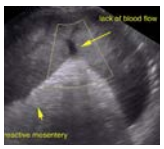
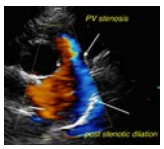
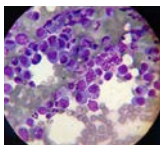
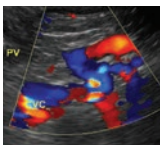

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PATIENT

Toby Jinks

SPECIES

Feline

BREED

Ragdoll

SEX

Neutered Male

AGE

8 Years

WEIGHT

11.2 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Schanche

HOSPITAL NAME

TotalBond VH

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PRESENTING CLINICAL SIGNS

presented for vomiting with increased frequency - over last month vomiting frequency increased, over last week has started to vomit daily. Not sure if eating less as free feed with another cat, but decreased stool production seen in litter box - stool in box is formed and normal. Lost ¬ 0.5 lbs since May 2022. Possible increased drinking at home. History of infiltrative bowel disease diagnosed in 2017 by US, did not pursue biopsies at that time - at that time was put on Purina HA diet and started on Prednisolone. Became very lethargic and would not eat on Prednisolone so that was stopped. Eventually would also not eat HA diet, so switched to farmina diet. Only eats dry food. On physical exam mild cachexia developing with weight loss and ropey GI loops. Blood work was quite unremarkable - Alb 4.1, Crt 1.9, BUN 28, Platelet 80 but adequate in estimate, T4 1.6, USG 1072, RBC 11-20 but cysto sample, UPC 0.1, SDMA 9.9.

Abnormal PE/Chem/CBC/UA Results: Alb 4.1, Crt 1.9, BUN 28, Platelet 80 but adequate in estimate, T4 1.6, USG 1072, RBC 11-20 but cysto sample, UPC 0.1, SDMA 9.9.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal in size (3.82 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 3.61 (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 area of the right adrenal gland is examined without evident pathology.

The left adrenal gland is normal in size (0.25 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a mildly coarse/heterogenous echotexture. 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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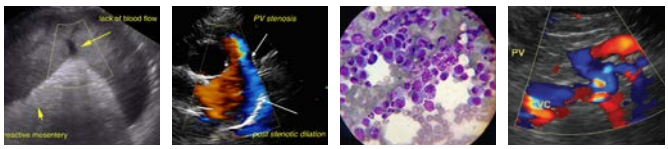

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Gastrointestinal

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.

Adrenal glands are plump/swollen in size. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. 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.

The mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

PRIMARY FINDINGS

- **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.

- **Reactive mesenteric lymph nodes –** infiltrative neoplastic disease cannot be ruled out but is considered less likely.

- **Scalloped spleen –** can be associated with benign or malignant infiltrative disease. Common causes include a reactive spleen secondary to immune stimulus or early infiltrative round cell neoplasia such as lymphoma or mast cell tumor.

SECONDARY FINDINGS

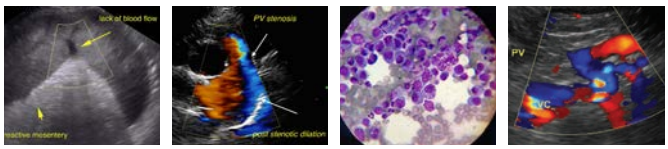
- Urinary bladder debris

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 spleen could be considered if patient's coagulation status is appropriate as a minimally invasive way to look for evidence of possible infiltrative round cell neoplasia. Alternatively, if a diagnosis is not obtained cytologically, biopsies of the GI tract, being sure to include ileum, if possible, are recommended to definitively diagnose and therefore manage the suspected infiltrative bowel disease.

Given the fact that this patient use to tolerate HA and stopped eating it, and does not reportedly



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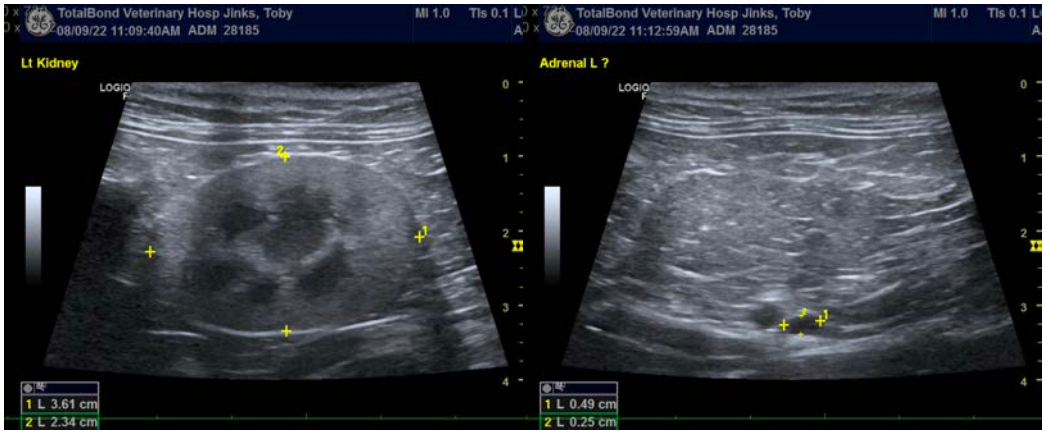
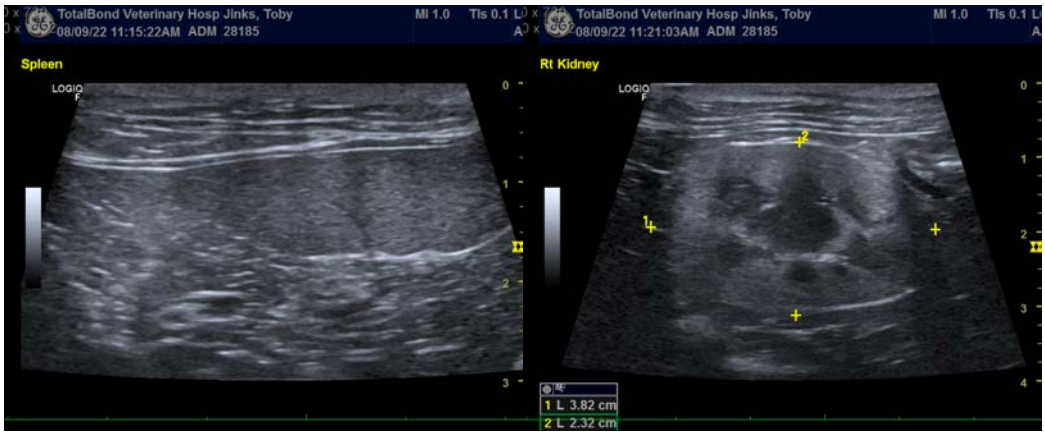
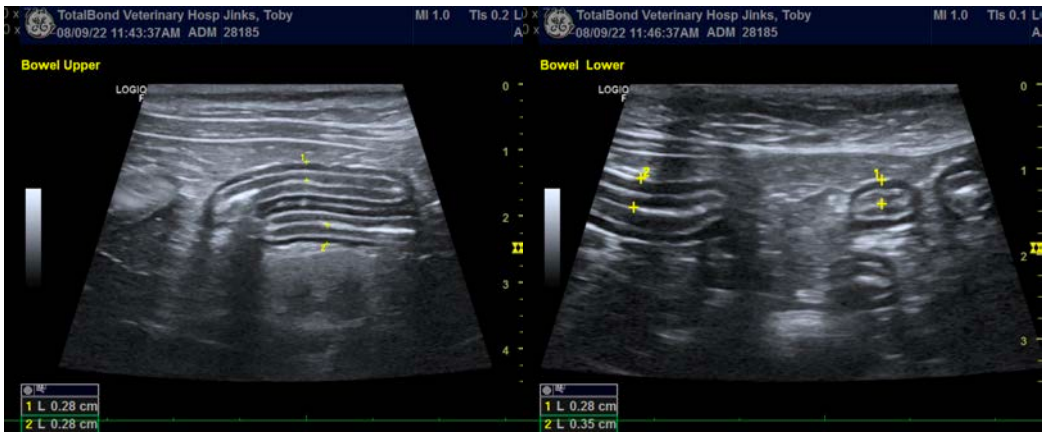
tolerate steroids, if biopsies cannot be obtained, other empirical therapies could include a new or different novel or hydrolyzed protein diet, empirical deworming with a 5-day course of Panacur, cobalamin supplementation (unless cobalamin is evaluated and supplementation is not warranted), and a different immunosuppressant such as modified cyclosporine or potentially chlorambucil.

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.







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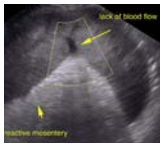
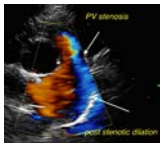
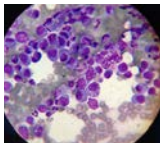
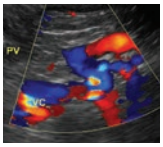

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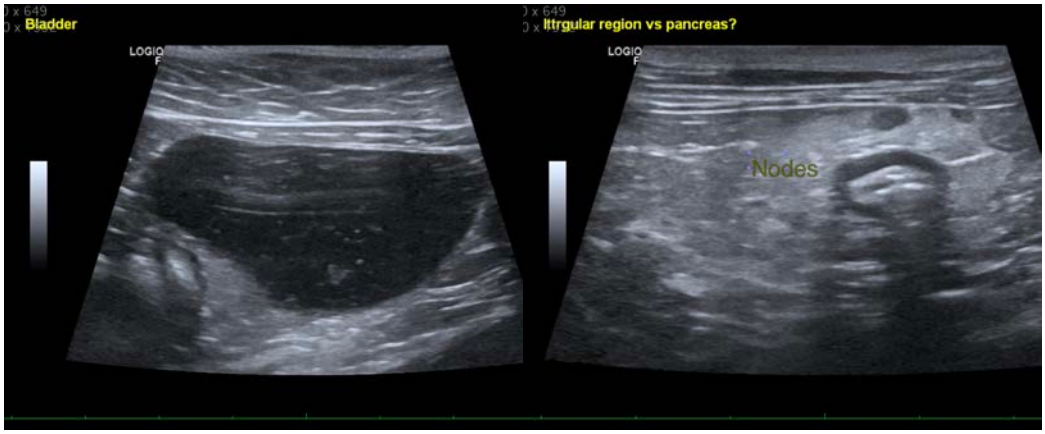

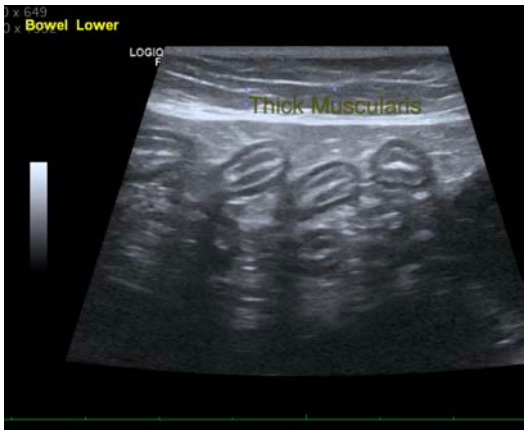

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
Beth.Johnson@sonopath.com