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Clinical Sonography & Telecytology
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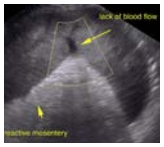
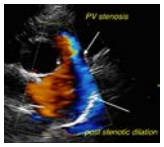
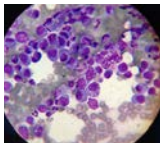
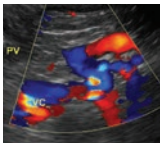

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1-800-838-4268 info@sonopath.com

PATIENT
Penelope Mitzcik

SPECIES
Feline

BREED
DLH

SEX
Spayed Female

AGE
14.5

WEIGHT
9.2

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Dr. Susan Lincoski

HOSPITAL NAME
University Drive VH

REFERRING VET
Dr. Susan Lincoski

INVOICE
44740

DATE
8/16/23

PRESENTING CLINICAL SIGNS

Penelope had gastrotomy/enterotomy last July upon suspicion of gastric FB/pyloric outflow obstruction noted radiographically. She was found to have a large trichobezoar. Biopsies were obtained, and they were consistent with small-cell/T-cell lymphoma (see reports) Owner has been giving her prednisolone 5mg eod with great results, (Chloramucil discussed and priced but owner decided to just do prednisolone) , until past few weeks. Noted uptick of vomiting, decreased appetite. Increased back to 5mg daily prednisolone and AUS to assess.

Abnormal PE/Chem/CBC/UA Results: CBC 7/20 WNL except lymphopenia (423/uL L), Chem and T4 all WNL.

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 (3.89 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 (3.57 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 (0.23 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.38 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.

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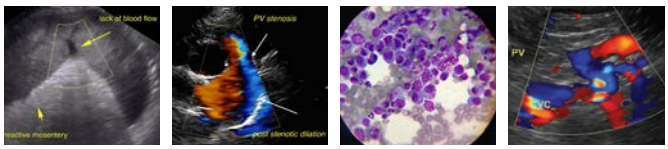

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Gastrointestinal

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.

Diffusely, the visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). In a clip labeled "mid abdomen" there is a focal loop of bowel that measures 0.40 cm thick and exhibits loss of layering. The specific location of the bowel loop and the length of the thickening is unable to be determined based on these images. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

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

A trace amount of anechoic free fluid is noted in these images.

Mesenteric 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.

ULTRASONOGRAPHIC FINDINGS

- The focal area of thickened small bowel with loss of layering is a characteristic of malignancy, and given this patient's history is concerning for infiltrative neoplasia (i.e., lymphoma), perhaps a progression of the previously diagnosed disease.
- The lymphadenopathy concurrently supports lymphoma. Reactive lymph nodes are possible but considered less likely.
- Trace amount of free fluid is noted in these images.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Fine needle aspirates of the enlarged lymph nodes +/- the focal area of small bowel thickening could be considered if patient's coagulation status is appropriate. Alternatively, given the historical diagnosis, consultation with a veterinary oncologist could be considered to discuss changing therapy based on this information alone.

Having said that, if not recently evaluated, and to help guide medical therapy, 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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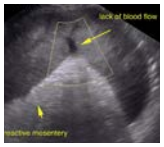
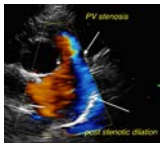
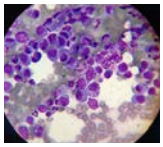
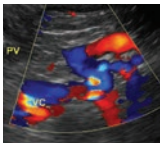

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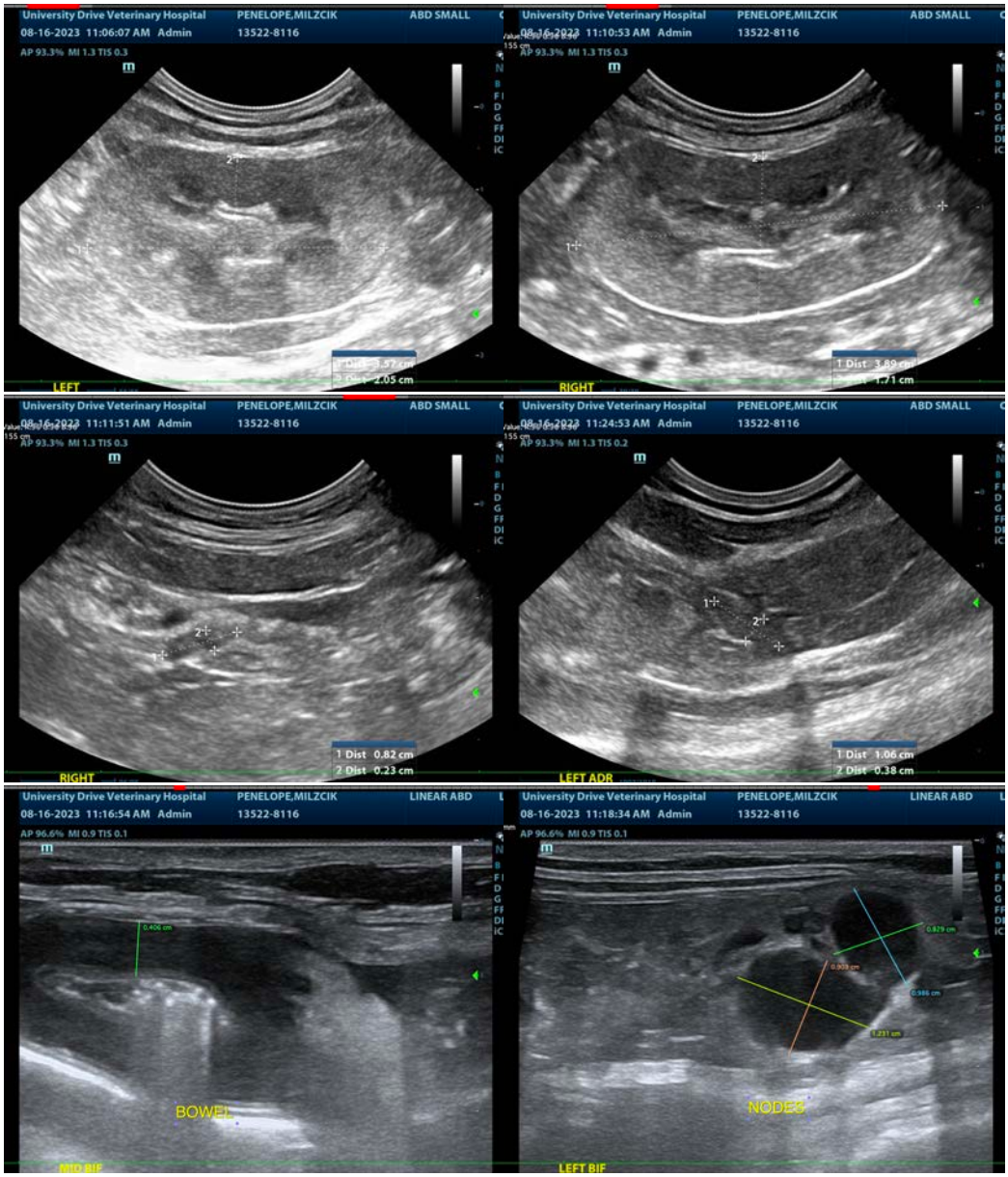

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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