



PATIENT

Joesie Hubbard

PRESENTING CLINICAL SIGNS

Patient presents for recurrent diarrhea. R/O neoplasia vs. other. No reported meds, no reported blood work.

SPECIES

Feline

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

BREED

DSH

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal.

SEX

Spayed Female

The **kidneys** presented a relatively uniform cortical hyperechogenicity when compared to the renal medulla, spleen and liver. No overt masses were noted. Corticomedullary definition was nebulous and the ratio favored the cortex slightly. The ureters were not visible and assumed to be normal. These changes are most consistent with chronic interstitial nephritis yet infiltrative disease could not be entirely ruled out without biopsy though neoplasia is not suspected. The right kidney measured 3.31 cm with minor pyelectasia. The left kidney measured 3.61 cm.

AGE

15 Years

Adrenal Glands

WEIGHT

N/A

The regions of the **adrenal glands** were unremarkable.

Spleen

INTERPRETED BY

Eric Lindquist, DMV

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted.

DABVP, Cert. IVUSS

Liver

IMAGING PERFORMED BY

Kelly Vazquez

The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

HOSPITAL NAME

Westwood Regional

Gastrointestinal

REFERRING VET

Dr. Cattiny

The **stomach** itself was unremarkable. Diffuse intestinal thickening noted with variable hypertrophy of the muscularis layer. Mesenteric lymph nodes were mildly enlarged, reactive, measuring up to 1.5 cm x 1.0 cm.

Pancreas

INVOICE

36676

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

DATE

4/1/22

Free Abdomen

Minor amount of free fluid noted.



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DATE

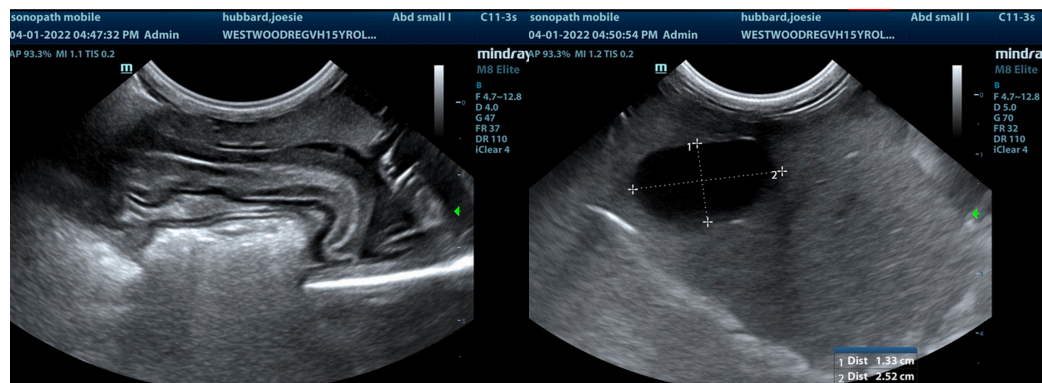
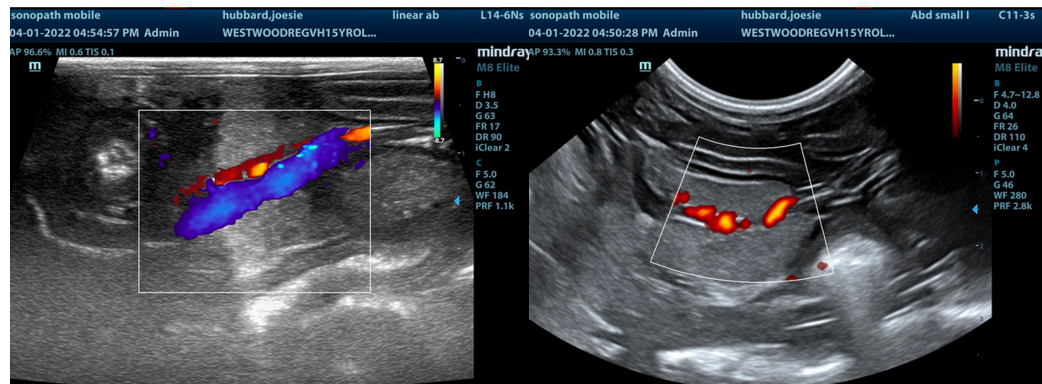
4/1/22

ULTRASONOGRAPHIC FINDINGS

- Diffuse intestinal thickening with mesenteric lymphadenopathy
- Chronic renal changes
- Free fluid – likely owing to lymphatic congestion or cachexia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The intestinal tract does not meet neoplastic criteria. However, an emerging round cell neoplasia/lymphoma cannot be completely ruled out. Mesenteric lymph node pattern would suggest reactive nodes. However, round cell neoplasia cannot be ruled out. FNA would be somewhat difficult and not likely diagnostic in this type of presentation. Therefore, full thickness intestinal and lymph node biopsies would be recommended. Ultrasound guided abdominocentesis could be attempted. However, the pockets of fluid are small. Cytospin with immediate slide preparation recommended to assess for exfoliating neoplasia. However, the most direct measure to definitive diagnosis would be surgical biopsies of the GI tract and lymph nodes.





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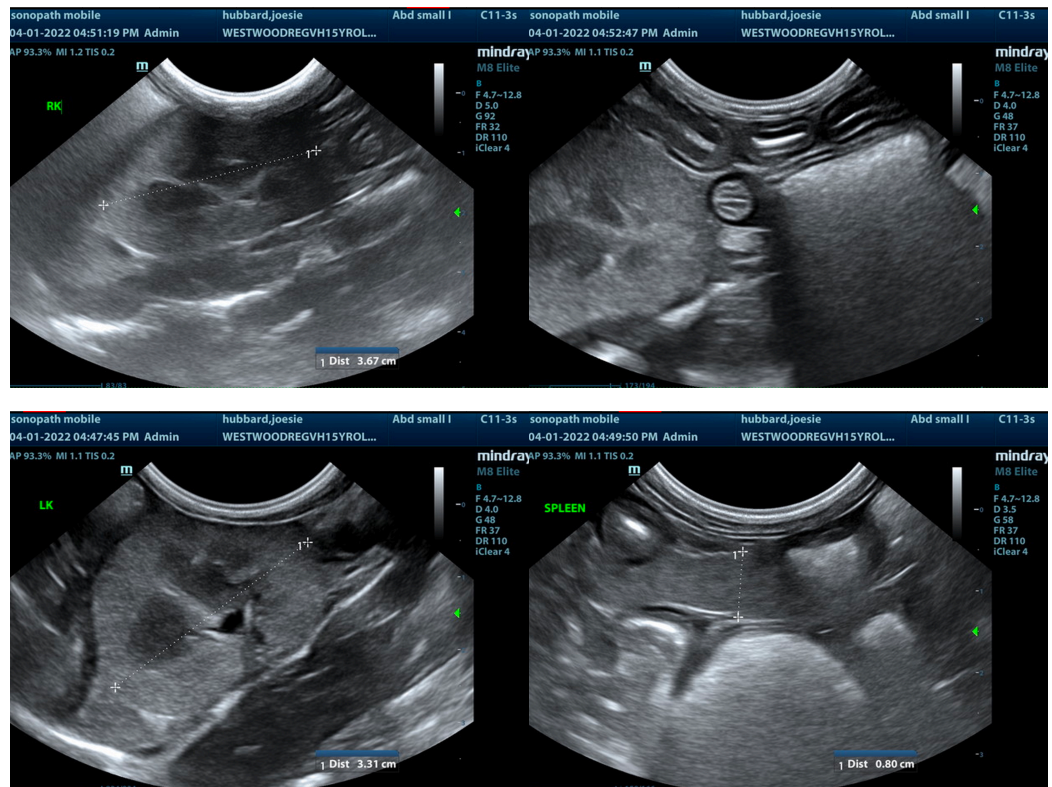
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com

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