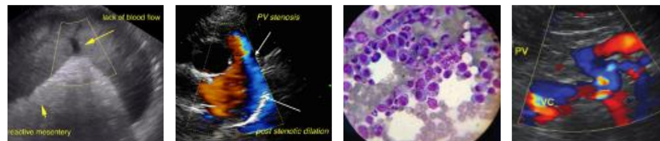


SonoPath.com™
1-800-838-4268 info@sonopath.com

PATIENT

Simon Somero

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

15.5 Years

WEIGHT

6.93 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VET

Famly Pet Practice

INVOICE

17807

DATE

10/18/22

PRESENTING CLINICAL SIGNS

History: Current Medications: Prednisolone 5mg 1/2 tab PO BID Methimazole 2.5mg 1 tab PO BID Cosequin 1 cap PO SID Patient History: P was seen at OVRS 6/25/21 AUS was done. Summery: 1. Hepatomegaly, hepatopathy, and severe hepatic lymphadenopathy. This is compatible in appearance with round cell neoplasia, unlikely to represent a benign etiology, with feline infectious peritonitis less likely. 2. Diffuse splenopathy, also likely infiltrative neoplasia. 3. Diffuse infiltrative enteropathy, also compatible in appearance with round cell neoplasia, less likely to represent inflammatory bowel disease. 4. Mild bilateral chronic renal degenerative disease. Ultrasound performed by Dr. Rachel Smith, DACVR Since the AUS the P has had decreased mobility, changes with medications, weight loss (within the last month 1lb down (9/22/22) lowest weight 6.93lbs. Overall muscle wasting evident throughout, loss of appetite. We have been monitoring for anemia, renal values, T4 levels. P has a Hyperthyroid, suspect Lymphoma again. P has show further concerns since 10/16/22. Only eating about 25% daily food. Rear end weakness, P seems unstable getting around, Occ dragging the RR leg. P has been hiding more often, not as social. No noticed use of the litter box.

Abnormal Examination Findings: Overall, weaker, more lethargic than normal. Lt pk mucus membranes. Marked weight loss, muscle wasting over hindend - down 1lb in 3 weeks. Mild abdominal sensitivity, but no distended/round abdomen noted. Able to stand, but ataxic in hindend, keeping a hunched/squatting appearance. Have prev discussed suspected OA, but now concern that acute weakness is associated with worsening anemia. Palpable pulses in both hindlimbs, feet slightly cooler to touch, but overall, normothermic. Have discussed declining QOL with Owner and progressive disease, guarded px

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.

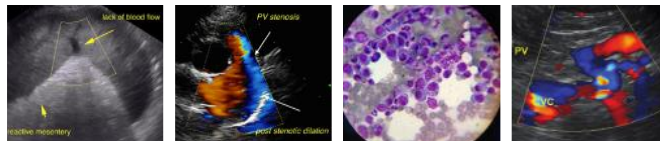
Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. The left kidney measured 3.8 cm. The right kidney measured 3.55 cm.

Adrenal Glands

The area of both adrenal glands is examined without evident pathology.

Spleen

Spleen is subjectively large in size with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a mildly coarse/heterogenous echotexture. Multifocal well demarcated hyperechoic homogenous nodules are noted. Enhanced hyperechoic mesenteric fat is noted surrounding the spleen. Splenic vasculature appears normal.



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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.

The gallbladder is visible but small, not distended, resulting in a slightly thick irregular hyperechoic appearing wall. This is likely a normal patient variant given the recent gallbladder contraction, however, chronic or historical results, cholangitis can't be ruled out.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty, except for a small amount of echogenic fluid/chyme within the pyloric antrum. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

Pancreas

Pancreas is prominent in size with swollen irregular contour. Parenchyma is heterogenous characterized by hyperechoic tissue remodeling intermixed with ill-defined hypoechoic nodules. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no apparent lymphadenopathy. There is a scant amount of anechoic free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

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

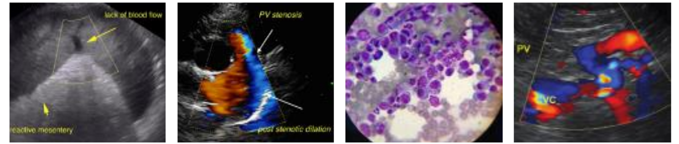
- Scalloped spleen– can be associated with benign or malignant infiltrative disease. Common causes include a reactive spleen secondary to immune stimulus or early infiltrative round cell neoplasia such as lymphoma or mast cell tumor.

  *Hyperechoic splenic nodules- most consistent with benign myelolipomas, however fibrosis or calcification of old hematomas or infarcts, granulomatous disease or even infiltrative neoplastic disease cannot be ruled out.

- Pancreatic nodular hyperplasia – Infiltrative neoplasia cannot be ruled out but is considered less likely. Chronic smoldering pancreatitis is also suspected.

Secondary Findings

- Age-related kidney changes



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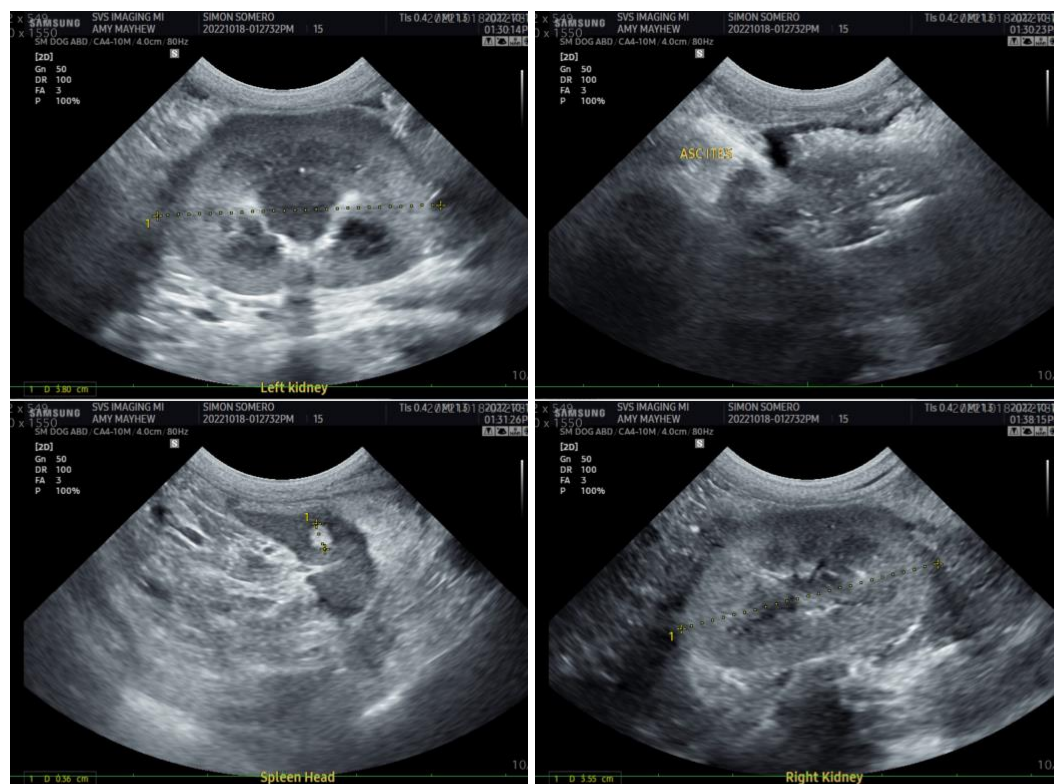
- Urinary bladder debris

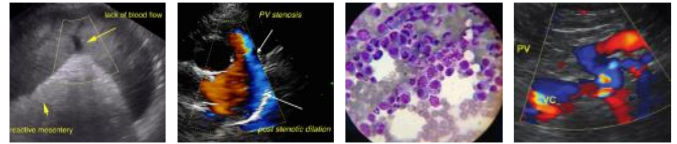
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The described hepatic and splenic pathology may be related to the previously suspected/diagnosed lymphoma. The lack of bowel changes or lymphadenopathy seen previously is likely due to steroid administration. A fine needle aspirate of the spleen and liver could be considered if patients coagulation status is appropriate. Additionally, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory for further evaluation of GI and pancreatic function, could be considered to see if additional cobalamin supplementation., may be warranted.

Urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

Ultimately, however, this patients disease progression and pelvic limb weakness/ataxia is likely secondary to either the progressive anemia or potentially infiltrative of the suspected lymphoma into the nervous system. If elected to pursue, a blood transfusion may help improve patients strength and if a diagnosis of lymphoma has been obtained, additional chemotherapies could be initiated on top of he Prednisone.





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The information and recommendations provided are based on the images presented by the referring veterinarian. 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