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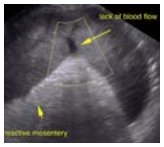
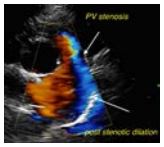
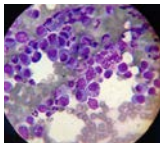
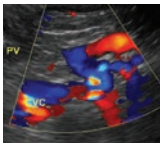

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1-800-838-4268 info@sonopath.com

PATIENT
Jennifer Share

SPECIES
Feline

BREED
DSH

SEX
Spayed Female

AGE
21 Years

WEIGHT
6.7 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Dr. Susan Lincoski

HOSPITAL NAME
University Drive VH

REFERRING VET
Dr. Susan Lincoski

INVOICE
40395

DATE
8/12/33

PRESENTING CLINICAL SIGNS

Weight loss, recent and progressive past few months. hind end weakness/muscle atrophy. Acting herself otherwise, eating, drinking and normal habits.

Abnormal PE/Chem/CBC/UA Results: See attached lab work. Exam is unremarkable except for sarcopenia mostly hind end.

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.

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 or mineral observed. The left kidney measured 3.2 cm. The right kidney measured 3.11 cm. A chronic infarct is noted in the left kidney.

Adrenal Glands

The areas of the adrenal glands are examined without evident pathology.

Spleen

The spleen is subjectively at the upper limit of normal size with normal smooth margins maintained. Parenchyma is diffusely hypoechoic with a coarse heterogeneous echotexture characterized by multifocal non-discrete hypoechoic nodules. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mottled by multifocal discrete hypoechoic nodules of varying sizes “moth-eaten”. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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 with early emerging loss of layering noted multifocally. 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.

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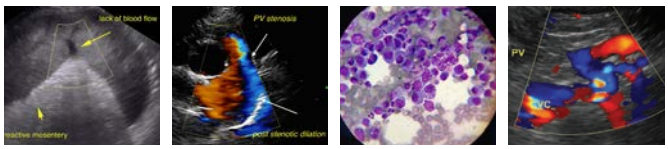

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Pancreas

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.

Mild mesenteric lymphadenopathy is noted.

PRIMARY FINDINGS

- **Nodular Liver -** This finding is concerning for infiltrative disease such as round cell neoplasia or metastatic neoplasia. Benign disease (nodular hyperplasia) cannot be ruled out but is considered less likely.
- **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 (leave amyloidosis out if canine) as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- **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.
- **Mild mesenteric lymphadenopathy –** Differentials include both infiltrative neoplasia, given the concurrent pathology, as well as reactive lymphadenopathy.

SECONDARY FINDINGS

- Age related kidney change with a chronic infarct in the left kidney
- **Gallbladder debris** - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness, however, it can also be associated with hepatobiliary disease in cats and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

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.

A fine needle aspirate of the liver +/- the spleen is recommended if patient's coagulation status is appropriate. If a diagnosis cannot be obtained cytologically, with lymphoma being a top differential, ultimately biopsies of the GI tract and liver nodules may be necessary to definitively diagnose and therefore manage the infiltrative disease.

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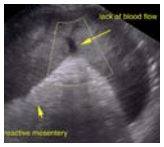
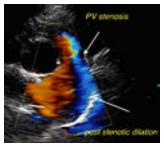
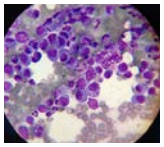
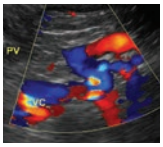

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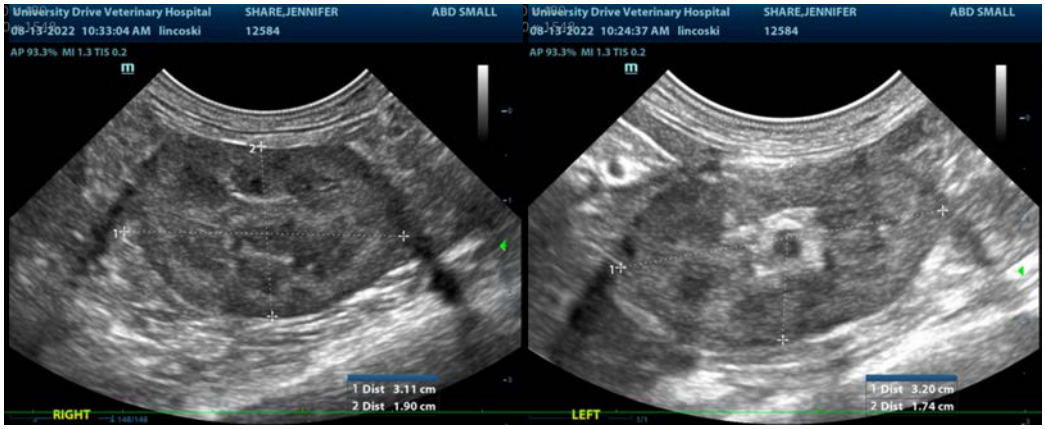
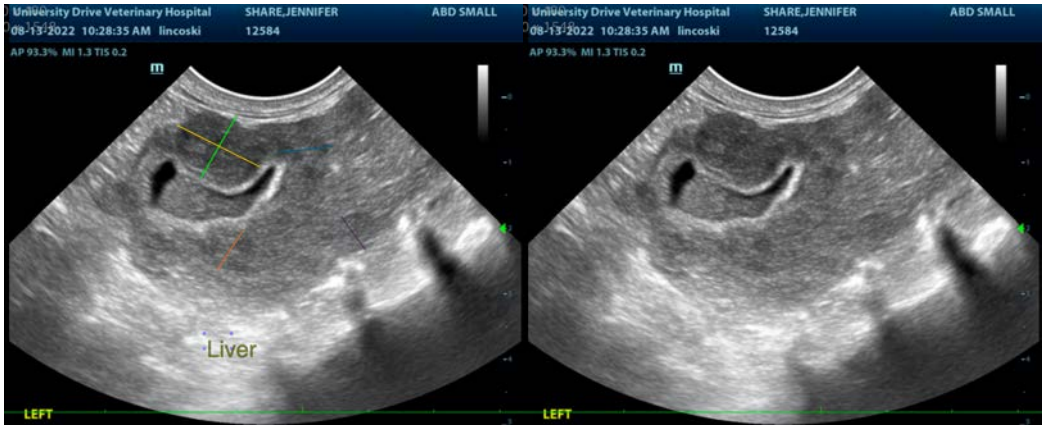
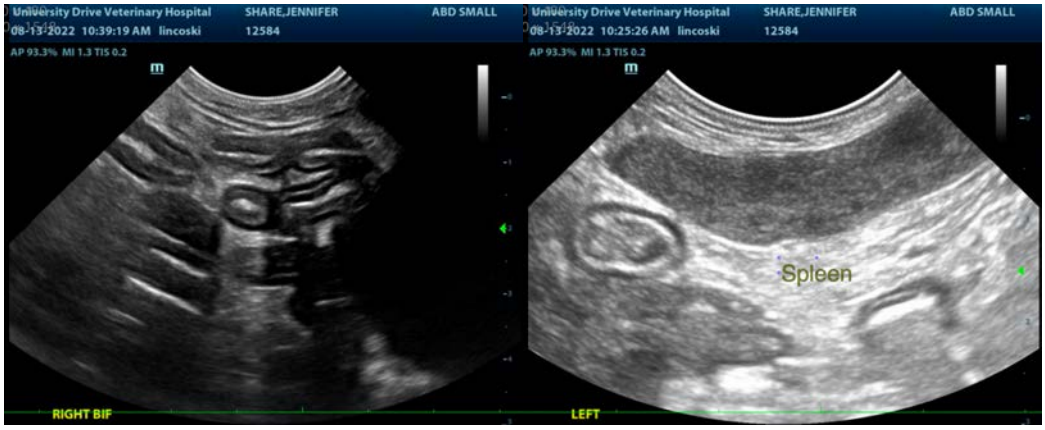
If further diagnostics cannot be obtained, empirical therapies could include empirical cobalamin supplementation, unless cobalamin is evaluated and supplementation is not warranted, and Prednisolone +/- Chlorambucil if not contraindicated based on patient's contraindications, comorbidities, etc.







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

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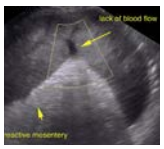
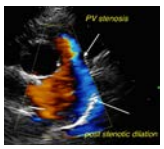
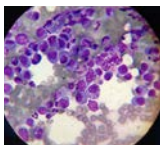
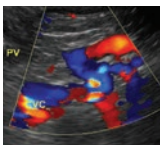

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can be of any further assistance please contact me.

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