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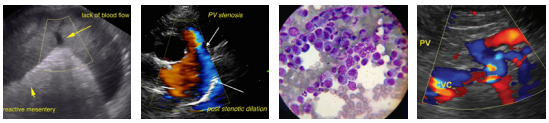

imagine SOUND LLC.
IMAGING PERFORMED BY
dbimaginesound@gmail.com 917-647-4318

PATIENT

Henry Robinson

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

10 Years

WEIGHT

8.07 Pounds

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert IVUSS

IMAGING PERFORMED BY

Denise Bruno, LVT, RDMS

HOSPITAL NAME

Brooklyn Heights VH

REFERRING VET

Dr. Thomson

INVOICE

37001

DATE

4/19/22

PRESENTING CLINICAL SIGNS

fever 104.5* - improved on antibiotics + anti - inflammatory Lethargy - improved on meds. Anorexia. BW - NSF. snap fPL - Neg, UA/Urine culture Neg. Meds: Orbax, convenia, cerenia, syringe feeding A/d Evaluate for pyelonephritis, neoplasia, infection.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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.

The **kidneys** were slightly swollen with some loss of corticomedullary definition and pericapsular inflammatory pattern. The left kidney measured 4.36 cm. The right kidney measured 4.47 cm.

Adrenal Glands

The **adrenal glands** were uniform, yet bilaterally swollen and hypoechoic. This is most consistent with stress-induced hyperplasia. The right adrenal gland measured 0.57 cm.

Spleen

The **spleen** was mildly enlarged (0.62 cm) with uniform, but subtly micronodular parenchyma, and undulating capsular contour. This is consistent with reactive spleen owing to immune stimulus or early infiltrative disease such as mast cell disease or lymphoma. 25-gauge FNA would be ideal if weight loss is an issue to differentiate early round cell neoplasia versus splenitis or reactive spleen all of which can present in this manner.

Liver

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.

Gastrointestinal

The **stomach** itself was unremarkable. Variable intestinal thickening noted with some areas of loss of detail. Wall thickness measured up to 0.70 cm, particularly in the jejunum. Regional lymphadenopathy noted. The lymph nodes presented abnormal length to width ratio with distorted, swollen, irregular contour. Parenchymal detail was indiscernible. This is most consistent with lymphoproliferative disease such as lymphoma/round cell neoplasia, metastatic disease, or an aggressive inflammatory process. FNA, cytology and culture are warranted. Example of lymph node measured 1.4 cm x 0.76 cm.

Pancreas

The **pancreas** was hypoechoic with undulating contour and nodular changes. Minor duct dilation noted.

ULTRASONOGRAPHIC FINDINGS

- Variable intestinal thickening with loss of mural detail, presenting neoplastic criteria
- Regional lymphadenopathy

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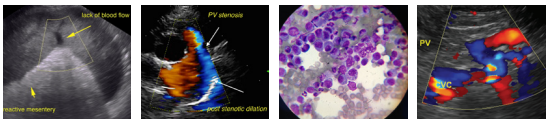

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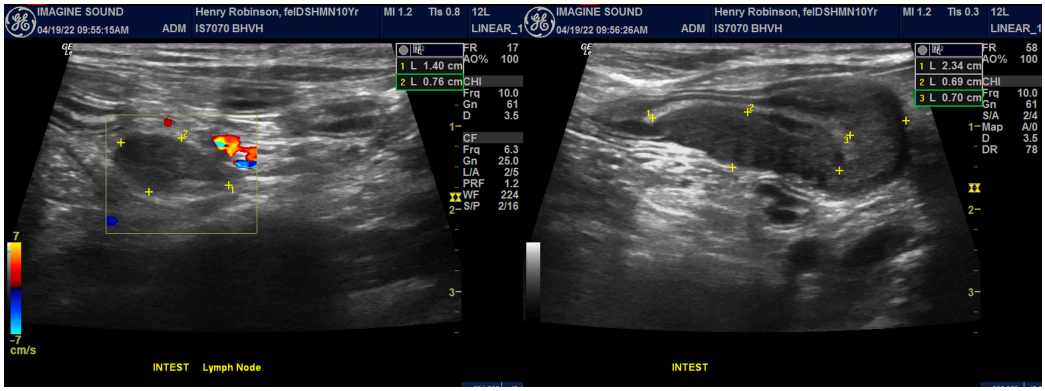
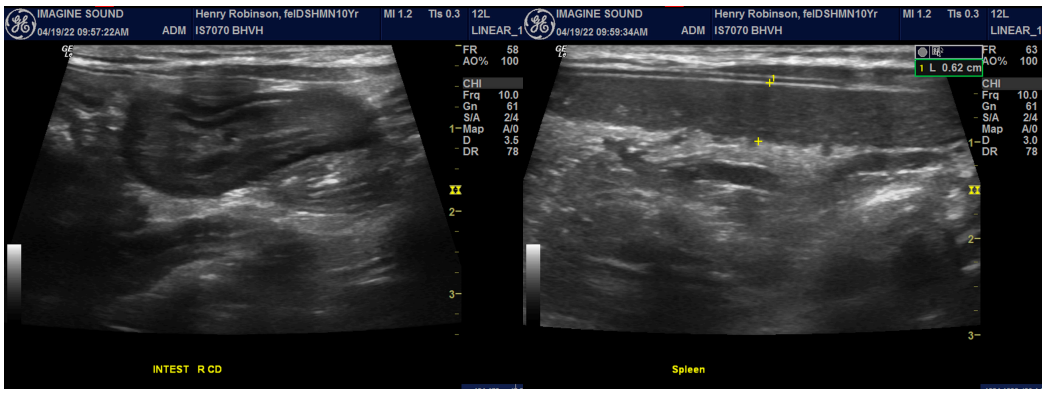
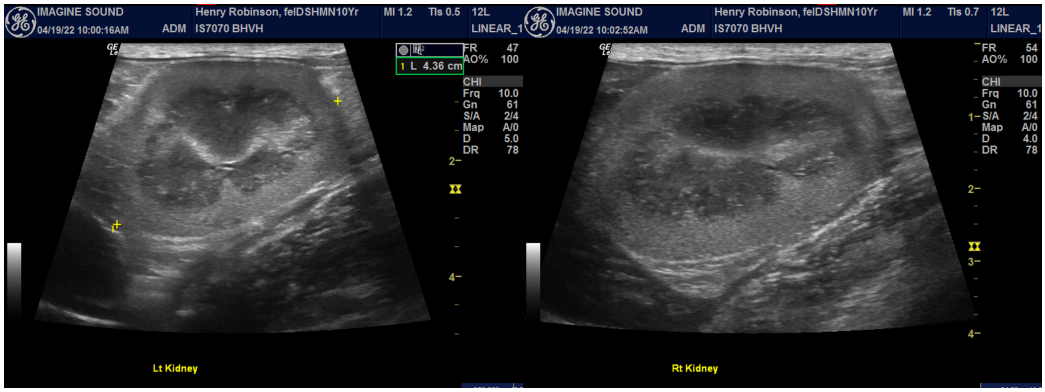
- Swollen kidneys with pericapsular inflammatory pattern – potential emerging renal lymphoma.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

FNA of the kidneys, intestinal thickening, and accessible lymph nodes all warranted. Round cell neoplasia, acute on chronic inflammatory bowel, dry form FIP all potentials with probability of a neoplastic infiltrate. Prognosis is guarded. However, the pathology is relatively in an early phase and may be very responsive to eventual chemotherapy if necessary.







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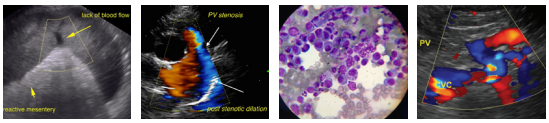

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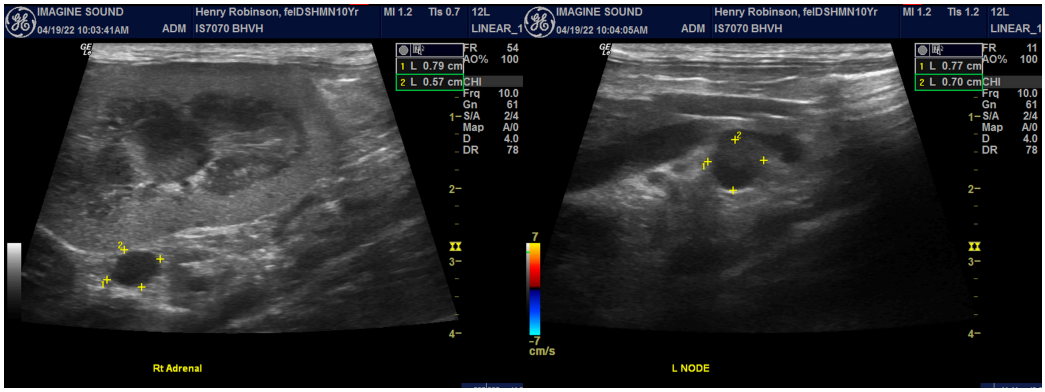

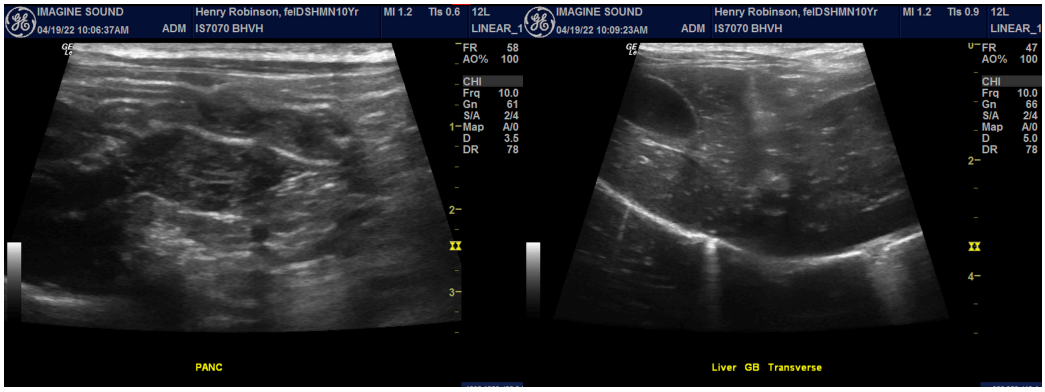

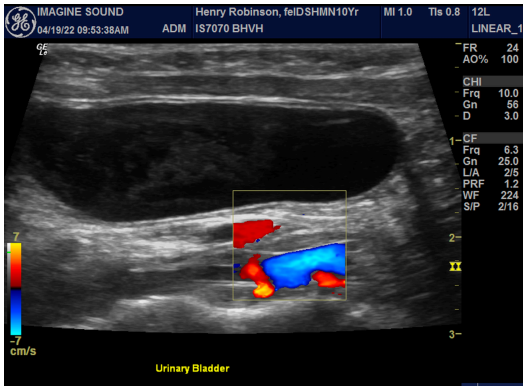

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

info@SonoPath.com