



PATIENT

Martha Dillard

SPECIES

Feline

BREED

SEX

Spayed Female

AGE

12

WEIGHT

7.12

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Adrienne Waffle

HOSPITAL NAME

Torch Lake VC

REFERRING VET

Dr. Karen Reabe

INVOICE

45868

DATE

3/14/23

PRESENTING CLINICAL SIGNS

P presented with a suspected abdominal mass. Radiographs are unclear. P is vomiting and has a decreased appetite.

Abnormal PE/Chem/CBC/UA Results: Elevated WBC

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 (3.39 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 (3.31 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 area of the right adrenal gland is examined without evident adrenal gland pathology.

The left adrenal gland is normal in size (0.39 cm), 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.

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 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



PATIENT	hyperechoic. In the caudal abdomen, there are several small bowel loops that are mildly thicker and do exhibit loss of mural detail. The lumen is empty with no evidence of obstruction or foreign material.
Martha Dillard	
SPECIES	The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.
Feline	Pancreas
BREED	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.
SEX	Free Abdomen
Spayed Female	There is no evidence of free peritoneal effusion noted in these images.
AGE	There is no apparent lymphadenopathy noted in these images.
12	PRIMARY FINDINGS
WEIGHT	<ul style="list-style-type: none"> Gastrointestinal lymphoma (suspect) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. Given the concurrent pathology noted, infiltrative neoplasia is considered more likely, but benign IBD cannot be ruled out without tissue sampling.
7.12	SECONDARY FINDINGS
INTERPRETED BY	<ul style="list-style-type: none"> Urinary bladder debris
Beth Johnson, DVM DACVIM	INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS
IMAGING PERFORMED BY	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.
Adrienne Waffle	Ideally, biopsies of the GI tract, being sure to include ileum if possible, are recommended to definitively diagnose and therefore manage the infiltrative bowel disease.
HOSPITAL NAME	If biopsies cannot be obtained, empirical therapies could include diet change, empirical deworming with a 5 day course of Panacur, cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.). Other supportive therapeutic considerations could include fiber supplementation, especially with large bowel diarrhea and/or a probiotic.
Torch Lake VC	Additionally, if not recently evaluated, a 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.
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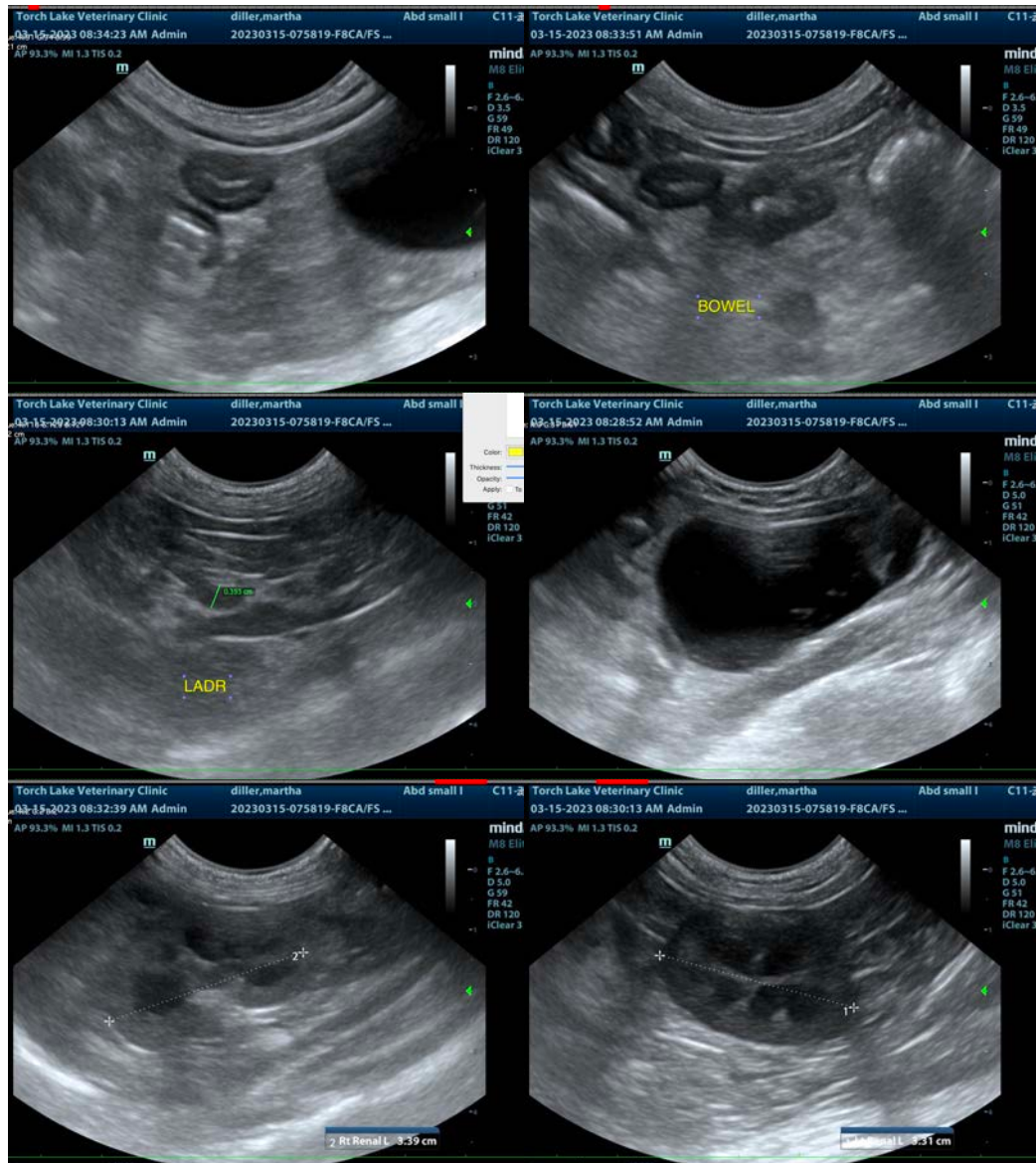
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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