

**PATIENT**

Ringo Mance

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

9 Years

WEIGHT

7.19 Pounds

INTERPRETED BYBeth Johnson, DVM
DACVIM**IMAGING PERFORMED BY**

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VETUnion Lake VH - Dr.
Marti Notarius**INVOICE**

44042

DATE

1/6/23

PRESENTING CLINICAL SIGNS

Went to OVRS 12/29/22 for being lethargic, anorexic and vomiting. After x-ray, they found that there is a mid-abdominal mass present which is likely intestinal origin. At the center of this mass is a ground glass appearance and possible calcification. There is also early or partial obstruction suspected.

Abnormal PE/Chem/CBC/UA Results: Pain could be a 1 Abd-snp to maybe slight reaction, there is a mod sized mass and thick intestines caudal right mid abdomen. -Thin. HX elevated wbc and anemis (mild). **Please see attached report and labs

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal in size (4.45 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal in size (4.06 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (0.60 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 with normal smooth margins. Parenchyma is normal in echogenicity with a coarse/heterogenous echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged (swollen contour). Mild parenchymal remodeling with diffusely mildly coarse architecture and increased portal markings is present. No focal nodules or masses are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as mild to moderate suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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.

Pancreas**BREED**

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Pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. Pancreatic duct dilation is noted.

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Free Abdomen

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

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Mesenteric lymph nodes are enlarged with swollen irregular capsular contour and loss of normal length to width ratio (rounded in shape). Nodes are hypoechoic with loss of normal parenchymal detail.

Round hypoechoic cranial abdominal/pancreaticoduodenal lymph nodes are also noted.

PRIMARY FINDINGS**WEIGHT**

7.19 Pounds

- **Coarse splenomegaly** – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

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- **Aggressive mesenteric lymph nodes** – most consistent with infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.

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- **Cranial abdominal lymphadenopathy** – also concerning for infiltrative neoplasia. A benign reactive lymphadenopathy can't be ruled out but is considered less likely.

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- **Hypoechoic hepatomegaly** – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.

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- **Gastrointestinal lymphoma (suspect) pattern** – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. Given the concurrent pathology noted, infiltrative neoplasia is considered more likely, but benign IBD cannot be ruled out without tissue sampling.

SECONDARY FINDINGS**INVOICE**

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- Urinary bladder debris
- Chronic active pancreatitis

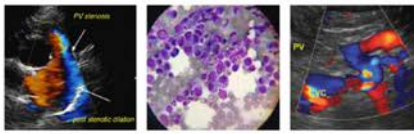
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- **Mild to moderate gallbladder debris** - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness, however, it can also be associated with hepatobiliary disease in cats and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

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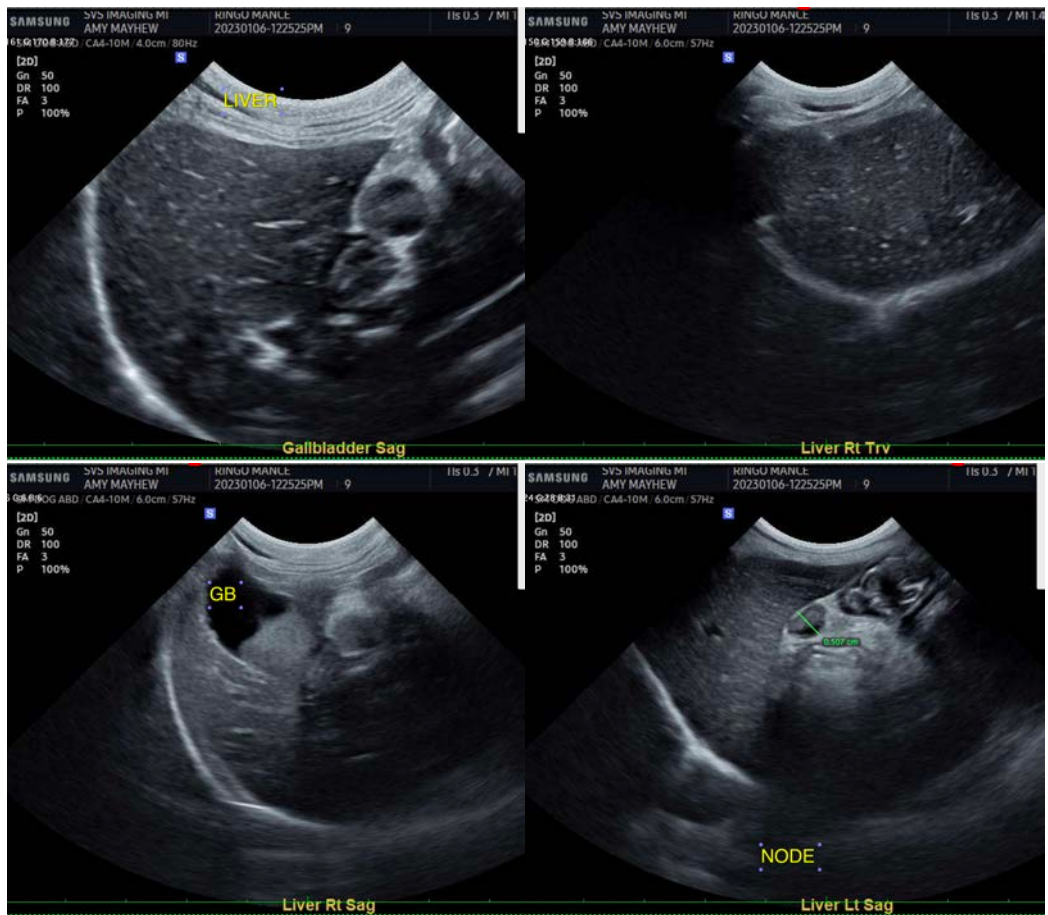
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

As is reportedly already pending, fine needle aspirate of the mesenteric lymph nodes +/- the spleen and/or liver 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.

If a diagnosis is not obtained cytologically, ideally biopsies of the GI tract, being sure to include ileum, if possible, as well as the enlarged lymph nodes, etc. may be required to definitively diagnose and therefore manage the suspected infiltrative bowel disease.

Given the marked reported eosinophilia, a benign hypereosinophilic syndrome is possible versus infiltrative neoplasia. Regardless, while awaiting results, empirical deworming with a 5-day course of Panacur is recommended, as is, if tolerated, transition to a hydrolyzed protein diet in addition to supportive/symptomatic management of clinical signs.



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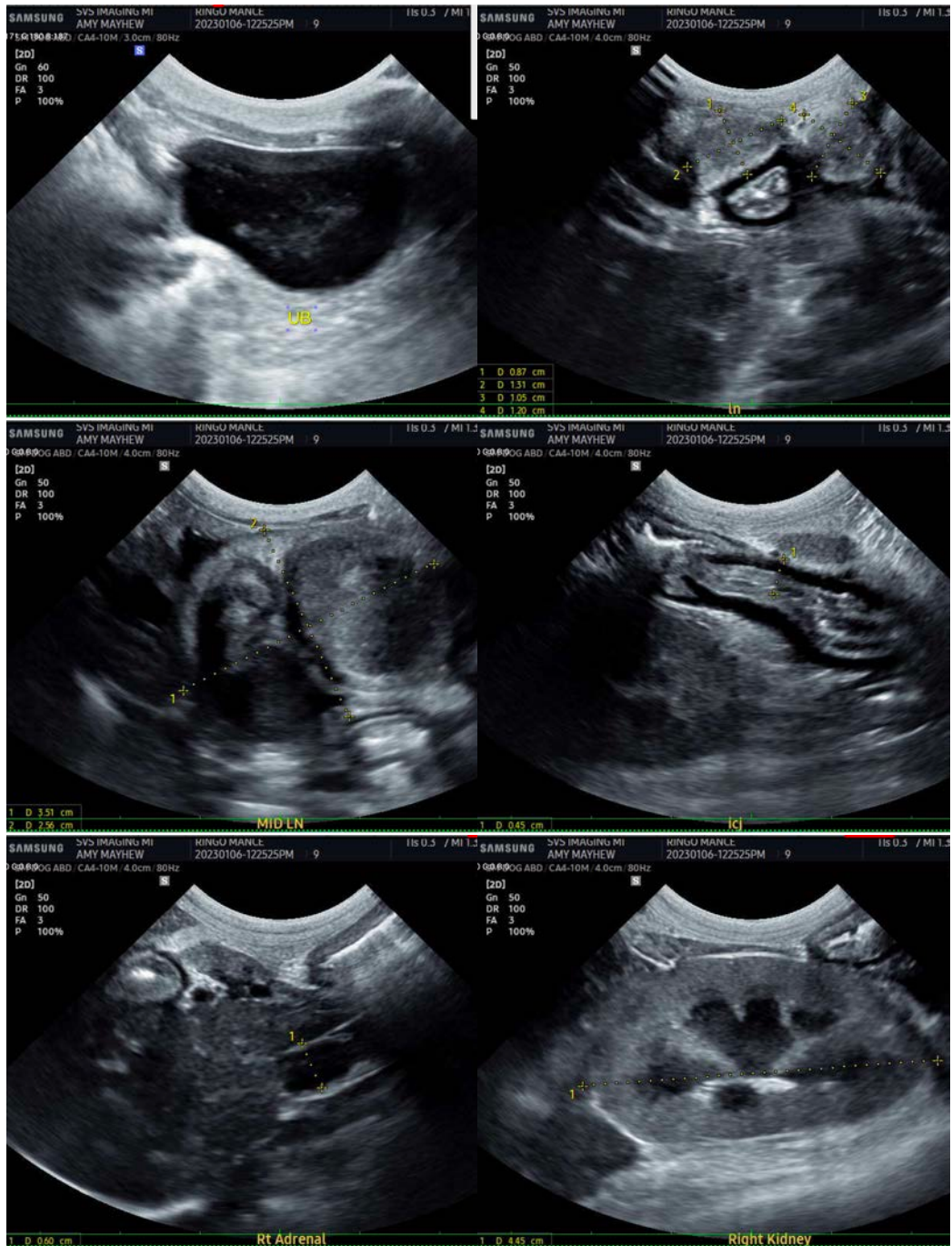
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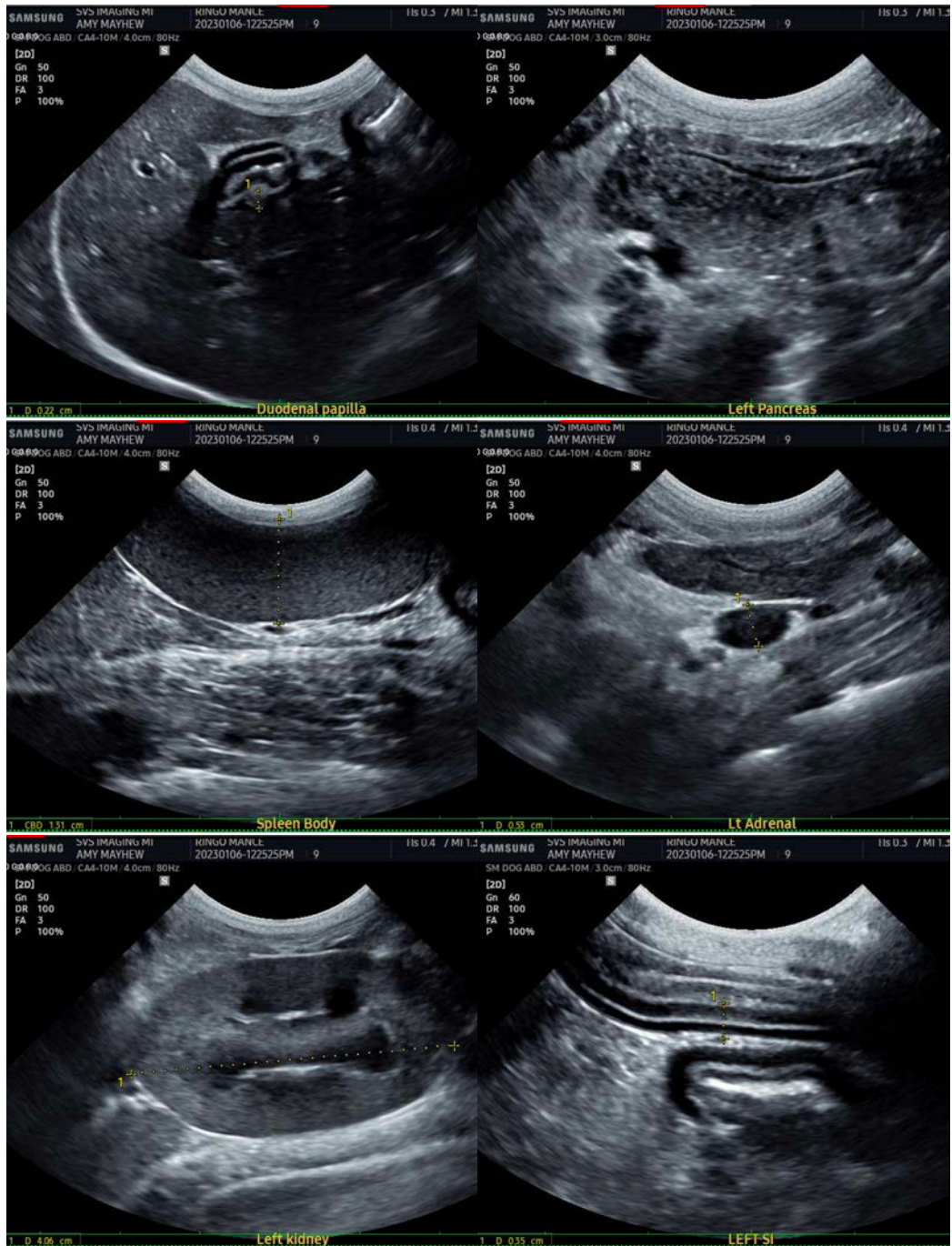
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
Beth.Johnson@sonopath.com