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Clinical Sonography & Telecytology

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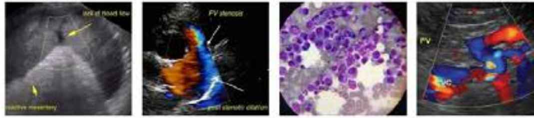


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Percy Chernava

SPECIES

Feline

BREED

Scottish Fold

SEX

Neutered Male

AGE

2 Years

WEIGHT

6.6 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Sierra Animal Wellness

REFERRING VET

Dr. Peggy Roberts

INVOICE

42214

DATE

10/19/22

PRESENTING CLINICAL SIGNS

Weight loss, decreased appetite, mid abdominal mass. Blood work: HCT 27% WBC 16,000 neutrophilia. Elevated total protein and globulin with A/G No ascites or pleural effusion. No ocular or neuro signs.

Abnormal PE/Chem/CBC/UA Results: Temp 104- No sedation

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 (3.0 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 (3.64 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.

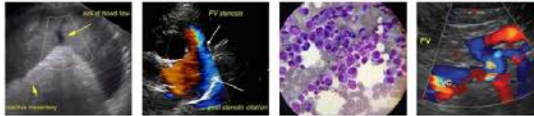
Adrenal Glands
The right adrenal gland is normal in size (0.57 cm at the cranial pole and 0.53 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.52 cm thick), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

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. No focal nodules or masses are observed. Splenic vasculature appears normal.

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.



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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.

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.

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

Pancreas

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.

Overlying or adjacent to the left limb of the pancreas, there is an approximately 1.0 cm round, hypoechoic structure that I believe is an enlarged lymph node. However, a pancreatic nodule cannot be definitively ruled out.

Free Abdomen

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

The pancreaticoduodenal lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

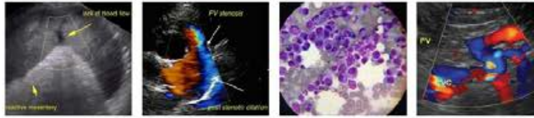
In the mid abdomen, an approximately 4.0 cm sized hypoechoic mass is noted that is mesenteric lymph nodes in origin.

PRIMARY FINDINGS

- **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. The nodule described above in the area of the left pancreas is also believed to be a lymph node. However, pancreatic nodule cannot be definitively ruled out.

- **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.

- **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.



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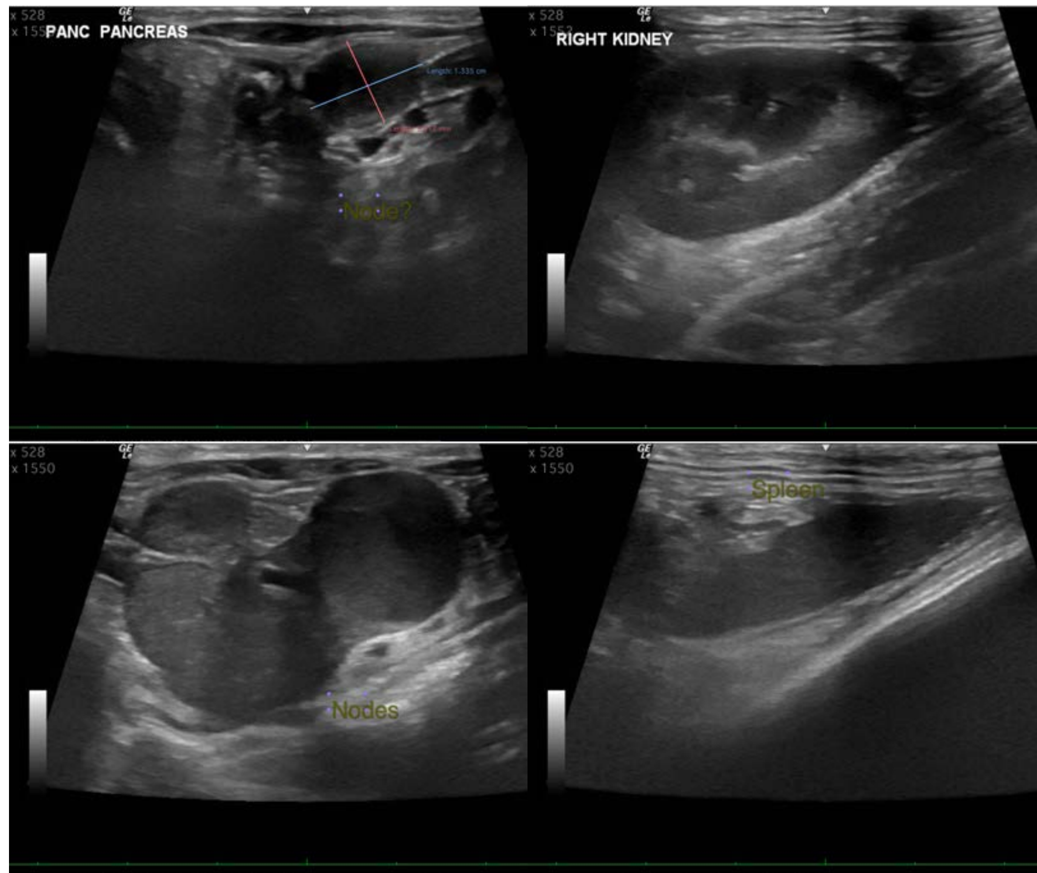
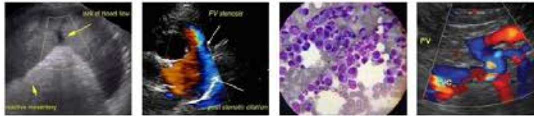
SECONDARY FINDINGS

- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The top differential for this patient's described pathology combined with the clinical pathologic history, fever, etc. is an infectious disease such as FIP or lymphoma. Other differentials are possible, but those are the top two. Recommendations include a fine needle aspirate of the enlarged lymph nodes +/- spleen, if patient's coagulation status is appropriate, with submission of samples for cytology. If the index of suspicion for FIP is high, for example the albumin to globulin ratio is <0.6, and/or the lymph node cytology is not diagnostic for lymphoma, then additional submission of the fine needle aspirate to Auburn for FIP PCR could be considered.





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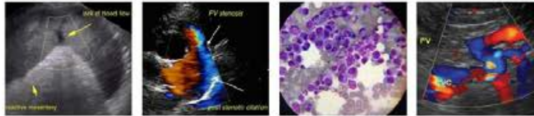

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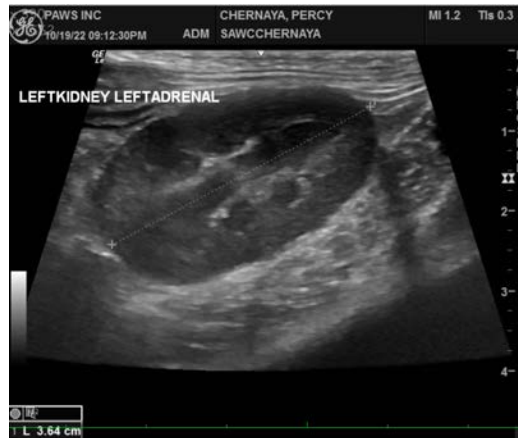

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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