

DATE PRESENTING CLINICAL SIGNS

8/22/22

Patrick is a 14 y/o MN DSH who was referred for chronic vomiting - Chronic vomiting, intermittently projectile starting about 2 months ago - vomiting about 3 times a week - no projectile vomiting in the past week - eating less losing weight and decreased muscle mass - has not eaten anything the the past 2 days - vomited bile yesterday - lethargic, not acting himself - vomiting water - no change in urination - hiding more - diarrhea about 1 month ago which resolved - RDVM BW: 8/16 ALT 187, 8/20 PLT 39, SDMA 21.

PATIENT

Patrick Whery

Medications: - none, no preventatives
Current Medications: Ondanestron, protonix, buprenorphine, ampi/sub, mirtazapine.

SPECIES

Feline

Lab Results: See attached.
Radiographs: Soft tissue structure in cranial abdomen, concern for neoplasia, poor abdominal detail

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

BREED

Domestic Shorthair

Imaging Performed By: Rachel Brillhart, RDMS.

SEX

Neutered male

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.

AGE

1/1/08

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 mineral or infarcts observed. Mild, bilateral pyelectasia was noted. The left kidney measured 4.2 cm. The right kidney measured 4.25 cm.

WEIGHT

9.6 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

Adrenal Glands

Left adrenal gland is normal in size (0.55 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.65 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

HOSPITAL NAME

Animal Emergency
Hospital

Spleen

Spleen is subjectively large in size with a swollen and scalloped/undulating capsular contour. Multifocal coalescing nodules are noted throughout the parenchyma. Splenic vasculature appears normal. Enhanced hyperechoic surrounding fat is noted.

REFERRING VET

Dr. Thompson

INVOICE

32438

Liver

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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 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.

The visible small intestines are normal in wall thickness and layering. 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 observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is a scant amount of anechoic free fluid is present.

Diffuse, mesenteric and sublumbar 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

Primary Findings

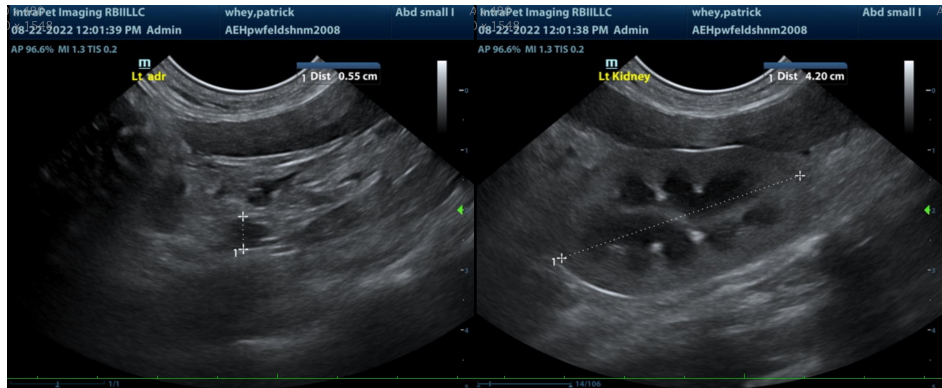
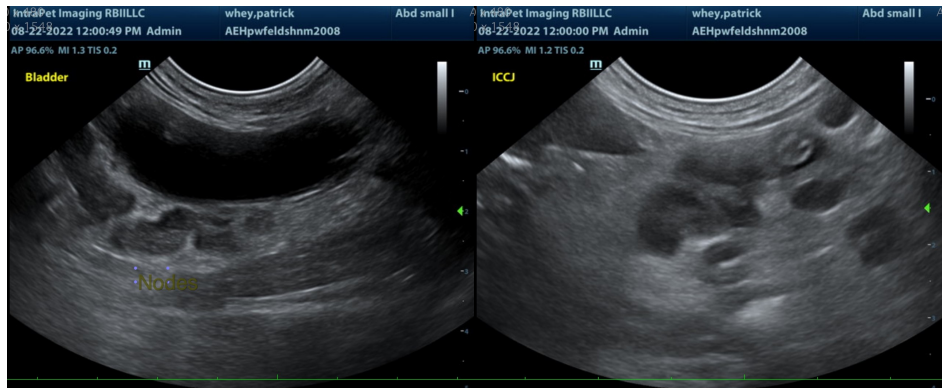
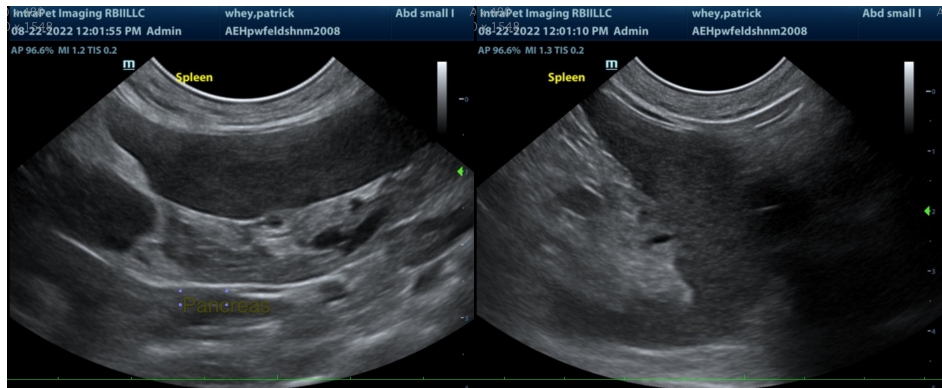
- **Honeycomb Spleen** – This finding is strongly suggestive of infiltrative disease such as round cell neoplasia. Benign disease cannot be ruled out but is considered less likely.
- **Hyperechoic hepatomegaly** – This appearance is most consistent with benign hepatic lipidosis. Infiltrative disease such as amyloidosis or round cell neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.
- **Aggressive mesenteric and sublumbar lymph nodes** – most consistent with infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.

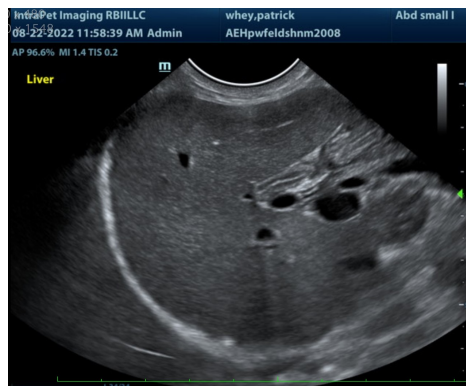
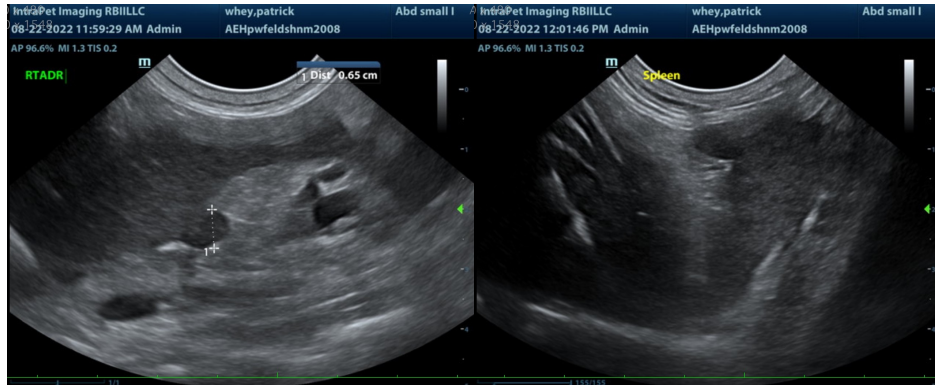
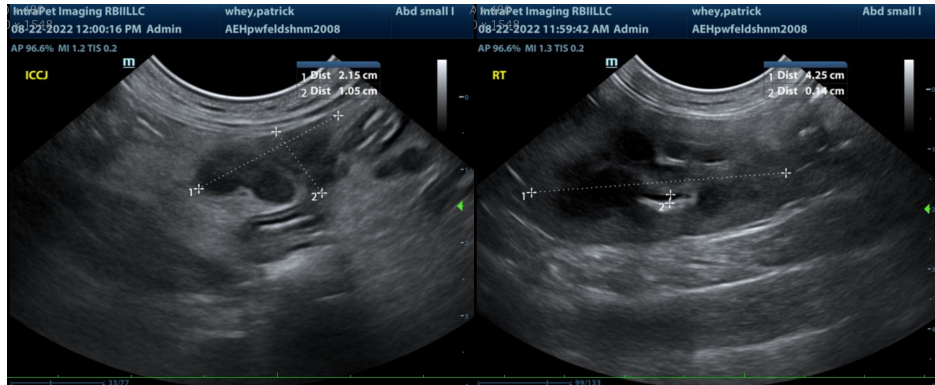
Secondary Findings

- **Age related renal changes with mild bilateral pyelectasia.**
- **Pancreatic age-related remodeling** – Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The top differential for this patient is affecting both the spleen, liver and lymph nodes is infiltrative neoplasia. Therefore, recommendations include FNA of the spleen, liver and lymph nodes if possible and if the patient's coagulation status is appropriate.





The information and recommendations provided are based on the images presented by the referring veterinarian. 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