

PATIENT PRESENTING CLINICAL SIGNS

Ghosty Lobiondo

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

14 Years

WEIGHT

7.67 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

Vetco Total Health
South Salem

REFERRING VET

Dr. Joynt

INVOICE

42550

DATE

11/3/22

no sensitivity to palpation. loops of bowel seem a bit thick/ropey. mass (approx 3 cm, semifirm, irregular, mobile) noted ventral abdomen just cranial to bladder. mass is distinct from kidneys. can palpate stool in colon that seems distinct from mass. abd rads; overall good serosal detail. mod amt of food in stomach w/ no distention. loops of bowel appear thickened/edematous w/ mild amt of gas, no distention and no obvious peristalsis. formed feces in colon. on rt lateral possible subtle soft tissue density ventral (mid in regards to cranial/caudal), density not seen on lt lateral. Current Medications Mirtazapine Transdermal Primary Question/Differential to Be Answered in This Exam picky eater last 3 yrs. last few mo losing wt and not eating much at all. appetite much better in last wk when on mirtazepene. loops of bowel feel thickened, ropey. low ca and albumin. suspicious of IBD. ddx alimentary lymphoma.

Abnormal PE/Chem/CBC/UA Results: Eosinophils 2.659 K/ μ L Glucose 54 mg/dL IDEXX SDMA 16 μ g/dL Calcium 7.7 mg/dL Potassium 5.7 mmol/L Na: K Ratio 26 29 - 42 Total Protein 5.4 g/dL Albumin 1.9 g/dL ALT 20 U/L Creatine Kinase 492 U/L

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 right kidney measures 3.76 cm. The left kidney measures 3.6 cm.

Adrenal Glands

The right adrenal gland is normal in size (1.0 cm long x 0.51 cm thick), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.67 cm long x 0.46 cm thick), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). 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.



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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

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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 markedly 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

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 lymphadenopathy is noted. The lymph nodes maintain an elongated shape with a hypoechoic, prominent appearance.

PRIMARY FINDINGS

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- **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.
- Chronic active pancreatitis
- **Mesenteric lymphadenopathy** – Both reactive lymphadenopathy as well as infiltrative neoplasia such as lymphoma are differentials and cannot be differentiated without tissue sampling.

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SECONDARY FINDINGS

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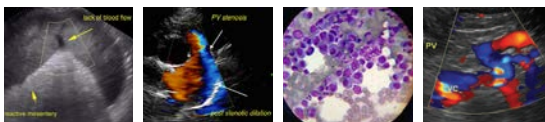
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- Urinary bladder debris
- Age related kidney changes

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**A discrete mass was not visible. However, given the thick bowel and lymphadenopathy, either of those abnormalities could potentially have been what was palpated as the reported mass.



PATIENT **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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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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Tissue sampling is recommended, beginning with a fine needle aspirate of the enlarged mesenteric lymph nodes if possible and if patient's coagulation status is appropriate, and if a diagnosis is not obtained cytologically, then ultimately biopsies of the GI tract are recommended to definitively diagnose and therefore manage the infiltrative bowel disease.

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While hypoadrenocorticism is very rare in cats and unlikely given the plump appearance of this patient's adrenal glands, given the history of gastrointestinal signs combined with an eosinophilia, hypoglycemia, hypoalbuminemia, and hyperkalemia, etc., ruling out hypoadrenocorticism is recommended in the form of an ACTH stimulation test.

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In the meantime, empirical deworming with a 5-day course of Panacur is recommended, as is a diet change to a hydrolyzed protein diet on a trial and error basis, as some patients don't respond to one brand of hydrolyzed protein diet and do respond to another. Cobalamin supplementation is also recommended, unless not indicated based on gastrointestinal panel results, as well as a probiotic such as Visbiome or Provable. Additionally, an ionized calcium level is recommended with calcium supplementation recommended if necessary based on that result.

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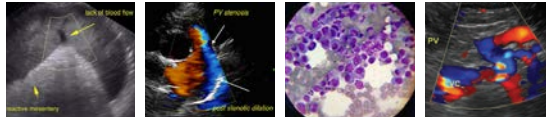
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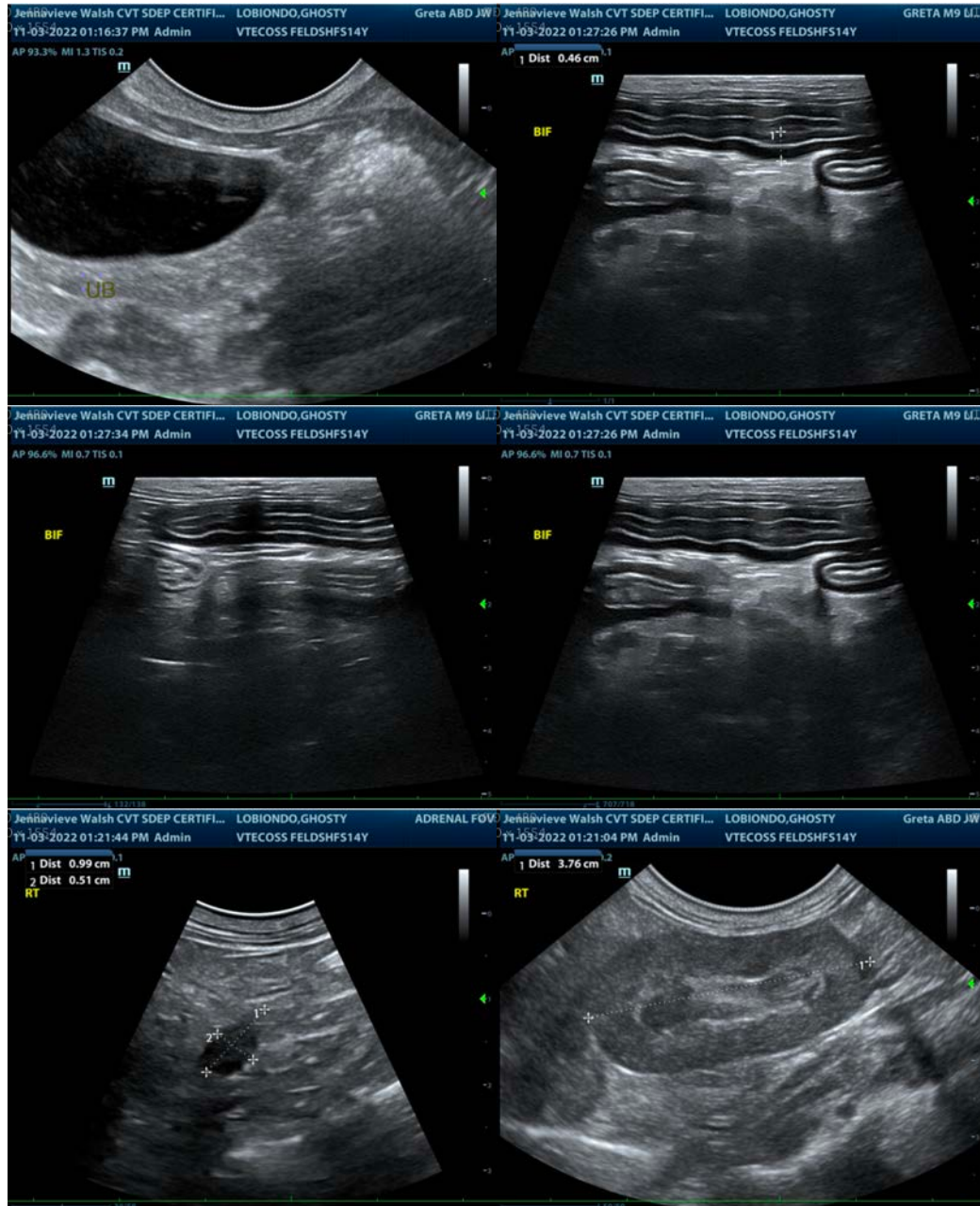
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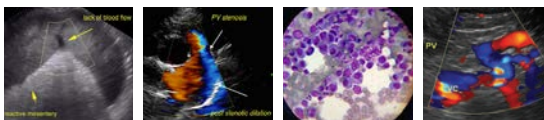
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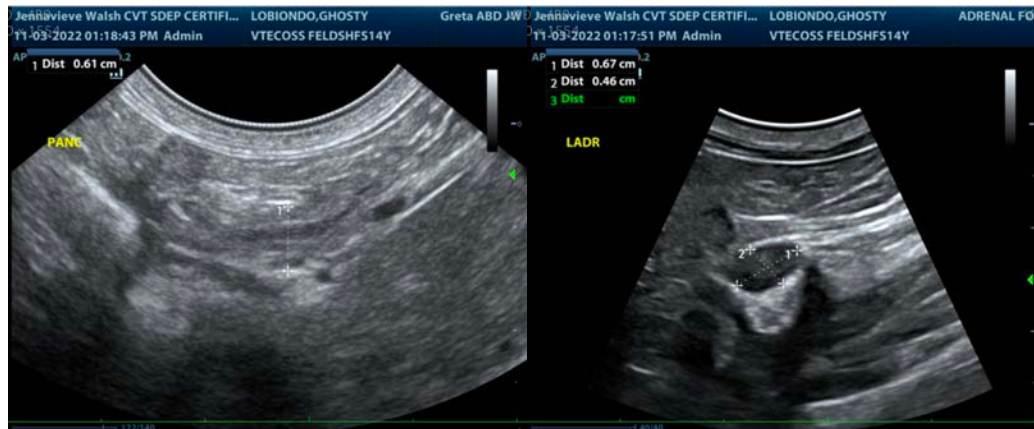
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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