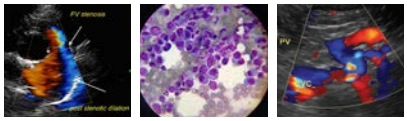
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

DATE

8/15/23

PATIENT

Liala Sandok

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

10/2/11

WEIGHT

9.44 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Tmonium AH

REFERRING VET

Dr. McMichael

INVOICE

44672

PRESENTING CLINICAL SIGNS

Significant weight loss over the past month. T4: 3.2 in Jan with normal fT4. T4 in Jun 3.0- out of town DVM T4 3.9 on August 8th. Concern for weight loss and decreased appetite. Pet has been hiding and decreased appetite.

Current Medications: None.
Lab Results: T4: 3.9 (out of town bloodwork- will email when able), anemia Hct 25.3%.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson, BS, RDMS.

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 (3.49 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 (3.51 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. A small 0.50 cm cortical cyst is noted.

Adrenal Glands

The area of the right adrenal gland was examined without adrenal gland pathology noted.

The left adrenal gland is normal in size (0.56 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 thick, measuring 1.04 cm thick along the cranial aspect of the body of the stomach approaching the pyloric antrum. Loss of mural detail is noted in this area. Additionally, along the caudal aspect of the body of the stomach, there is a 1.1 cm x 0.80 cm hypoechoic nodule/mass that appears to be a separate intramural thickening. 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 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.

Prominent gastric lymph nodes are noted surrounding the thick gastric wall. Additionally, in the area of the Ileocecocolic junction, there is a 1.5 cm x 0.90 cm hypo- to anechoic partially cystic oblong structure that appears to be lymph node. Having said, a mildly fluid distended cecum can't be ruled out.

ULTRASONOGRAPHIC FINDINGS

- Thick gastric wall with loss of layering, which is a criteria for malignancy – Concerning for infiltrative neoplasia (i.e., lymphoma versus other). A benign inflammatory condition is possible but considered less likely.

- Mild/subtle 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.

- The concurrent lymphadenopathy is concerning for infiltrative lymphoma as well versus other metastatic disease. Reactive lymphadenopathy can't be definitively ruled out without tissue sampling.

- The structure identified adjacent to the Ileocecocolic junction also appears to be a lymph node – An infiltrative neoplastic node (i.e., lymphoma) versus reactive lymph node are possible. However, mildly fluid distended cecum can't be definitively ruled out given the appearance and location of the structure.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

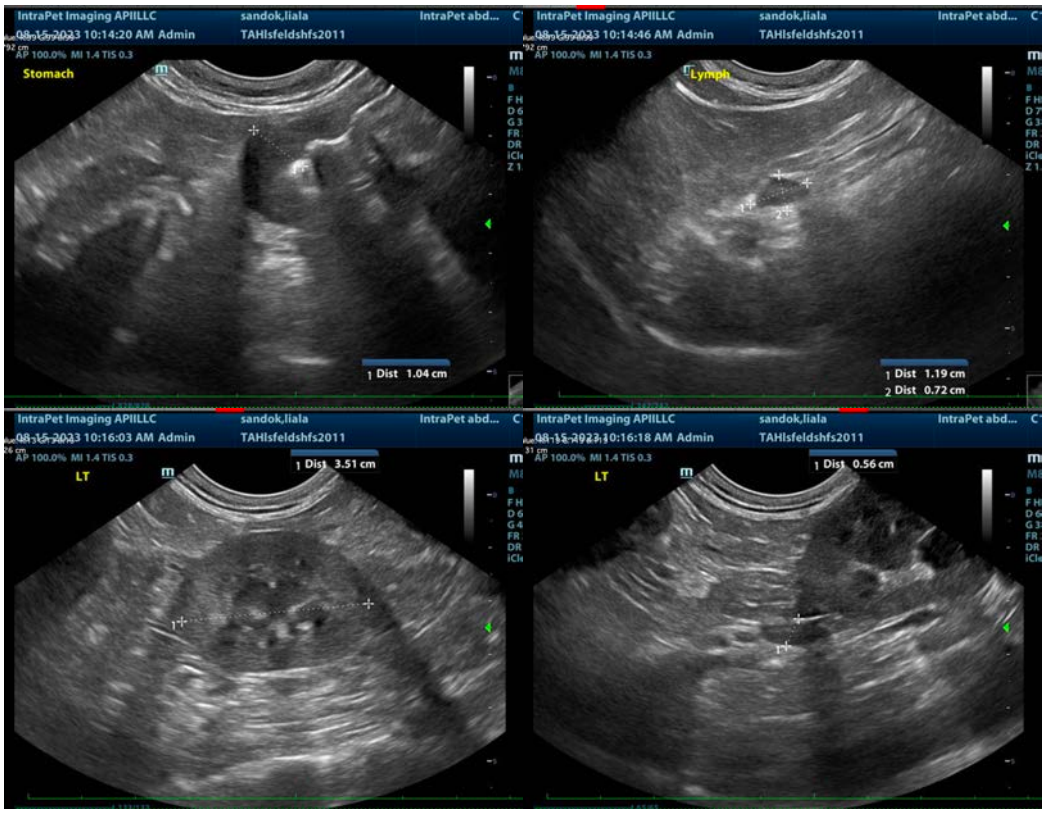
Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

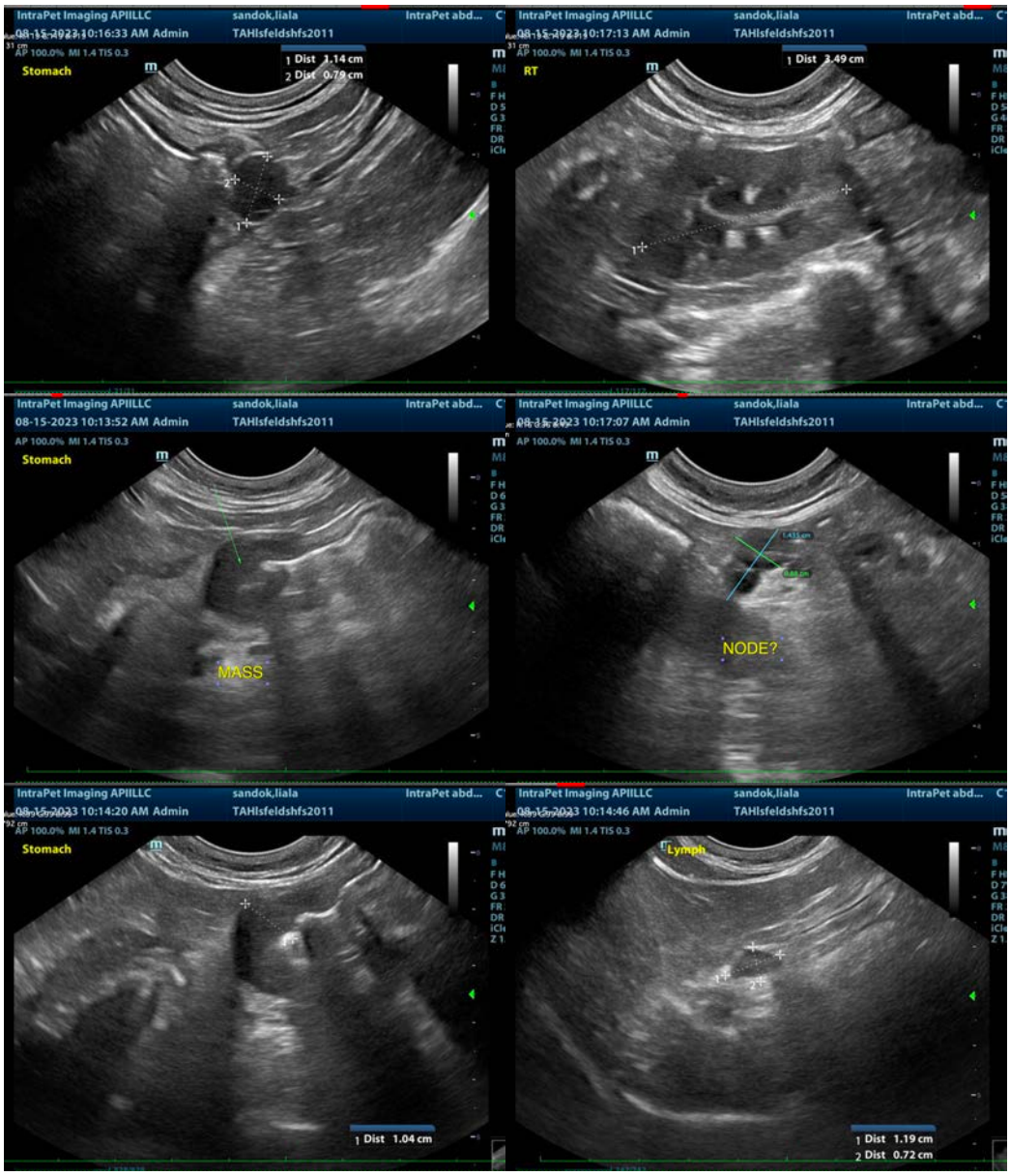
Fine needle aspirates of the gastric wall +/- the lymph nodes (the lymph nodes may be difficult to reach) could be considered if patient's coagulation status is appropriate.

Alternatively, or if a diagnosis cannot be obtained cytologically, upper GI gastroscopy/endoscopy could be considered for further visual evaluation and biopsies of both the stomach and proximal small bowel.

An exploratory laparotomy versus endoscopy could be considered for full thickness biopsies. However, based on these images, the gastric wall thickening appears to be somewhat multifocal, and therefore full excision of the gastric mass may not be possible.

Given the subtle but diffuse small bowel changes, if sampling is pursued, bowel as well as gastric sampling should be considered.

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2 Dist 0.79 cm
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Lymph
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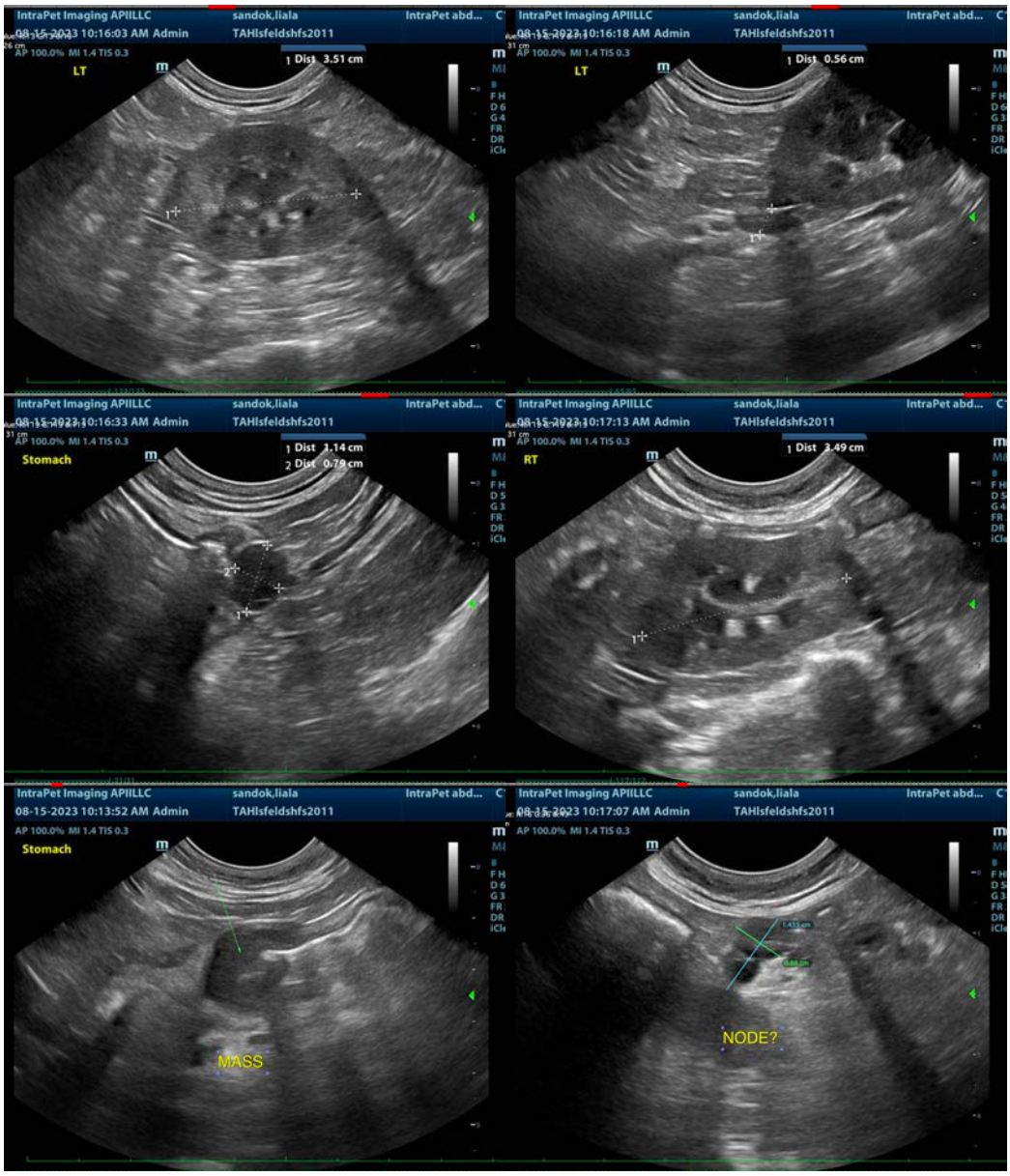
2 Dist 0.72 cm



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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