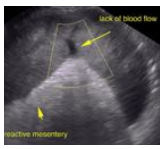
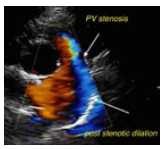
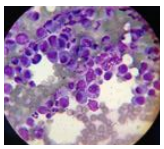
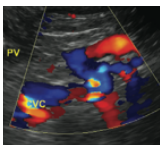

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PATIENT

Aslan Horne

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

16 years

WEIGHT

4.3 kg

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Dr. Trudeau

HOSPITAL NAME

Petworks VH

REFERRING VET

Dr. Trudeau

INVOICE

43497

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PRESENTING CLINICAL SIGNS

History: Vomits twice a day for a decade the clients say. Drooling a lot over the past weeks/month.; severe wt loss over the past 2 years - was 7+kg -doughy and gassy+++ abdomen
Abnormal PE/Chem/CBC/UA Results: CBC/Chem - NF except slight elevated Glob PCV 30%

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys were both normal size and structure, with smooth capsule and normal corticomedullary definition and ratio (cortex 1/3 of medulla). Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. The right kidney measured 3.94 cm. The left kidney measured 3.91 cm.

Adrenal Glands

The adrenal glands were not visualized.

Spleen

The spleen was normal with a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma and smooth capsule, with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. The gall bladder is moderately distended with anechoic fluid, with hyperechoic non-shadowing gravity dependent debris present. There is no surrounding signs of active inflammation.

Gastrointestinal

A focal loop of small intestine on a still image of measured lymph node is markedly thickened (0.35cm) with severely thickened muscularis layer most consistent with developing intestinal mass. The remainder of the visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension and many areas of gas shadowing. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering with a prominent muscularis layer. Visualized peristalsis appears appropriate.

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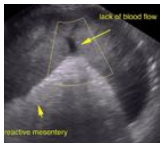

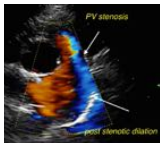

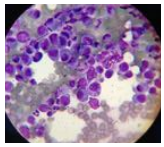
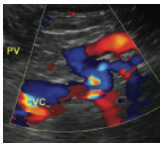

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The stomach contains minimal luminal contents with some gas shadowing obstructing full visualization. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness.

Sections of colon are visualized with minimal colonic contents as well as sections with gas shadowing. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The base and limbs of the pancreas were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour and parenchyma were normal. No overt evidence of active inflammatory or neoplastic disease was noted.

Lymph Nodes

Hypoechoic nodular region labeled “mid abd mesenteric” is suspected to represent prominent mesenteric lymph nodes which appear rounded and hypoechoic. They are surrounded by hyperechoic mesentery suggestive of active inflammation.

Free Abdomen

No masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

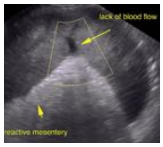
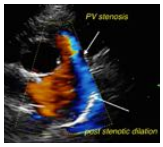
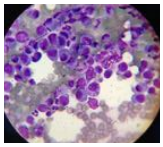
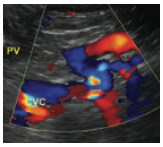
Primary Findings

1. Suspect small intestinal mass
2. Prominent muscularis layer in small intestine
3. Mesenteric lymphadenopathy
4. Gall bladder debris
5. Scant free fluid

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Focal small intestinal thickening with diffusely prominent muscularis layer is most consistent with infiltrative disease of the small intestine with inflammatory bowel disease or GI lymphoma being the top differentials. Intraoperative US-guided bx would be optimal in this patient to obtain the most representative samples in the GI tract. I cannot rule out a preneoplastic (LSA) state however and follow-up sonograms recommended especially If the patient is not responding to empirical efforts. Endoscopic biopsy is less invasive but may miss lesions due to inability to sample more than top 1-2 layers of GI tract and inability to obtain samples from all sections of the GI tract. Surgical biopsies are more likely to be diagnostic but are more invasive. Exploration of the nodular mesenteric area could be done at the same time if surgical GI biopsy is elected. A GI panel (PLI/cobalamin/folate) will help determine the severity of SI dysfunction, and need for vitamin supplementation.

Empiric treatment for IBD includes diet trial with either hydrolyzed or select protein diet, vitamin b-12 supplementation, GI support as needed (anti-nausea, appetite stimulant). Treatment with steroids

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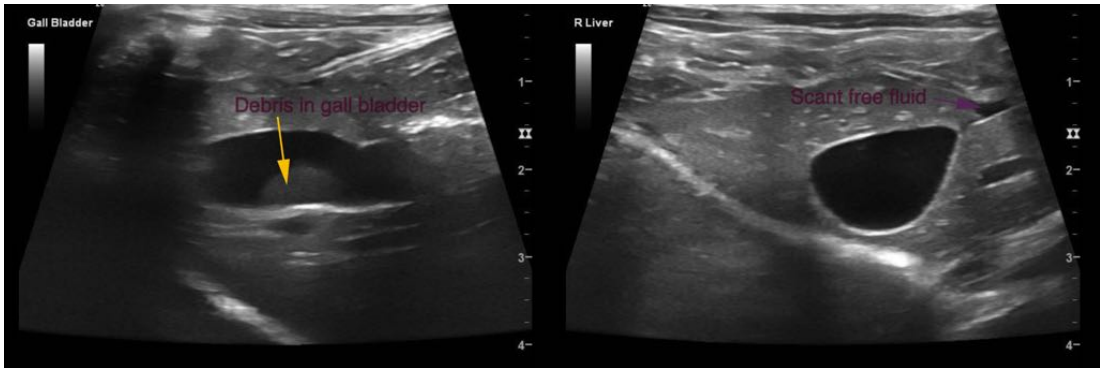
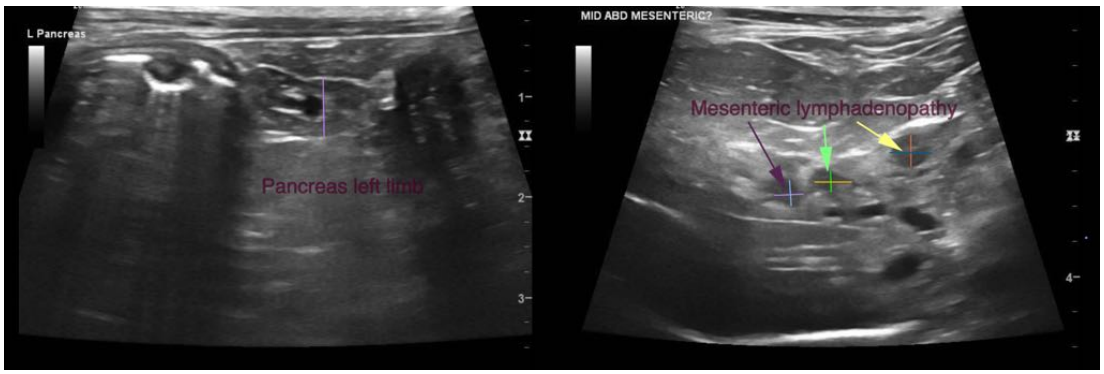
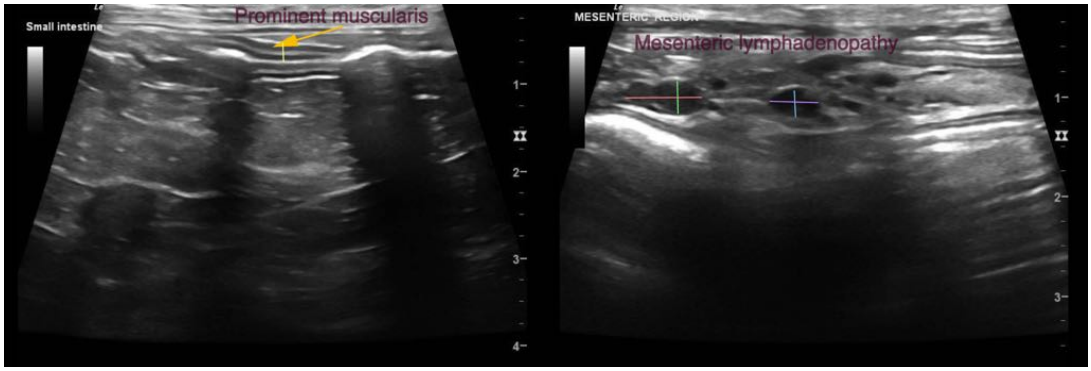
(budesonide vs prednisolone) is often required – biopsies should be acquired prior to treatment with steroids. Steroids may ultimately be tapered to the lowest effective dose or discontinued in some cases.

Lymphadenopathy with parenchymal changes and loss of normal length to width ratio is most concerning for infiltrative disease (lymphoma, MCT, other) and lymph node aspirate and cytology is recommended. Less likely but possible causes include infectious lymphadenitis (bacterial, viral, protozoal or less likely fungal infection) or reactive lymphadenitis (parasitism, migrating foreign body). Lymph node culture could be considered. A less likely possibility is that these rounded structures may represent masses such as is seen with carcinomatosis. The presence of free fluid is likely related to mild peritonitis.

Gall bladder debris is likely an incidental finding and is often subclinical and often does not warrant specific treatment or further investigation. Correlate clinical significance with bloodwork findings and clinical signs. Serial imaging for monitoring could be considered especially if liver enzymes subsequently become elevated.







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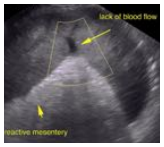
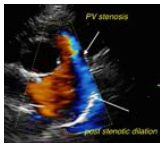
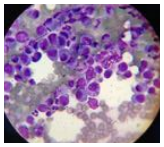
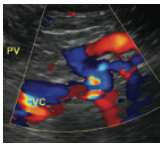

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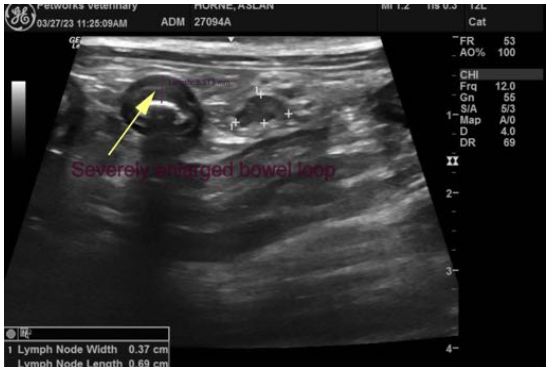

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC
info@SonoPath.com