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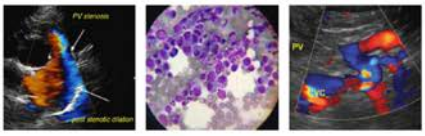

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PATIENT
Ramses Rodriguez

SPECIES
Feline

BREED
Sphynx

SEX
Neutered Male

AGE
5 Years

WEIGHT
8.6

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Amy Mayhew, LVT

HOSPITAL NAME
SVS Imaging MI

REFERRING VET
Dr. Taylor

INVOICE
46048

DATE
3/21/23

PRESENTING CLINICAL SIGNS

Presented today for decreased appetite, weight loss (0.5lb), vomiting, cloudy urine. Hx of vomiting episodes - started on Hill's sensitive stomach canned food and Biome dry end of Jan 2023. Doing well, eating well, no vomiting up until 2 weeks ago. O was gone for 10 days (returned 3-17-23) and he started eating less during that time. Vomited twice in the last 4 days. Lethargic, normal temp.

Abnormal PE/Chem/CBC/UA Results: Drew CBC/chem/T4/fPL today – pending. Impromptu abdominal ultrasound – he is not fasted (had only a little dry food at 10am). Exam overall unremarkable (no abdominal pain appreciated). UA – urine was a dark yellow – pH 8.0, USG > 1.050, 1+ cocci (<1 WBC/hpf, <1RBC/hpf), UBG 4mg/dL, Bil 1mg/dL** Urine culture pending. Hx of Restrictive Cardiomyopathy treated with pimobendan, plavix. Hx of FLAD/asthma – treated with Flovent and Albuterol inhalers.

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 normal in size with increased cortical echogenicity. Normal smooth peripheral margination and shape are maintained. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed. Infiltrative disease (infectious, neoplastic, etc.) or nephritis cannot be ruled out but is considered less likely. The left kidney measures 4.6 cm. The right kidney measures 4.6 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.33 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.35 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size (1.23 cm thick) with a swollen and scalloped/undulating 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.

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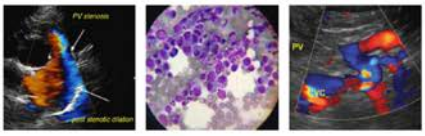

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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

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 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.

Free Abdomen

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

Diffusely, lymph nodes (including medial iliac lymph nodes, mesenteric lymph nodes, and cranial abdominal/pancreaticoduodenal) are enlarged with swollen irregular capsular contour and loss of normal length to width ratio (rounded in shape). Nodes are hypoechoic with loss of normal parenchymal detail.

PRIMARY FINDINGS

- The splenic changes are strongly suggestive of infiltrative disease such as round cell neoplasia. Benign disease can't be ruled out but is considered less likely.
- **Aggressive diffuse lymphadenopathy –** most consistent with infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.
- **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.

SECONDARY FINDINGS

- Urinary bladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

Tissue sampling is recommended to look for further evidence of infiltrative round cell disease such as lymphoma. A fine needle aspirate of the spleen as well as possibly enlarged lymph nodes could be considered if patient's coagulation status is appropriate.

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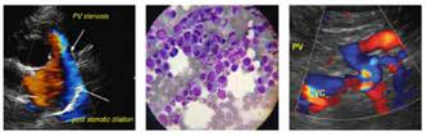

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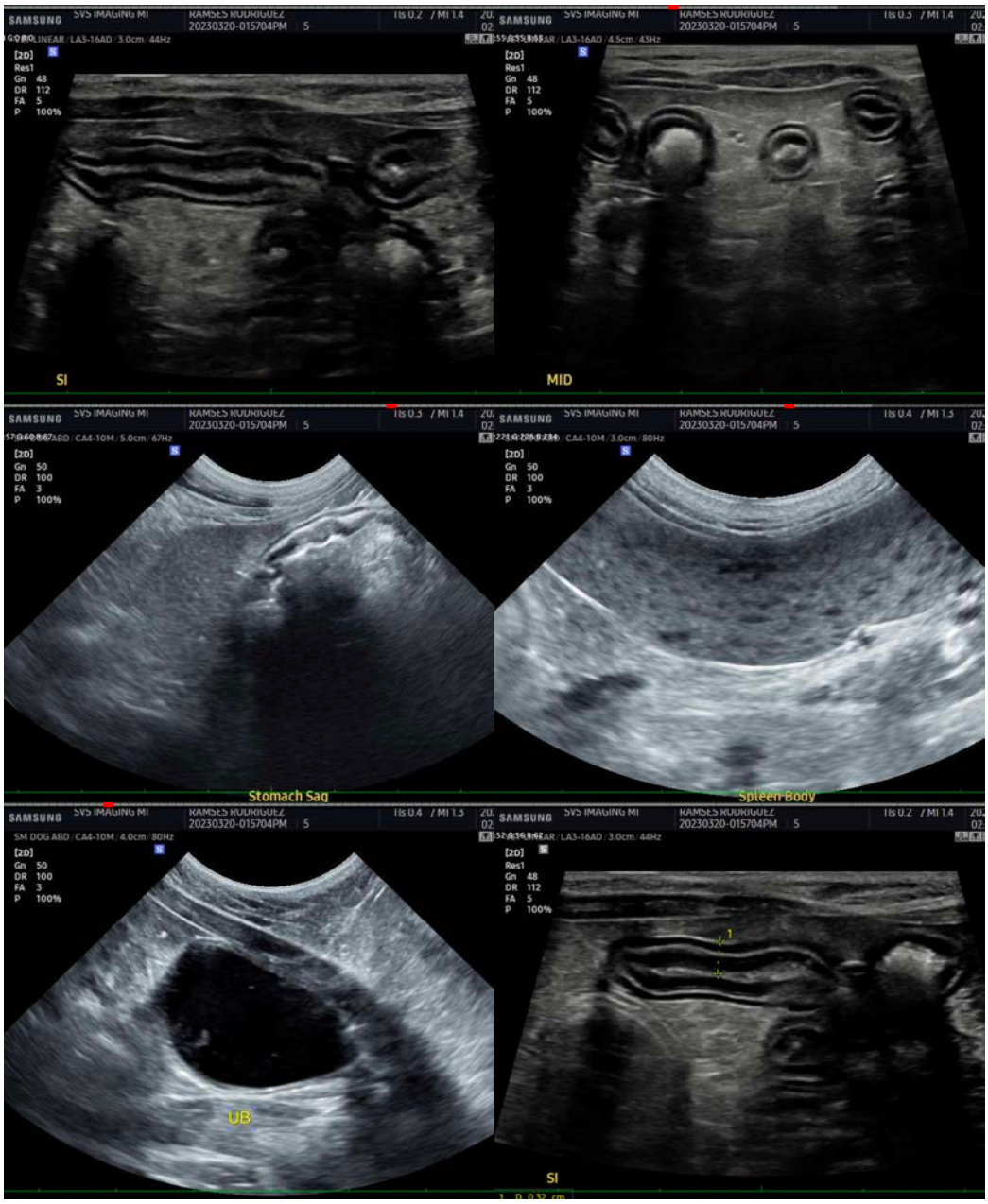
If a cytologic diagnosis is not obtained, ideally, biopsies of the GI tract, being sure to include ileum if possible, are recommended to definitively diagnose and therefore manage the infiltrative bowel disease.

If biopsies cannot be obtained, empirical therapies could include a probiotic (if diarrhea is present, such as visbiome or proviable), empirical deworming with a 5-day course of Panacur and, if tolerated, a transition in diet, based on trial-and-error response, beginning with a hydrolyzed protein diet. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several trials may be required.

Additional considerations could include cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.).



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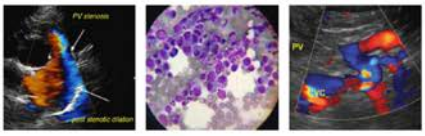

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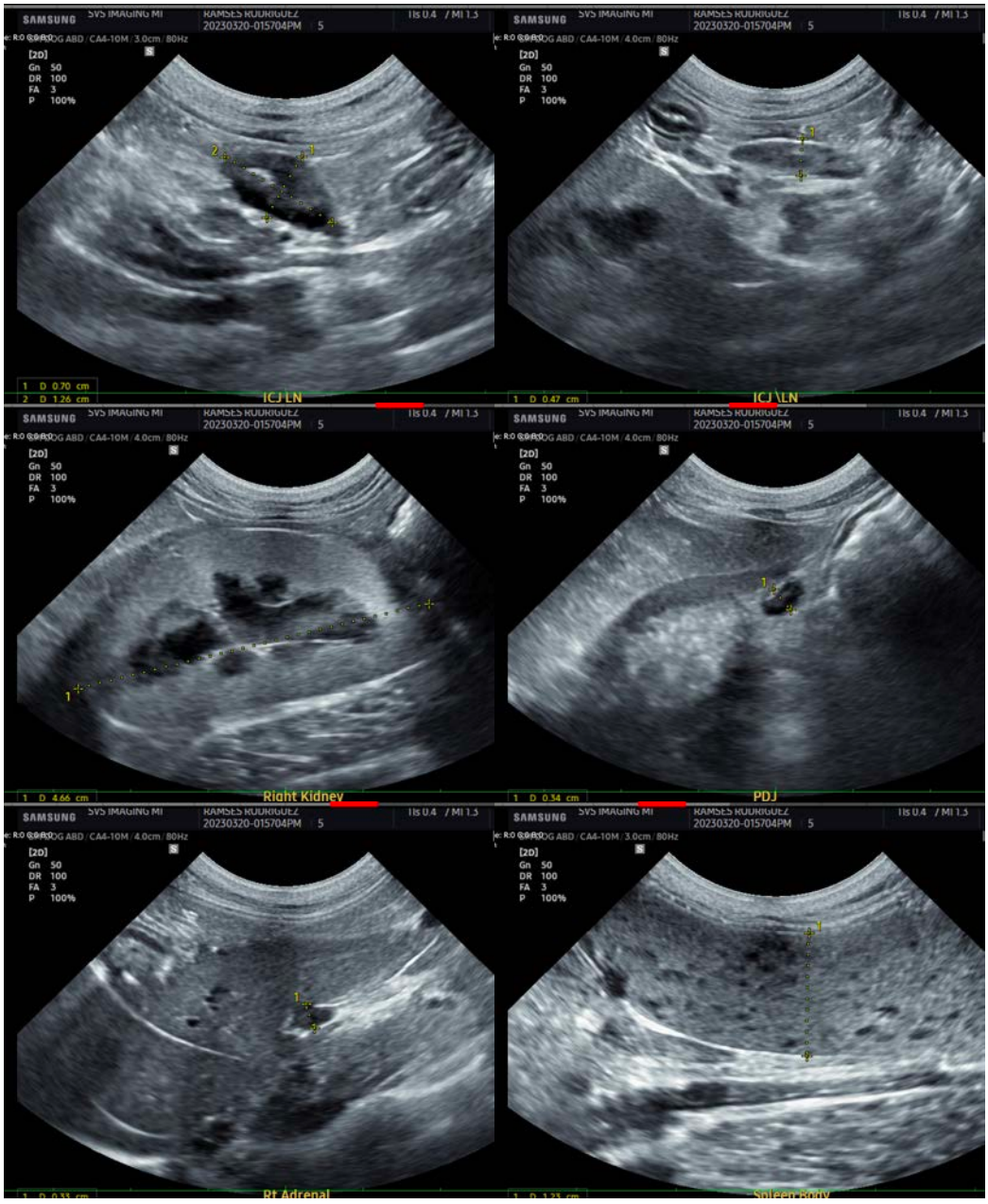

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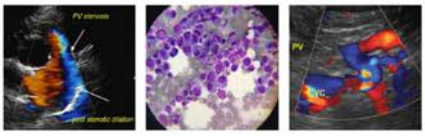

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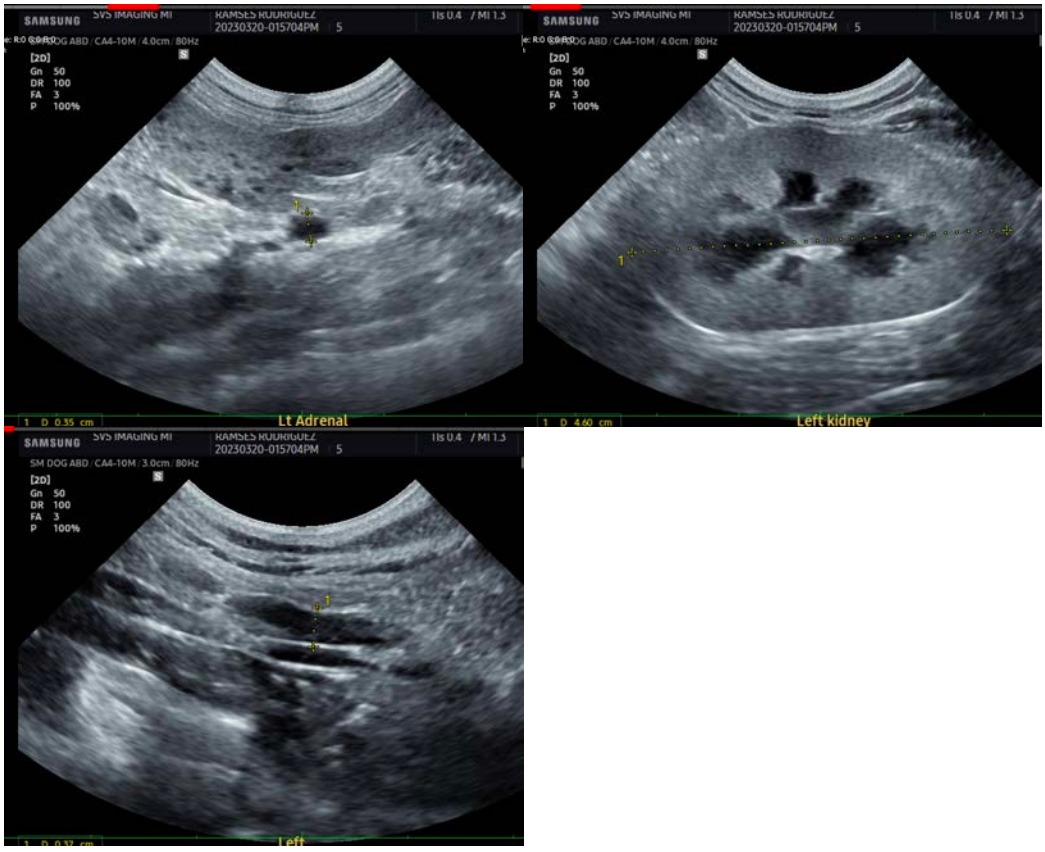

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
Beth.Johnson@sonopath.com