



PATIENT

Hooper Robinson

SPECIES

Feline

BREED

Domestic Shorthair

PRESENTING CLINICAL SIGNS

History: P presented for a 3 day history of anorexia, lethargy, and diarrhea. P went to urgent care over the weekend where bw was done and p given SQ fluids and cerenia. Sent home with metronidazole and omeprazole. O states p has not improved since visit (which was Sunday afternoon). P does have a history of intermittent vomiting and diarrhea - last treated July 2021 (x-rays and bw wnl at that time). Hx of feline asthma. Medications: Gabapentin 50mg PRN, prednisolone 1.25mg SID (for asthma), glycoflex.

Abnormal PE/Chem/CBC/UA Results: PE: 3lbs of weight loss since March 2022, muscle wasting, ~5% dehydrated, doughy and distended abdomen on palpation. CBC - mild leukocytosis characterized by mild neutrophilia Chem - Creat 1.9, BUN 28, all else wnl

SEX

Neutered male

AGE

15 years

WEIGHT

11.38 lbs

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with anechoic contents as well as suspended and gravity dependent echogenic debris and mineral/sand settled against the dependent wall. No masses or inflammatory changes are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia observed. Non-obstructive areas of mineralization/nephroliths are noted bilaterally. The left kidney is compensatory large and measures 4.42 cm. The right kidney is small and measures 2.92 cm.

INTERPRETED BY

Beth Johnson, DVM
DACVIM

Adrenal Glands

The area of the adrenal glands are examined without evidence of pathology.

IMAGING PERFORMED BY

Dr. Fritz

Spleen

The spleen is not well visualized in these images.

HOSPITAL NAME

Waterbury VH

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.

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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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PATIENT	<i>Gastrointestinal</i>
Hooper Robinson	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 with early/emerging hazy loss of layering is 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.
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>
15 years	
WEIGHT	There is no evidence of free peritoneal effusion noted in these images.
11.38 lbs	The 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.
INTERPRETED BY	A hypoechoic, round structure was noted in the area of the ileocecolic junction believed to be lymph nodes; however, a bowel mass cannot be definitively ruled out.
Beth Johnson, DVM DACVIM	What is believed to be the mid cranial abdomen there is a 4.0 cm in diameter heterogenous, hypoechoic structure again believed to be an enlarged lymph node. However, bowel mass or mass associated with the pancreas cannot be definitively ruled out.
IMAGING PERFORMED BY	ULTRASONOGRAPHIC FINDINGS
Dr. Fritz	Primary Findings
HOSPITAL NAME	<ul style="list-style-type: none"> • Aggressive lymph nodes appearing to effect mesenteric lymph nodes, lymph nodes around the ileocecolic junction and potentially cranial abdominal lymph nodes– most consistent with infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture. • 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. • Bowel mass versus enlarged lymph nodes cannot be definitively ruled out based on these images. • Chronic Kidney Disease – This appearance of the kidneys is consistent with chronic kidney disease such as chronic glomerular or interstitial nephritis, chronic pyelonephritis, etc.
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- **Urinary bladder debris** including mineral sand debris.

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HOSPITAL NAME

Waterbury VH

REFERRING VET

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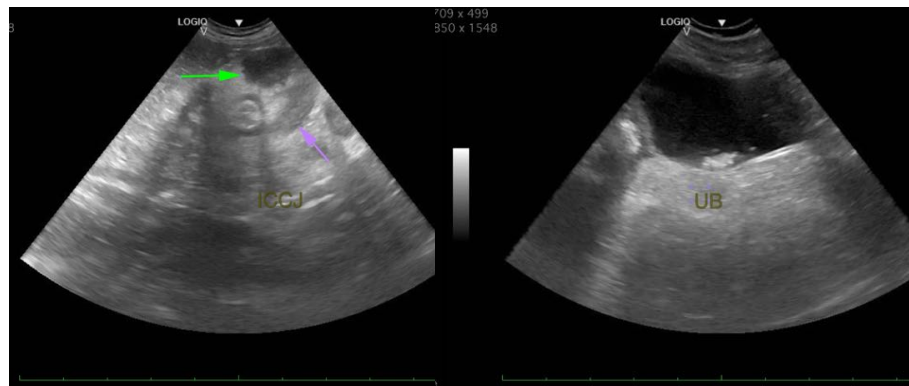
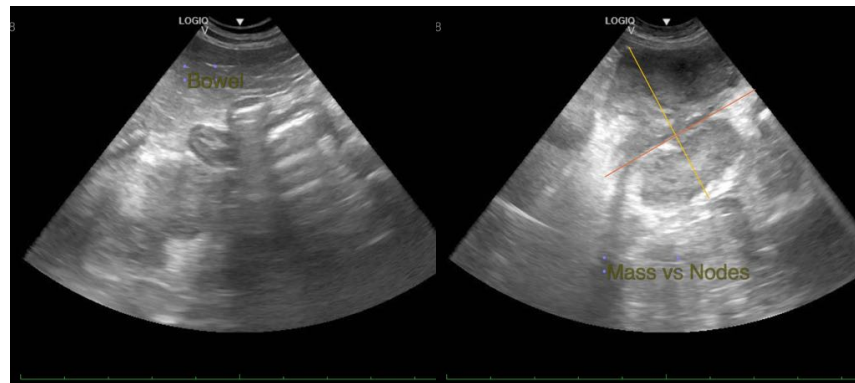
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. Further investigation of this patient's reported azotemia is recommended with urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.
2. FNA of the masses described, believed to be lymph nodes, is recommended if the patient's coagulation status is appropriate.
3. 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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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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