Adrenal Glands*

The left adrenal gland is normal size normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

### *Spleen*

The spleen is subjectively prominent in size, with irregular peripheral contours. At least 4 hypoechoic nodules are visualized, the largest measuring 1.36 cm in diameter. At least one of the nodules causes capsular expansion. In addition, a 0.65 cm heterogenous nodule is also seen. Splenic vasculature appears normal with no evidence of thrombosis.

### *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 gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are visible/tortuous, but not overtly dilated.

***Gastrointestinal***
The gastric lumen is moderate fluid-distended and hypomotile. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is segmentally fluid-distended (mild). The small intestinal wall is diffusely thickened (up to 0.35 cm) with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. Discreet masses are not identified. The colonic wall is normal.

***Pancreas***
The left limb is visible, with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

***Free Abdomen***
Trace free fluid is observed. The abdominal lymph nodes are normal/not visible.

## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

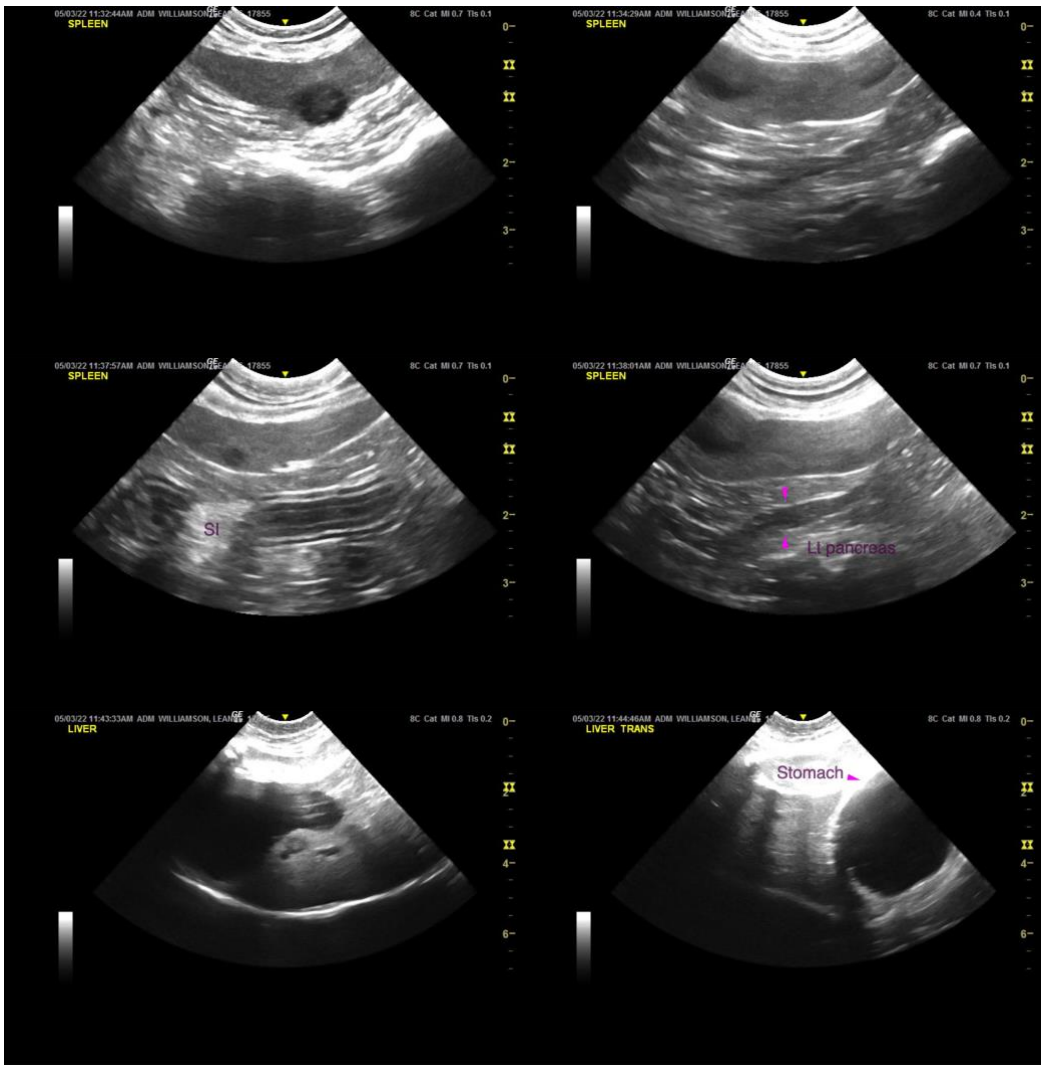
- The splenic nodules are concerning for infiltrative neoplasia (i.e., round cell tumor). However, a benign process (i.e., multi-focal inflammatory disease) cannot be completely excluded.
- Bowel pattern consistent with inflammatory bowel disease, with potential for emerging lymphoma
- Trace ascites
- Gastric hypomotility. This may be secondary to ileus or potentially, a pyloric outflow tract obstruction. Ileus is favored give the other sonographic changes. However, consider a repeat ultrasound in 12-24 hours to reassess the stomach and pyloric outflow tract.

### 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.
- Bilateral, chronic, age-related renal changes
- The hepatic nodule could be consistent with a benign process (focus of inflammation, other) or emerging neoplasia.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for neoplasia in the chest.
- Fine-needle aspirates of the splenic nodules are recommended, if clotting status is appropriate. Twenty-five gauge-needles should be used. Due to the possibility of mast cell disease, consider administering diphenhydramine at 2.20 mg/kg subcutaneously 15 minutes prior to aspiration to reduce the risk of mast cell degranulation.
- Also consider a GI panel including serum cobalamin and folate, TLI and PLI, as well as a fecal evaluation for ova and Giardia.




**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)
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