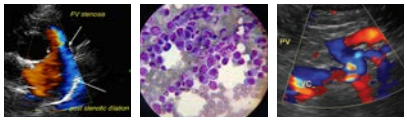
IMAGING PERFORMED BY

IntraPet.com



SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™

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DATE

9/21/22

PATIENT

Jelly Bean Choplin

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

1/22/08

WEIGHT

6.6 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Rachel Brilhart RDMS

HOSPITAL NAME

Airpark AH

REFERRING VET

Dr. Marcizewski

INVOICE

41505

PRESENTING CLINICAL SIGNS

Polyphagia, weight loss.

Current Medications: None.
Lab Results: NSF.
Radiographs: NSF.
Date of Previous IntraPet Ultrasound: No previous.

Sedation: Dexdomitor: 0.1 mLs Butorphanol: 0.1 mLs

Stat Report: Not requested.

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 (2.56 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 infarcts observed. Non-obstructive areas of mineralization/nephroliths are noted.

The left kidney is normal in size (3.02 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 infarcts observed. Non-obstructive areas of mineralization/nephroliths are noted.

Adrenal Glands

The right adrenal gland is normal in size (0.38 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.44 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

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. Multifocal discrete hypoechoic nodules of varying sizes are seen throughout the parenchyma. 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.

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.

The visible small intestine demonstrates areas of mildly thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. 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.

- **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. Differentials for the discrete nodules include primarily benign changes such as nodular hyperplasia. However, primary hepatic neoplasia, infiltrative round cell neoplasia, and even metastatic disease can mimic benign lesions and cannot be ruled out.

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

SECONDARY FINDINGS

- Non-obstructive nephrolithiasis bilaterally in the kidneys

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

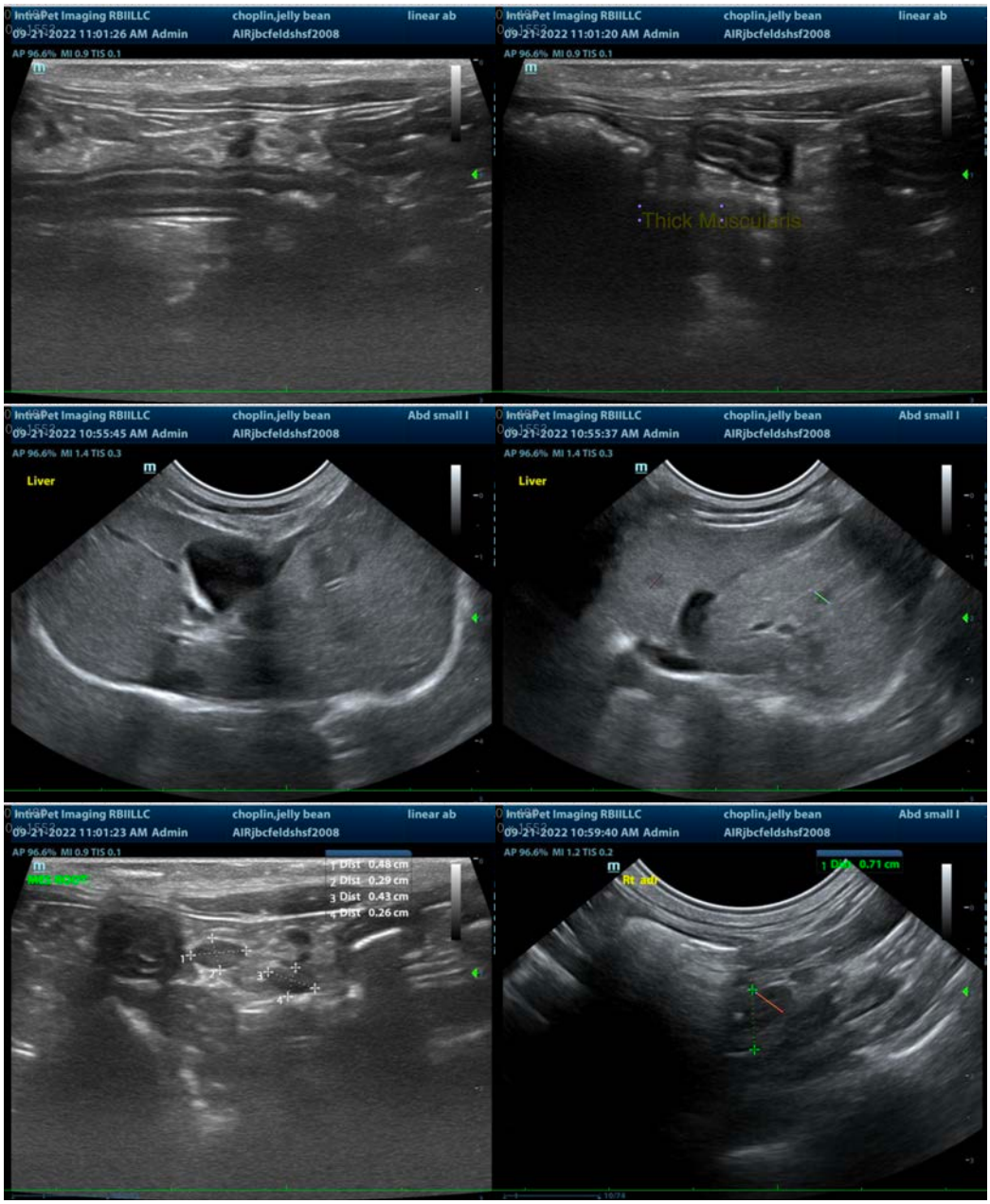
If not recently evaluated, a thyroid level is recommended, given this patient's reported polyphagia.

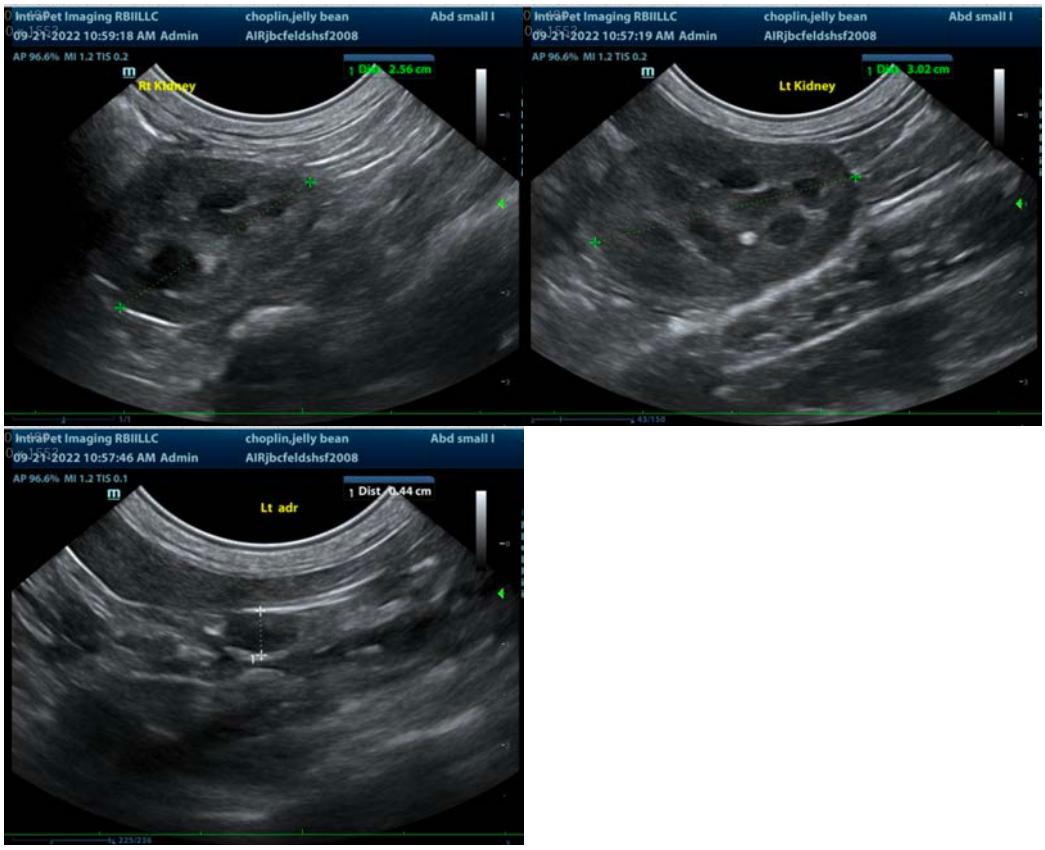
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Tissue sampling is ideally recommended to definitively diagnose and therefore manage this patient's suspected infiltrative bowel disease, if the thyroid level is normal. The least invasive option could include a

fine needle aspirate of the liver if patient's coagulation status is appropriate in case lymphoma is causing the liver changes. If not, then biopsies of the GI tract, being sure to include ileum, if possible, may be necessary.

In the meantime, empirical deworming with a 5-day course of Panacur, cobalamin supplementation (unless not indicated based on GI panel results), and a transition to a hydrolyzed protein diet, are all recommended.





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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