



PATIENT

Blackjack Bartlett

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

16 years

WEIGHT

5.1 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Evan Bell

HOSPITAL NAME

Cedarview AH

REFERRING VET

Dr. Holzman

INVOICE

31578

DATE

7/11/22

PRESENTING CLINICAL SIGNS

BMs varying between soft and firm, vomits regularly Rectal prolapse for 30-60 minutes following BMs CBC/Biochem/U/A/T4 - Eosinophilia (2.8), U/A USG 1.014 Dewormed and switched diet from Fibre Response (from previous cat) with no change to rectal prolapse, but otherwise seems to be tolerating diet well.

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.

Kidneys are overall normal in size 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 cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. The left kidney measured 4.1 cm. The right kidney measured 4.3 cm.

Adrenal Glands

Left adrenal gland is normal in size (0.23 cm at the cranial pole and 0.26 cm at the caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The region of the right adrenal gland is examined without evident pathology.

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. See other.

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.



| | |
|-----------------------------|---|
| PATIENT | <i>Gastrointestinal</i> |
| Blackjack Bartlett | The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent. |
| SPECIES | 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. |
| Feline | |
| BREED | The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas. See other |
| Domestic Shorthair | |
| SEX | <i>Pancreas</i> |
| Neutered male | 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. |
| AGE | <i>Free Abdomen</i> |
| 16 years | Mesenteric lymph nodes are prominent in size with swollen capsular contour as well as hyperechoic, enhanced fat in the are of the ileocecolic junction. |
| WEIGHT | In the right mid to right cranial abdomen there is a cystic mass that appears to communicate with bowel and appears to be located near the ileocecolic junction. Communication with small bowel cannot be ruled out and the cystic structure extends far enough cranially that pancreas or liver involvement cannot be 100% definitively ruled out. Differentials include a dilated, fluid filled, irregular looking cecum versus an actual cystic fluid filled mass versus potentially lymph node. Association with the pancreas and/or liver are considered less likely, but cannot be ruled out. |
| 5.1 lbs | |
| INTERPRETED BY | |
| Beth Johnson, DVM DACVIM | |
| IMAGING PERFORMED BY | ULTRASONOGRAPHIC FINDINGS |
| Evan Bell | Primary Findings |
| HOSPITAL NAME | 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. |
| Cedarview AH | |
| REFERRING VET | Reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely. |
| Dr. Holzman | Midabdominal cystic mass that appears to be associated with bowel and appears near the ileocecolic junction. Differentials as stated above include atypical appearance of a fluid distended, irregular cecum versus a cystic mass associated with bowel versus cystic lymph node. Association with the pancreas and/or even liver given how far it reaches cranially cannot be definitively ruled out. |
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Secondary Findings

Age related renal changes.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

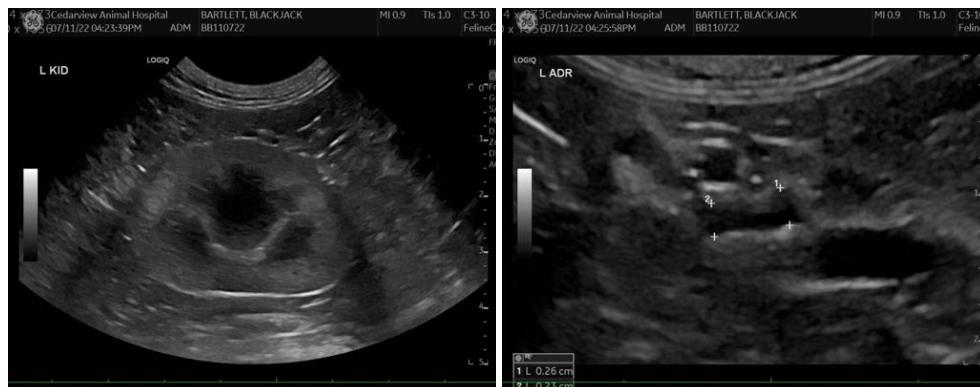
- Given this patient's history of vomiting, eosinophilia combined with the diffusely thick muscularis, inflammatory bowel disease is considered probable. Therefore, recommendations include:

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.

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 reported rectal prolapses could be secondary to constipation/obstipation. Therefore, medical management in the form of a high fiber colitis diet or fiber added to a novel or hydrolyzed protein diet if that is the diet of choice as well as a potentially a stool softener such as Lactulose or even Cisapride could be empirically tried with monitoring for improvement.
- Neither inflammatory bowel disease or constipation can explain the cystic structure in the midabdomen. Therefore, options including the aforementioned problems and monitoring the cystic structure versus more advanced imaging such as an abdominal CT scan for more definitive organ origination or given the need for small bowel biopsies an exploratory laparotomy could be considered with plans to obtain biopsies of the small bowel as suggested above as well as further investigate +/- remove structure of unknown origin.





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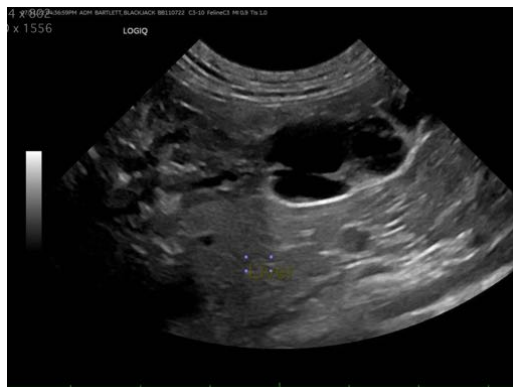
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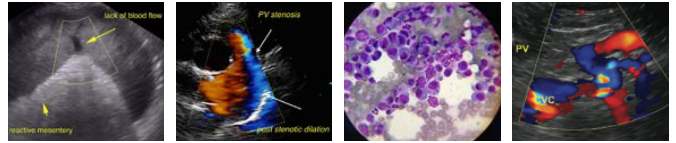


The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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



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