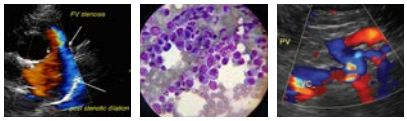
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
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DATE

6/28/22

PATIENT

Sanura Loizeaux

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

7/20/08

WEIGHT

7.5 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Stephanie Pearce RDCS, RVT

HOSPITAL NAME

Harborside Mobile VC

REFERRING VET

Dr. Hawkins

INVOICE

39077

PRESENTING CLINICAL SIGNS

PE in March I commented that she was too thin. Bloodwork was normal and no glaring abnormalities on PE. On 06/21, she was brought to the ER for multiple vomiting episodes. ER saw no issues in blood work or radiographs.

Current Medications: Cerenia 4mg SID.
Lab Results: no abnormalities.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

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. An almost 1.0 cm diameter cystic, walled off structure is noted at the ventral apical surface of the bladder, most consistent with an incidental congenital persistent urachal remnant.

The right kidney is normal in size (3.56 cm) 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 echogenicity and mild loss of corticomedullary distinction. There is no evidence of pyelectasia or infarcts observed. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted.

The left kidney is normal in size (3.27 cm) 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 echogenicity and mild loss of corticomedullary distinction. There is no evidence of pyelectasia or infarcts observed. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted.

Adrenal Glands

The right adrenal gland is normal in size (0.42 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.42 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 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 visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

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.

Sublumbar lymph nodes 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.

An oblong, heterogeneous, subcutaneous nodule is also noted in the caudal abdomen.

PRIMARY FINDINGS

- 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.
- Reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Aggressive sublumbar lymph nodes – most consistent with infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.
- Subcutaneous nodule

SECONDARY FINDINGS

- Age related pancreatic remodeling
- Age related renal changes with non-obstructive bilateral dystrophic mineralization
- Incidental congenital urachal remnant

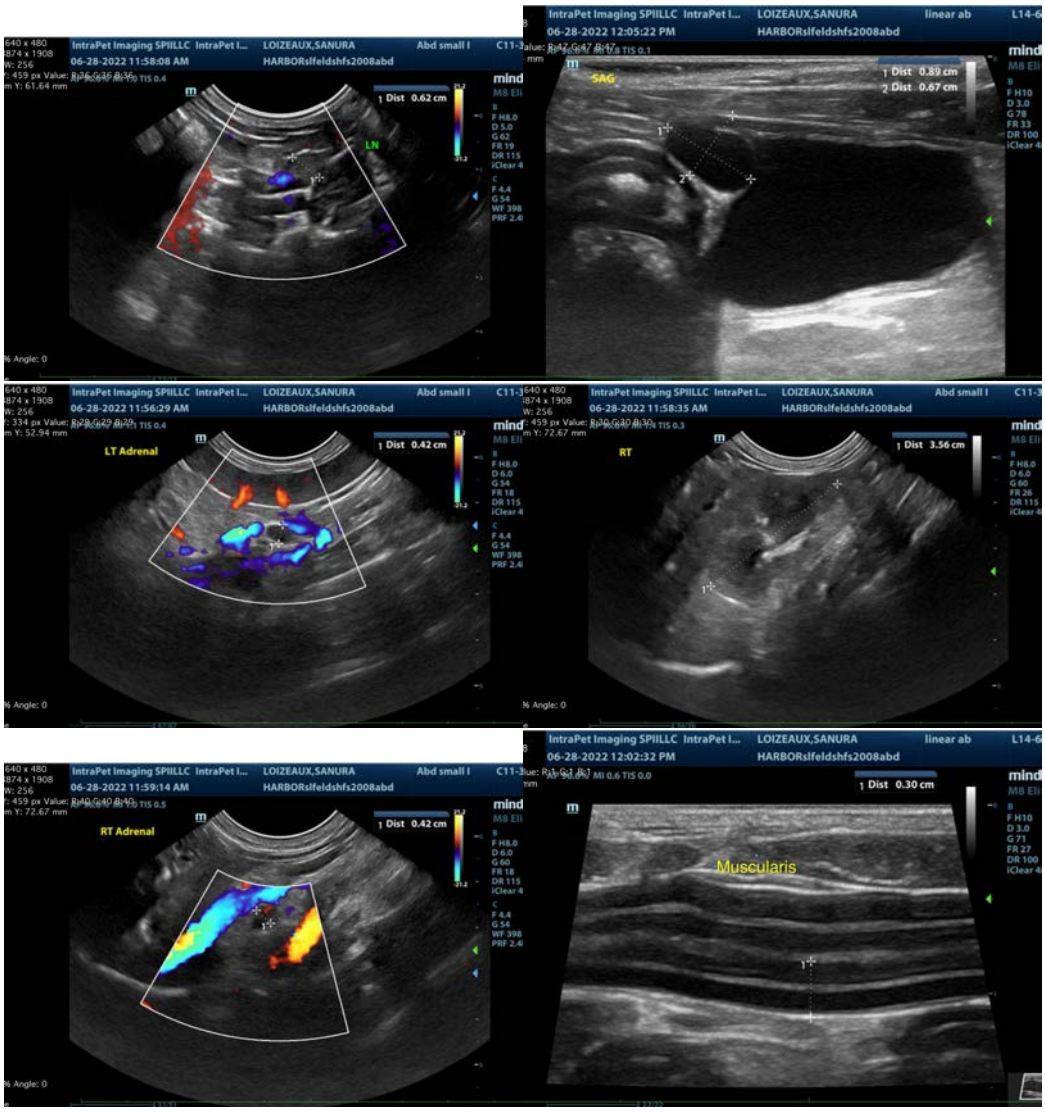
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

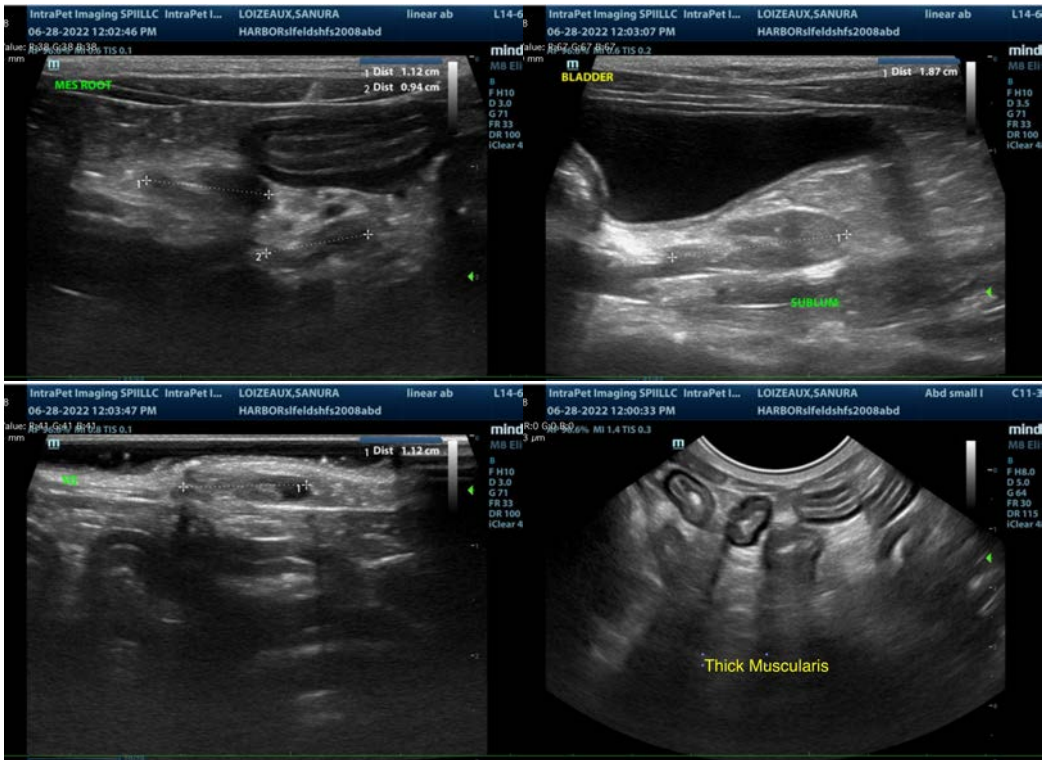
- Both benign as well as infiltrative neoplasia are differentials for the bowel and lymph node changes. However, given the severity of the change, infiltrative neoplasia is considered slightly more likely.

Therefore, recommendations include a fine needle aspirate of the enlarged lymph nodes, if possible. A fine needle aspirate of the subcutaneous nodules is also recommended if patient's coagulation status is appropriate. If a diagnosis is not obtained cytologically, recommendations include a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory for further evaluation of GI and pancreatic function.

- 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 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.





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
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