



**PATIENT**

Rustle Bly

**SPECIES**

Feline

**BREED**

Domestic Shorthair

**SEX**

Spayed female

**AGE**

13 years

**WEIGHT**

7.5 lbs

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Jessica Green

**HOSPITAL NAME**

Stanglein VC

**REFERRING VET**

Dr. Rothrock

**INVOICE**

32918

**DATE**

9/15/22

**PRESENTING CLINICAL SIGNS**

History: history of intermittent vomiting that has been increasing in frequency (happening daily). Previous rads concerning for inflammation throughout the GI tract but patient improved on bland diet and metronidazole at the time. Patient also has lost 2.3 pounds in 1 year.

Abnormal PE/Chem/CBC/UA Results: very mild anemia (RBC 6.72 but HCT normal), lymphopenia (likely due to stress)... have not taken rads in >1year

**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.

Left kidney is normal is size (3.15 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 or mineral observed. A chronic infarct was noted in the caudal pole.

Right kidney is normal is size (3.54 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**

Left adrenal gland is normal in size (0.31 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.45 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

**Spleen**

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**

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.

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.



<b>PATIENT</b>	<b><i>Gastrointestinal</i></b>
Rustle Bly	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.
<b>SPECIES</b>	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 some early/emerging loss of discrete layering appreciate in a focal loop in the midabdomen. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.
Feline	
<b>BREED</b>	The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.
Domestic Shorthair	
<b>SEX</b>	<b><i>Pancreas</i></b>
Spayed female	Pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. Pancreatic duct dilation is noted.
<b>AGE</b>	<b><i>Free Abdomen</i></b>
13 years	There is no evidence of free peritoneal effusion noted in these images.
<b>WEIGHT</b>	Mesenteric lymphadenopathy and a round, hypoechoic 0.5 cm pancreaticoduodenal lymph node are noted.
7.5 lbs	
<b>INTERPRETED BY</b>	<b>ULTRASONOGRAPHIC FINDINGS</b>
Beth Johnson, DVM DACVIM	<b>Primary Findings</b>
<b>IMAGING PERFORMED BY</b>	<b>Gastrointestinal lymphoma (suspect) pattern</b> – 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.
Jessica Green	
<b>HOSPITAL NAME</b>	<b>Mild lymphadenopathy.</b> Reactive lymphadenopathy as well as infiltrative neoplasia are differentials and cannot be differentiated without tissue sampling.
Stanglein VC	
<b>REFERRING VET</b>	<b>Secondary Findings</b>
Dr. Rothrock	<b>Chronic infarct in the caudal pole of the left kidney.</b>
<b>INVOICE</b>	<b><u>INTERPRETATION OF THE FINDINGS &amp; FURTHER RECOMMENDATIONS</u></b>
32918	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.
<b>DATE</b>	
9/15/22	



**PATIENT**

Rustle Bly

Ideally, biopsies of the GI tract, being sure to include ileum if possible, are recommended to definitively diagnose and therefore manage the infiltrative bowel disease.

**SPECIES**

Feline

If biopsies cannot be obtained, empirical therapies could include diet change, empirical deworming with a 5 day course of Panacur, cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.).

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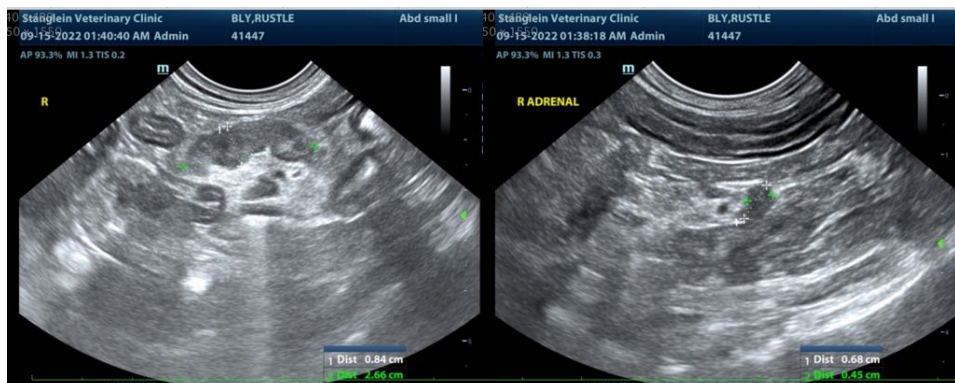
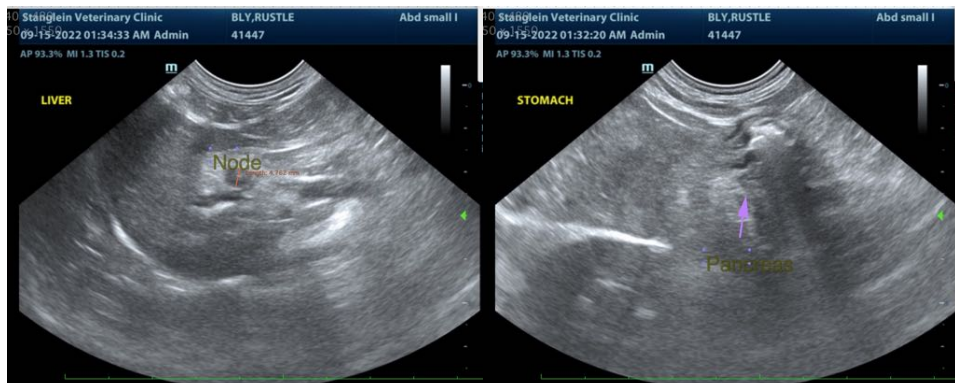
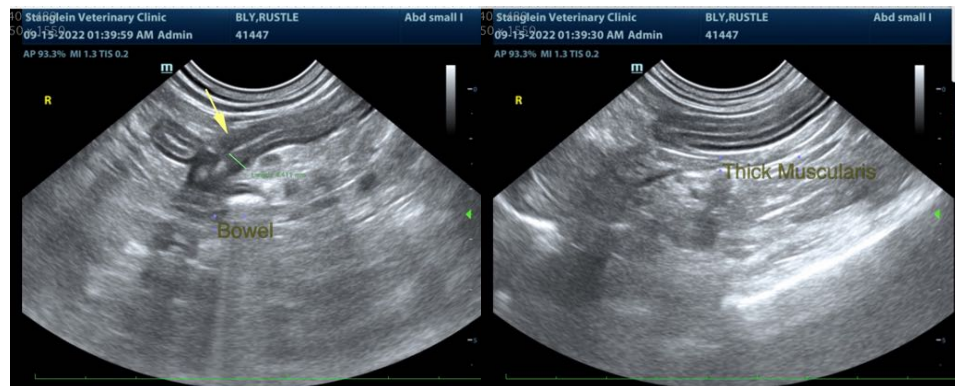
Dr. Rothrock

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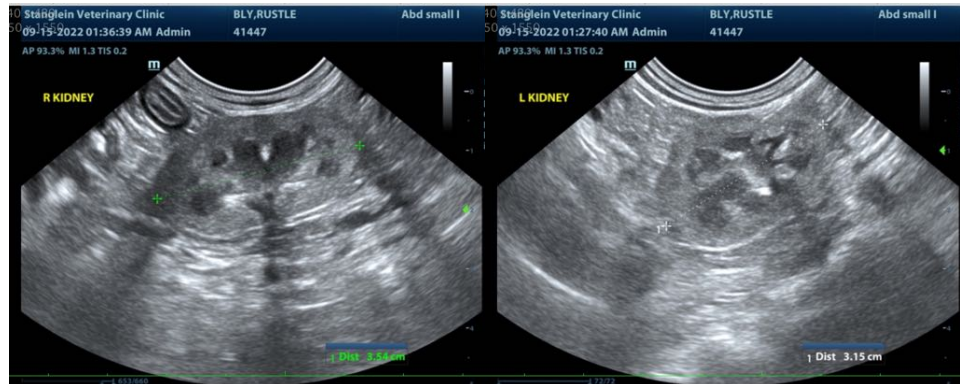
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DACVIM

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.

**IMAGING PERFORMED BY**

Jessica Green

**Beth Johnson, DVM DACVIM**

**HOSPITAL NAME**

Staglein VC

Beth.Johnson@SonoPath.com

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