



PATIENT

Moose Greer

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

6 Years

WEIGHT

32.9 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Carlos Abdul-Chani

HOSPITAL NAME

Byram Animal Hospital

REFERRING VET

Dr. Maria Cruz

INVOICE

38948

DATE

6/22/22

PRESENTING CLINICAL SIGNS

Vomiting on and off for 3 weeks. Current Meds: On Laxatone and Cerenia
Abnormal PE/Chem/CBC/UA Results: T4 = WNL ; Albumin = 4.5 ; TG's = 611 ; rest of bloodwork WNL / CBC = WNL ; SDMA = WNL Urinalysis: Not Done Urine S.G. = Not done

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately 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.

The right kidney is normal in size (5.35 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 (5.21 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 (1.63 cm long x 0.49 cm thick), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (1.74 cm long x 0.41 cm at the cranial pole and 0.50 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively enlarged in size with rounded margins but intact capsule. Parenchyma is homogeneously coarse/mottled in echotexture and normal to hypoechoic in echogenicity. 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 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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Pancreas

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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.

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Free Abdomen

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy. There is some suspicion for possible pleural effusion on the edge of some of these clips. Artifact can't be ruled out, and thoracic radiographs are recommended.

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ULTRASONOGRAPHIC FINDINGS

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- Inflammatory bowel disease (IBD) pattern - This finding has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No concurrent lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probably, but lymphoma cannot be definitively ruled out without tissue sampling.

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- Coarse splenomegaly – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

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- Possibly scant pleural effusion – further evaluation recommended.

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 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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- 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.

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- 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.

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- Fine needle aspirate of the spleen could be considered if patient's coagulation status is appropriate to further investigate possible round cell neoplasia prior to pursuing more



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aggressive biopsies. If elected, premedication with Diphenhydramine is recommended, just in case of mast cell tumor presence

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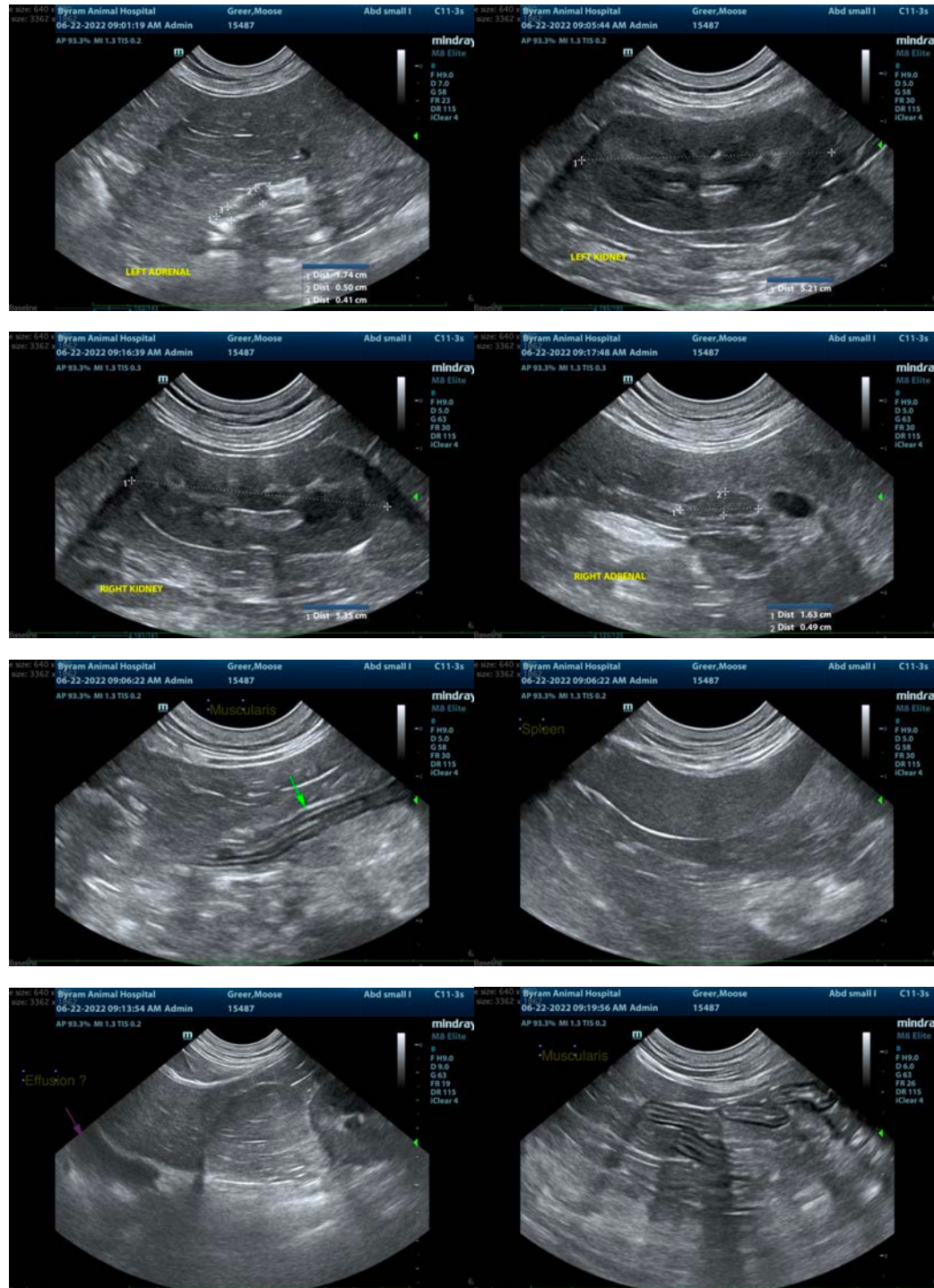
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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

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