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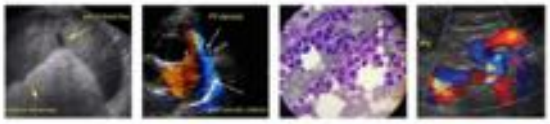

IMAGING PERFORMED BY
pawsonography@gmail.com 530-708-8340

PATIENT

Chicken Baloga

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

11 years

WEIGHT

8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT LVT

HOSPITAL NAME

Pine Creek VC

REFERRING VET

Dr Denny Nolet

INVOICE

11594

DATE

9.8.22

PRESENTING CLINICAL SIGNS

History: Heavy sedation dex/torb/ket--9/7Owner changed food to Blue Buffalo duck/potato and pt has been eating well and no vomiting since food change. O feels pt is improving and almost back to his normal behavior. 9/3/2022 ADR S: not eating and when he does, he is vomiting. ate 1 chicken treat just fine yesterday, then ate 4 treats and vomited. got advantage before his neck procedure. (abscess)

Abnormal PE/Chem/CBC/UA Results: LABs attached

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A small 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 1-2 cm, are normal.

The **left kidney** is normal size (3.71 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The **right kidney** is normal size (3.99 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The **left adrenal gland** is normal size (0.42 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 prominent in size 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 curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and homogenous in appearance. 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. A small to moderate amount of aggregated, echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The **stomach and intestine** are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal to mildly thickened (up to 0.31 cm) with retention of the normal layering pattern. There is disruption in the normal 1:3 muscularis: mucosal ratio in (some/most) segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

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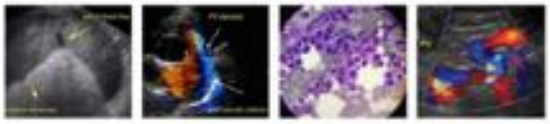

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Pancreas

The right limb of the **pancreas** is visible with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated. The base and limbs of the pancreas are isoechoic to surrounding omental fat. No focal lesions are observed. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

There is no obvious evidence of free fluid. At least two enlarged, irregular sublumbar **lymph nodes** are visualized, the largest measuring 1.47 cm in length. The nodes are mildly heterogenous in appearance. Surrounding mesentery is hyperechoic. Additional prominent lymph nodes are observed in the right cranial quadrant, at the mesenteric root. At the ileocecal colic junction, a prominent gastric lymph node is also seen.

Other

A **brief echocardiogram** reveals no obvious evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bowel changes consistent with inflammatory bowel disease with potential for emerging lymphoma.
- The prominent abdominal lymph nodes could be consistent with lymphadenitis, lymphoid hyperplasia, or infiltrative neoplasia. The sublumbar lymph nodes are more concerning for neoplasia than the cranial and midabdominal nodes.

Secondary Findings

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The splenomegaly may be secondary to sedation. Other considerations include lymphoid hyperplasia, extramedullary hematopoiesis, antigenic stimulation, splenitis or infiltrative neoplasia (i.e., lymphoma).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A malabsorption panel including serum cobalamin and folate, TLI and PLI, is recommended along with a fecal evaluation for ova and Giardia.
- If the patient's clinical signs do not completely resolve with diet change, further GI work-up (i.e., endoscopic or surgical biopsies) may be warranted.
- Consider a repeat ultrasound in 3-4 weeks to reevaluate the abdominal lymphadenopathy, with particular attention to the sublumbar nodes. Aspiration of these nodes can be considered now or if still enlarged at the recheck, if accessible and if clotting status is appropriate.

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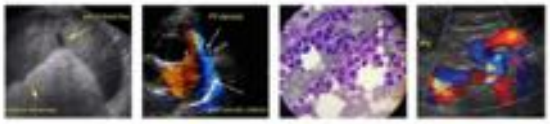

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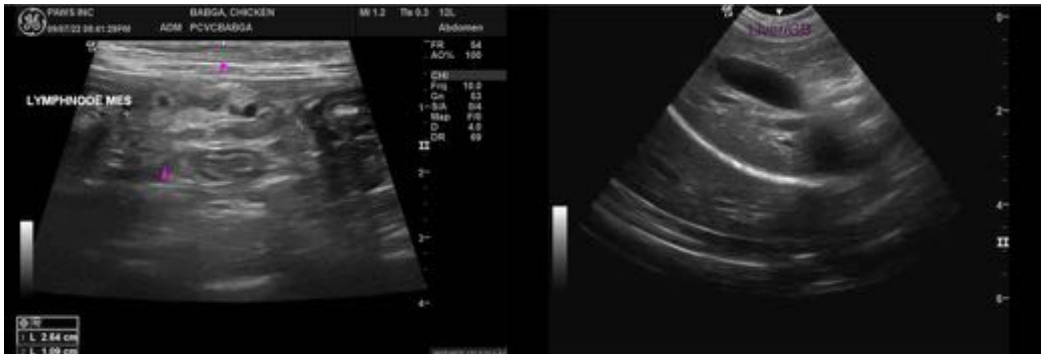

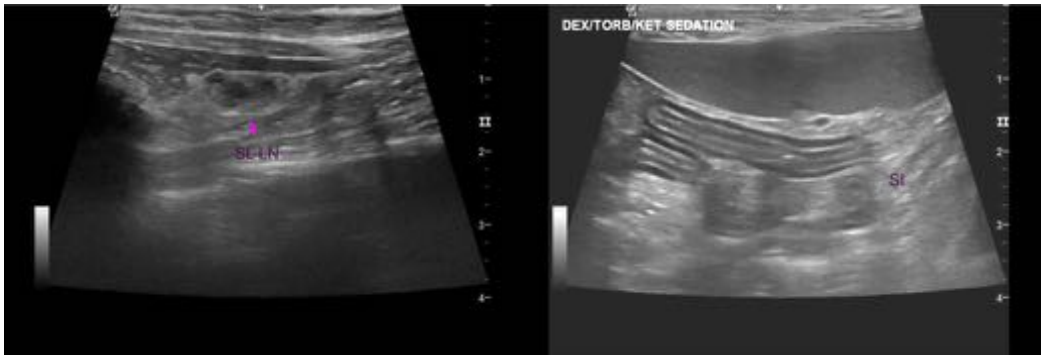

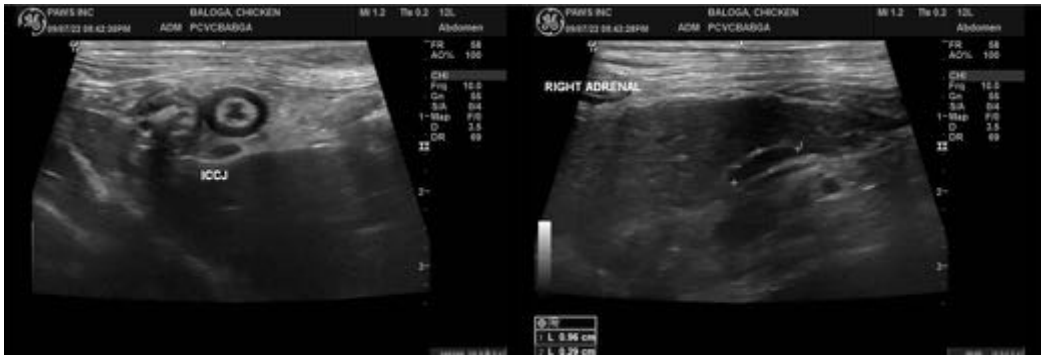

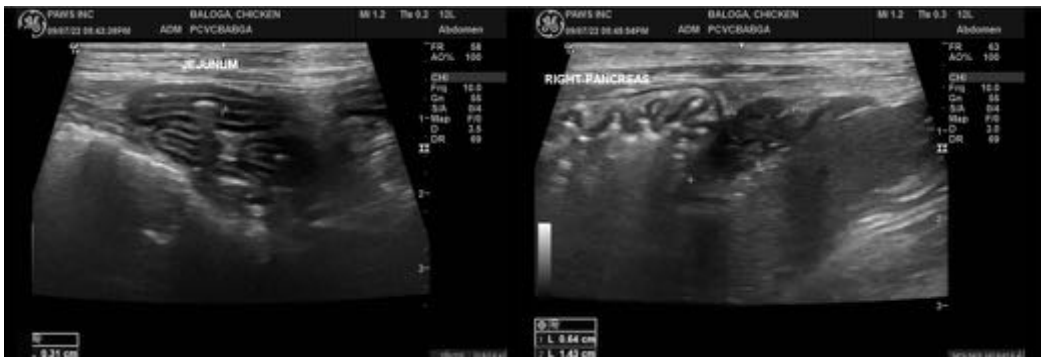

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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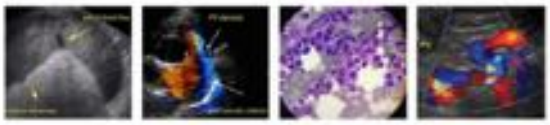

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

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