



PATIENT

Katie Kubiak

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

8 Years

WEIGHT

12.9 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging Michigan

REFERRING VET

Rochester VH

INVOICE

20211

DATE

12/19/22

PRESENTING CLINICAL SIGNS

History: Anorexia and constipation

Abnormal PE/Chem/CBC/UA Results: Please see attached.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal is size (3.86 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.

Right kidney is normal is size (4.05 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

Left adrenal gland is normal in size (0.34 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.34 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

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

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.

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

Diffusely, the visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty, except for focally, in the area of the pyloric antrum, there is a 2.3 thick by approximately 5.0 cm long intramural hypo- to anechoic structure that appears to be at least partially fluid filled.

The visible small intestine demonstrates areas of mildly 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 of the small intestine is empty with no evidence of obstruction or foreign material.



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

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Pancreas

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The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

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Free Abdomen

There is no evidence of peritoneal effusion.

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The mesenteric 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. Cranial abdominal lymphadenopathy in the area of the pyloric duodenal junction.

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ULTRASONOGRAPHIC FINDINGS

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- Intramural gastric lesion, that appears at least partially fluid filled. Differentials include an intramural abscess or hematoma or potentially infiltrative neoplasia with an abscessed or necrotic component versus other. Lymphadenopathy in the area could suggest reactive lymphadenopathy or metastatic lymphadenopathy and cannot be differentiated without tissue sampling.

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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.

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- Reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

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DACVIM

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

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A fine needle aspirate of the gastric lesion is recommended if patients coagulation status is appropriate, as well as cytology, as well as culture and sensitivity.

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Given the mild bowel changes described above, as well as the reportedly low folate and low/normal cobalamin, additional small bowel malabsorptive disease is also suspected, therefore, alternatively, an exploratory laparotomy could be planned for full thickness GI biopsies, as well as further explore +/- removal of the gastric lesion. However, given the location, full surgical resection can't be guaranteed.

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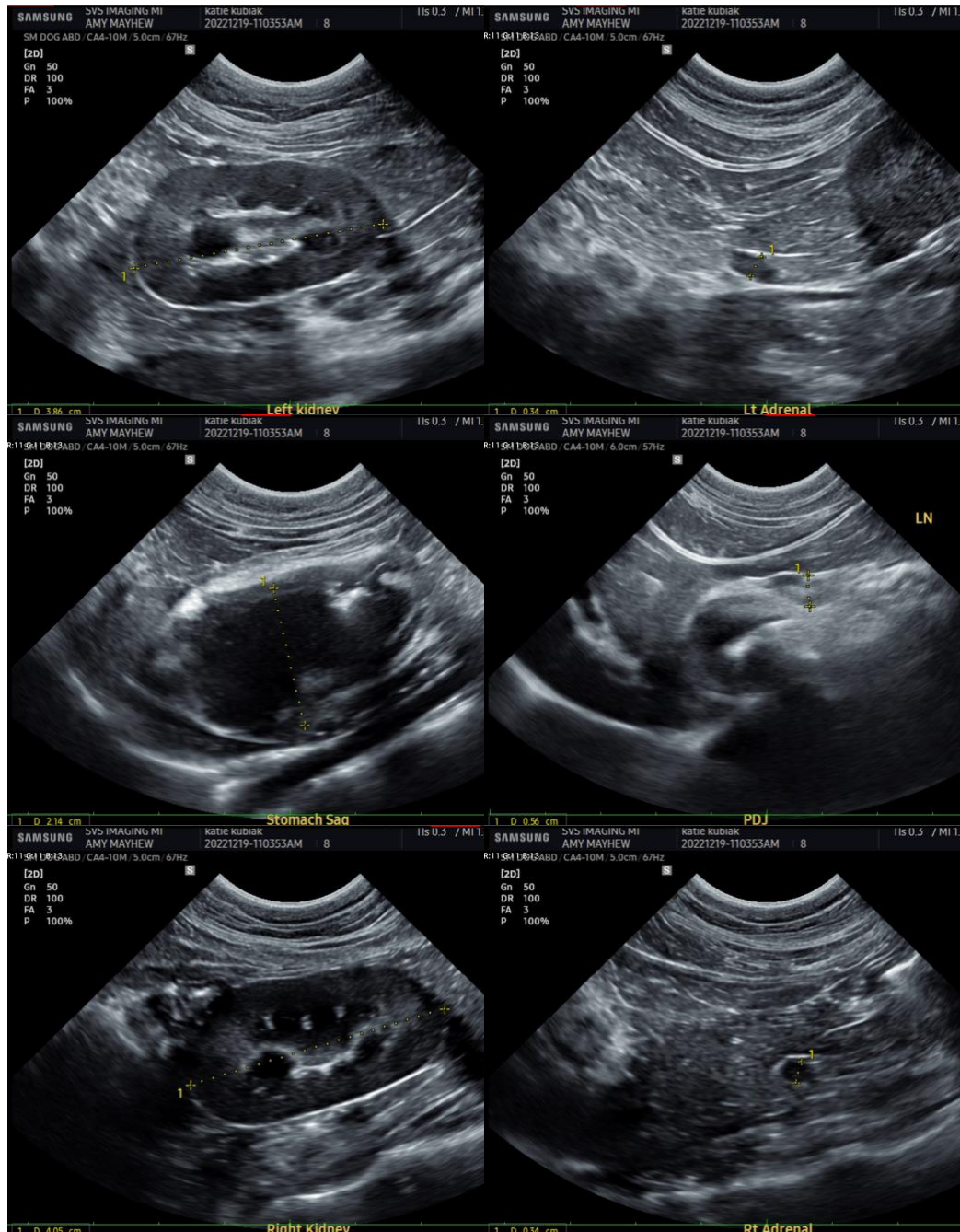
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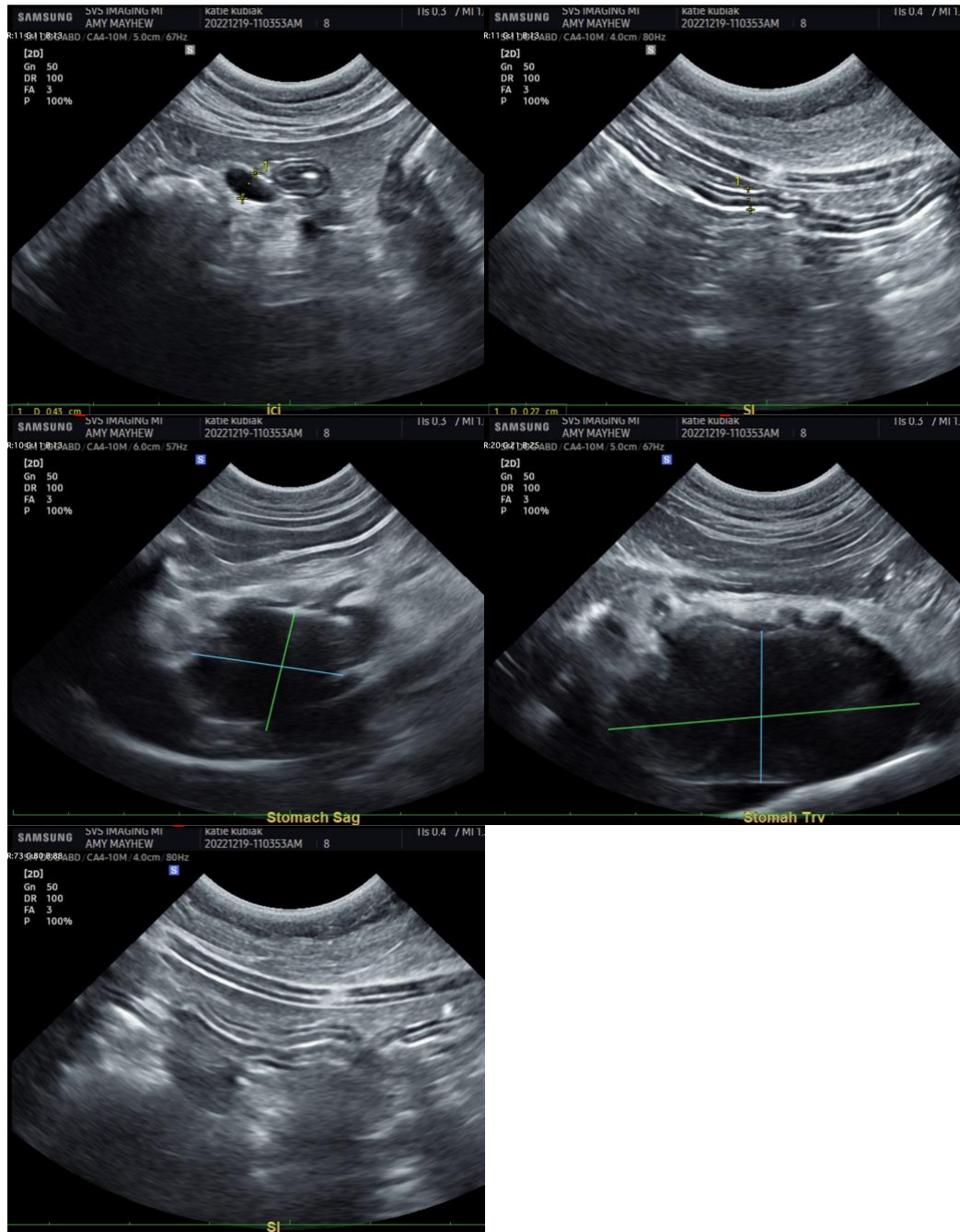
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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



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Beth.Johnson@SonoPath.com

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