



PATIENT

Galore Ferrell

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

16

WEIGHT

11.37

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Isabel Plourde

HOSPITAL NAME

TotalBond VH

REFERRING VET

Dr. Isabel Plourde

INVOICE

44539

DATE

1/26/23

PRESENTING CLINICAL SIGNS

Pt has had chronic intermittent vomiting since April of last year when switched to a urinary diet. In April the patient presented with inappropriate urination. Potential nephroliths were noted on rads at the time. UA at the time showed struvite crystals, but no bacteria. The pt has had vomiting since being on this new diet. Pt has also lost 0.6 lbs since October.

Abnormal PE/Chem/CBC/UA Results: BW in October fairly unremarkable aside from: Neutrophils 2,016- mildly low Platelets 21- there were clots in sample so most of this is likely artifact, however, pt also historically has had mild thrombocytopenia as far back as 2014 Crea was normal at 1.4 and T4 was normal at 2.0

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia or infarcts observed. The right kidney measures 4.55 cm. The left kidney measures 4.06 cm. Small non-obstructive nephroliths are noted bilaterally.

Adrenal Glands

The right adrenal gland is normal in size (0.34 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.53 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size (1.37 cm thick) with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a mildly coarse/heterogenous echotexture. Multifocal well demarcated, hyperechoic, homogeneous nodules are noted. Splenic vasculature appears normal. Hyperechoic enhanced pericapsular mesenteric fat is noted.

Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.



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The visible small intestine demonstrates areas of thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen is empty with no evidence of obstruction or foreign material.

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The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

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Pancreas

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The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

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Free Abdomen

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There is no evidence of free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

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PRIMARY FINDINGS

- **Scalloped spleen** – can be associated with benign or malignant infiltrative disease. Common causes include a reactive spleen secondary to immune stimulus or early infiltrative round cell neoplasia such as lymphoma or mast cell tumor.
- **Hyperechoic splenic nodules** – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.
- **Inflammatory bowel disease (IBD) pattern** – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No aggressive lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.

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SECONDARY FINDINGS

- Age related kidney changes with small bilateral non-obstructive nephroliths

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

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A fine needle aspirate of the spleen is recommended if patient's coagulation status is appropriate.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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Ultimately, if a diagnosis of infiltrative round cell neoplasia is not diagnosed cytologically from the splenic aspirate, biopsies of the GI tract may be necessary to definitively diagnose and therefore effectively manage the suspected concurrent infiltrative bowel disease.

In the meantime, in addition to supportively managing this patient's symptoms/clinical signs, recommendations include a transition back to the diet that the patient was eating before vomiting started, and/or considerations could be given to a hydrolyzed protein diet based on trial and error



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response.

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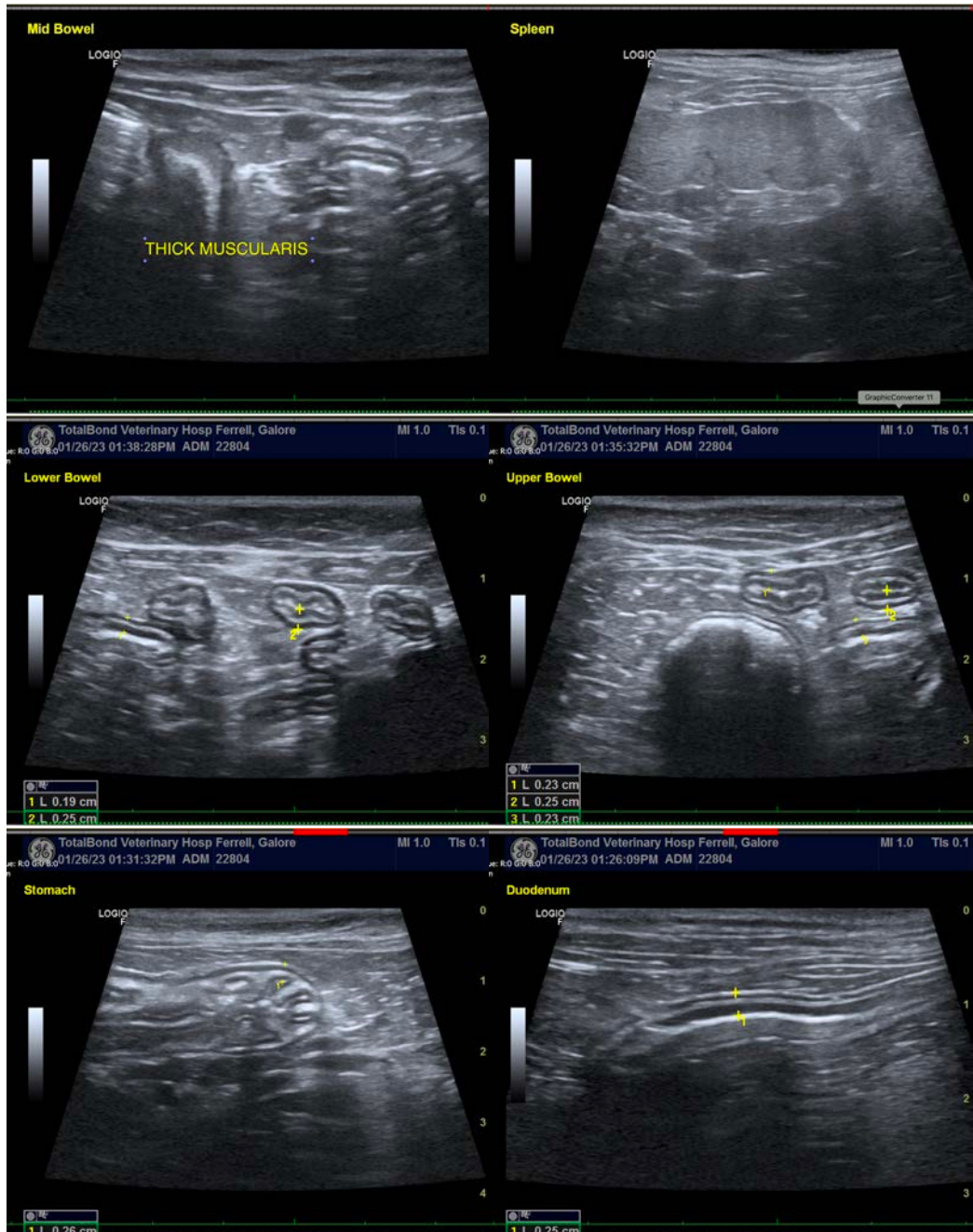
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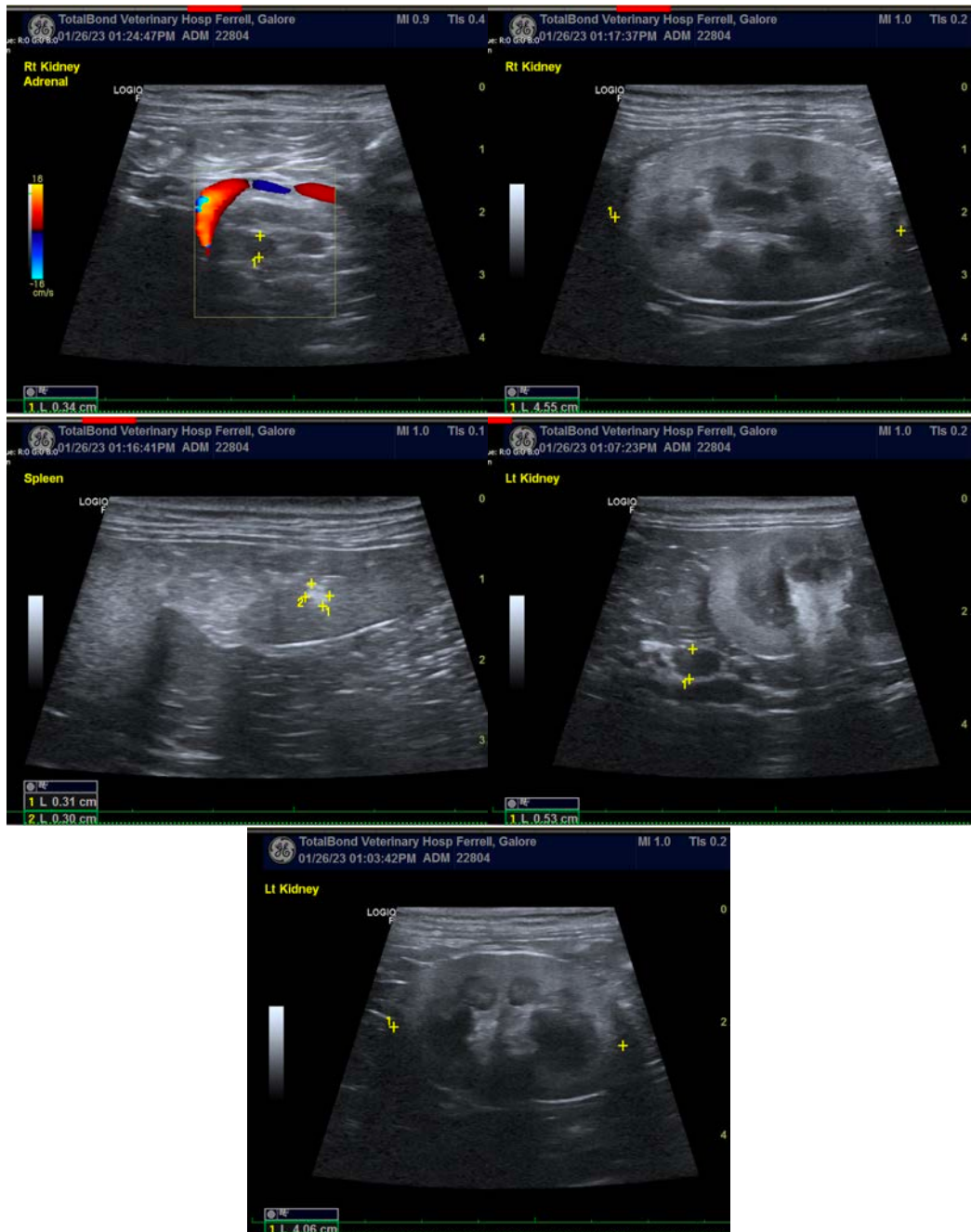
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
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