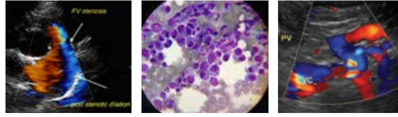

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DATE

11/10/22

PATIENT

Henry Jang

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

9/14/20

WEIGHT

10 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Stephanie Warga
RDCS, RVT

HOSPITAL NAME

Alexander AH

REFERRING VET

Dr. Alexander

INVOICE

42714

PRESENTING CLINICAL SIGNS

Peripheral lymphadenopathy on 10/25/22. T 103.2, FelV/FIV negative, BW- Globs 7.8, rest WNLs. Feline Flea/Tick Borne PCR- al negative. Pt started on Doxycycline 100mg/mL 1/2mL BID x10 days. Recheck on 11/9/22 with persistent sig enlarged peripheral LNs w/ pt now lethargic, <appetite, occasional open mouth breathing.

Current Medications: 10/26/22 Doxycycline 100mg/mL 1/2mL BID x10 days. 11/9/22 Convenia 0.45mL SQ, Prednisolone 15mg/5mL ½ mL BID.
Lab Results: See attached.
Radiographs: See attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

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 (4.37 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 (4.16 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 (0.34 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.50 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

Spleen is generally normal in size and shape with a smooth capsular contour. Parenchyma is diffusely nodular in appearance characterized by small discrete hypoechoic nodules. 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.

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 intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). 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 (< 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.

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

Sublumbar lymph nodes are prominent, hypoechoic/slightly heterogeneous in appearance, measuring approximately 1.0 cm thick x 2.5 cm long.

Mild mesenteric lymphadenopathy is also noted.

PRIMARY FINDINGS

- **Splenic micronodular hyperplasia pattern –** This nodular change is often associated with benign aging nodular hyperplasia. Infiltrative neoplasia, however, including both early hemangiosarcoma as well as round cell neoplasia cannot be ruled out. Given the young age of this patient, this finding is more concerning for infiltrative disease with both neoplasia or infectious disease such as FIP being differentials.

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

SECONDARY FINDINGS

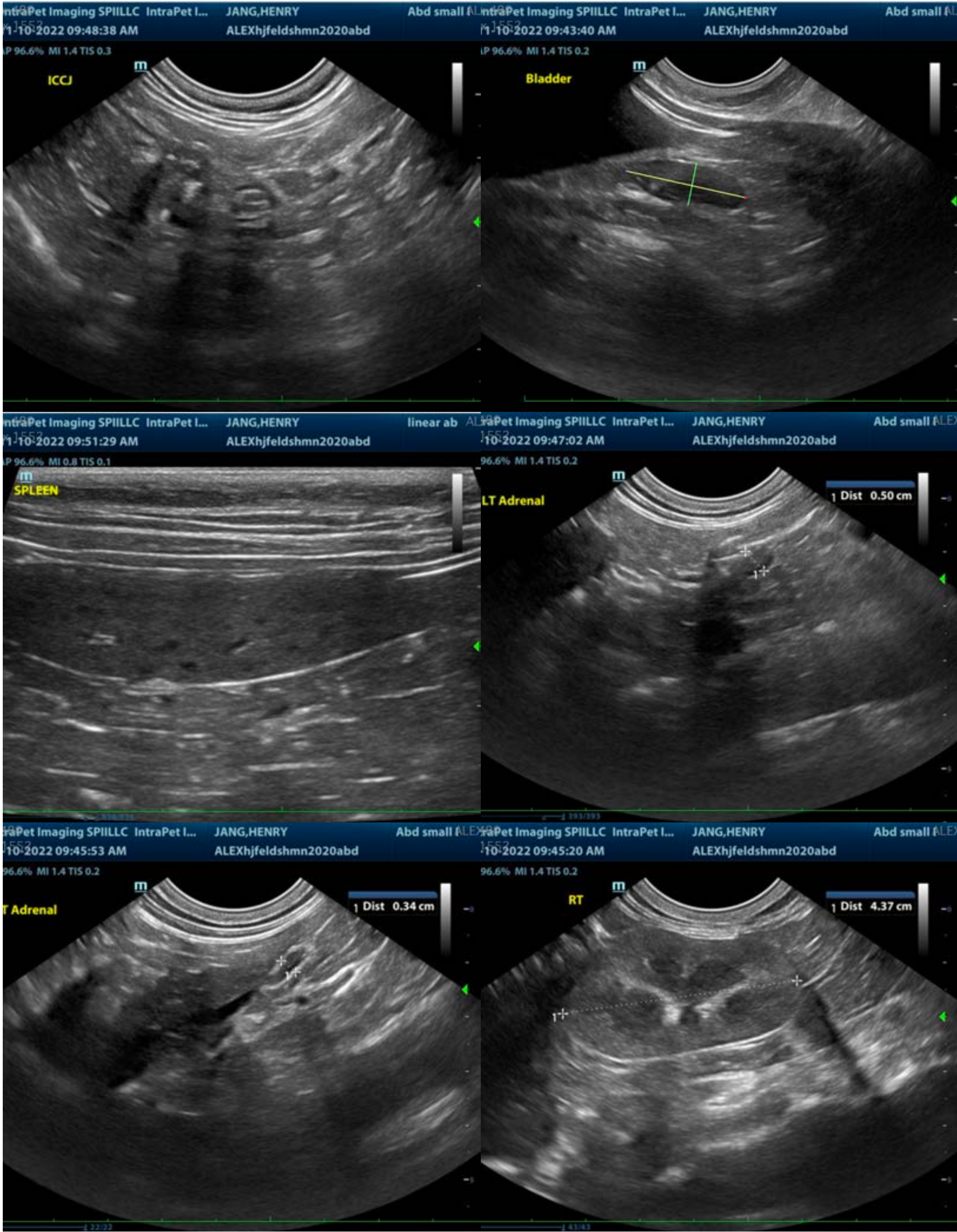
- Urinary bladder debris

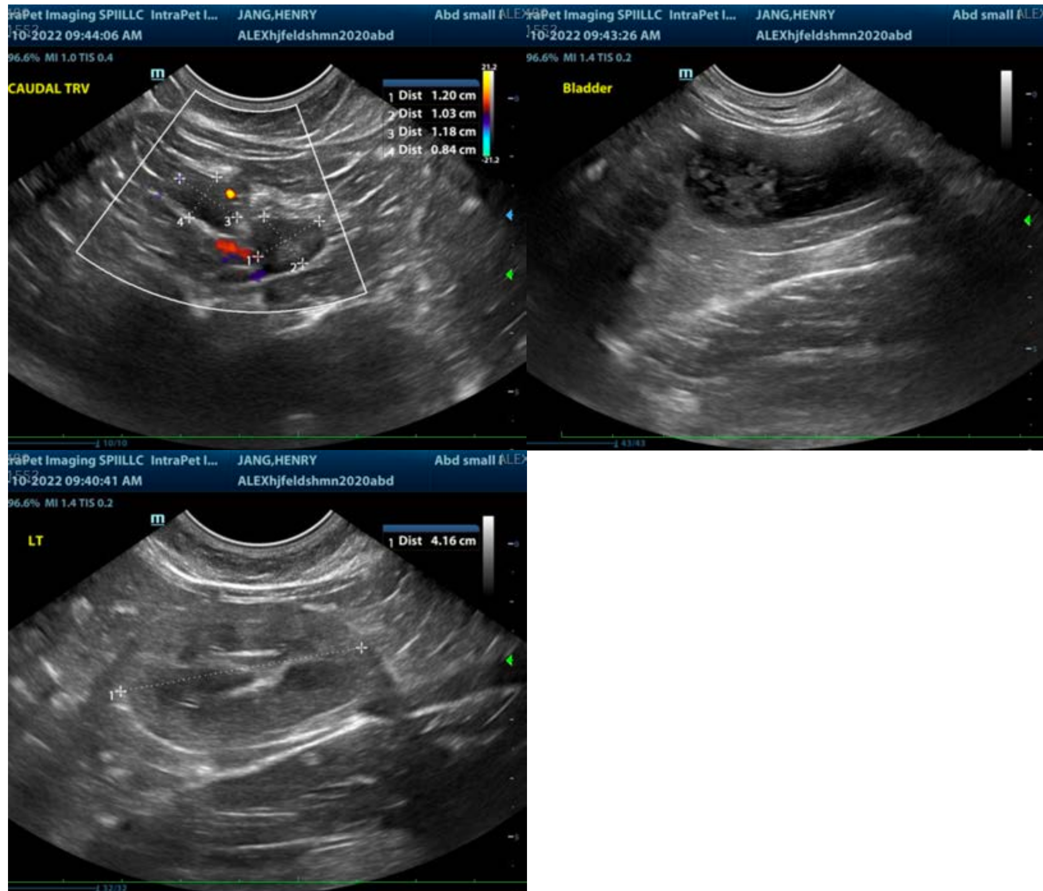
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patient’s reported hyperglobulinemia, generalized lymphadenopathy, splenic changes, etc., top differentials include infiltrative neoplasia such as lymphoma, or infectious disease with FIP being a top differential. Given the reported peripheral lymph node cytology results not diagnostic for lymphoma, FIP becomes a higher differential.

Recommendations include a fine needle aspirate of the spleen if patient’s coagulation status is appropriate to further evaluate possible lymphoma, and if not diagnostic for lymphoma, then submission of fine needle aspirate obtained samples of spleen and lymph node to Auburn for PCR recommended for further evaluation of FIP. If necessary, contact the lab directly for best tissue handling/submission recommendations.

If not recently evaluated, 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.





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