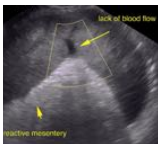

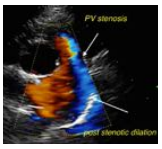

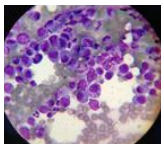
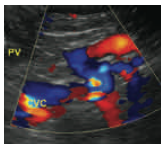

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1-800-838-4268 info@sonopath.com

PATIENT

Molly King

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed Female

AGE

14 years

WEIGHT

4.65 kg

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Trudeau

HOSPITAL NAME

Petworks VH

REFERRING VET

Dr. Trudeau

INVOICE

30721

DATE

5/25/22

PRESENTING CLINICAL SIGNS

History: vomiting, weight loss, and anorexia
CBC/Chem - NSF except for mild increase in SDMA and mild decrease in urea U/A - pending

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 was noted. Ureteral papillae were normal.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for this age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. Slight, non-obstructive mineralization was noted. The left kidney measured 4.14 cm. The right kidney measured 3.89 cm.

Adrenal Glands

Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 0.3 cm.

Spleen

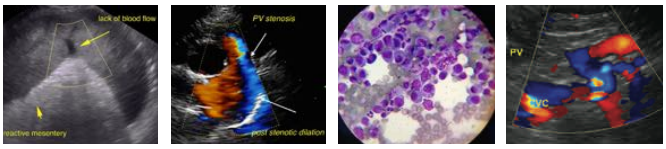
The **spleen** was slightly enlarged and measured 1.07 cm with slight scalloping contour.

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 **gastrointestinal** presentation revealed mild uniform prominence of the gastric mucosa as well as areas of "ropey" small intestinal wall with slight disruption of the normal 1:3 muscularis/mucosal ratio. The intestinal submucosa was slightly irregular, thickened and hyperechoic suggestive of low grade, chronic disease. Intestinal wall thickness measured up to 0.33 cm. The mesenteric lymph nodes are



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enlarged. A grouping of which measured 2.9 x 0.74 cm and were hypoechoic. The largest mesenteric lymph node measured 1.5 x 1.04 cm. Epigastric lymph node was also enlarged and rounded measuring 0.87 cm. Periserosal regional inflammation was noted.

Pancreas

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.

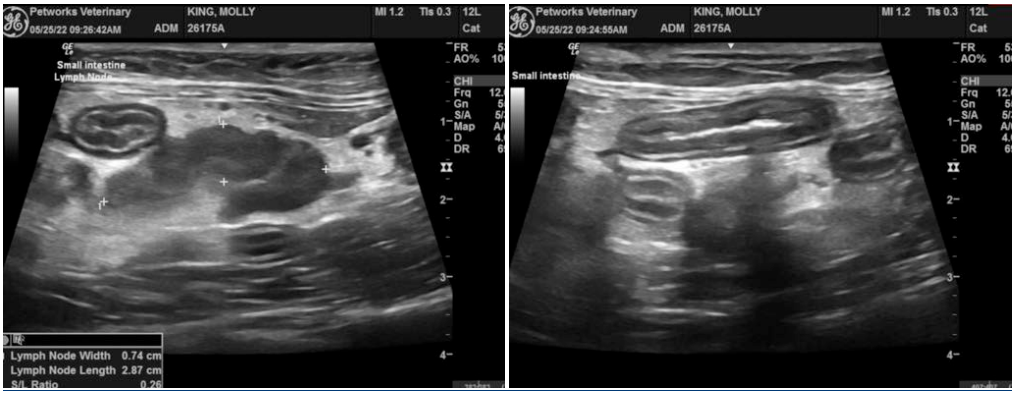
ULTRASONOGRAPHIC FINDINGS

Acute on chronic inflammatory bowel with lymphadenitis versus emerging round cell neoplasia.

Slight splenic enlargement.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There was no loss of mural detail noted in the GI tract. FNA, cytology and culture of the mesenteric lymph nodes and cytology of the spleen is also recommended. Mesenteric inflammation is noted associated with the small intestine as well. PCR or PARR evaluation for lymphoma may be appropriate. Emerging round cell neoplasia such as mast cell or lymphoma is a strong potential in this patient in an early phase. Dry form FIP is a remote potential. Sampling is essential.



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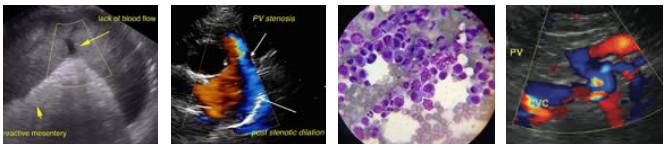

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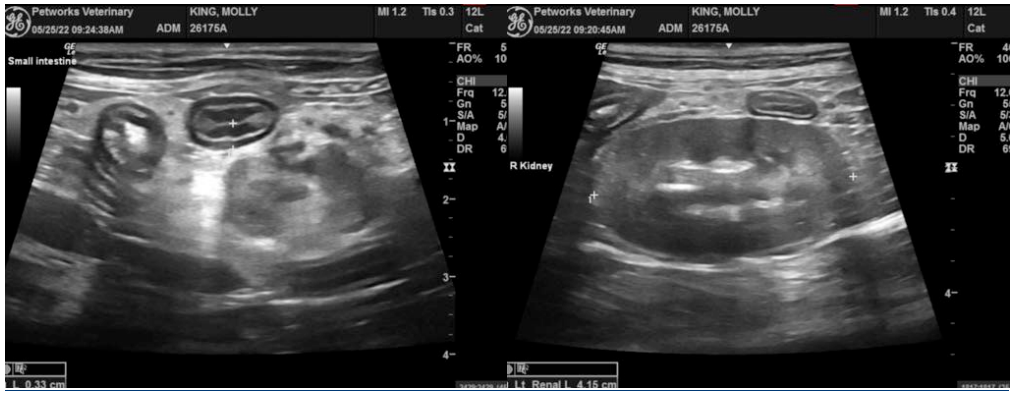

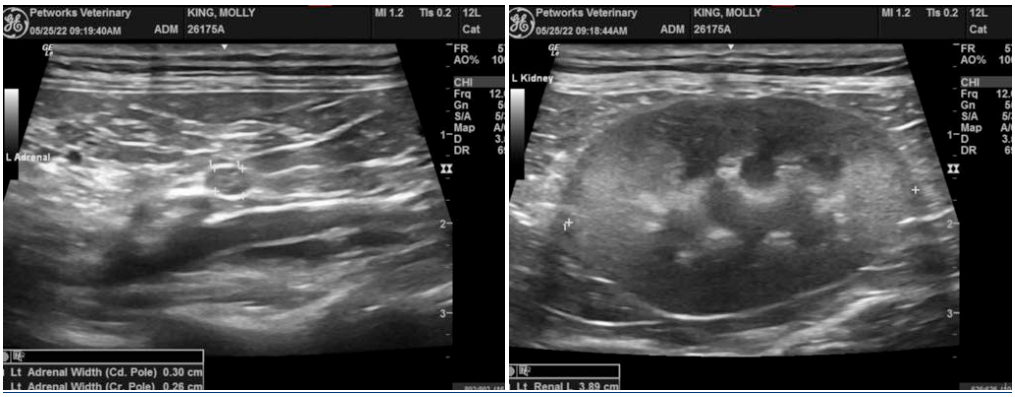

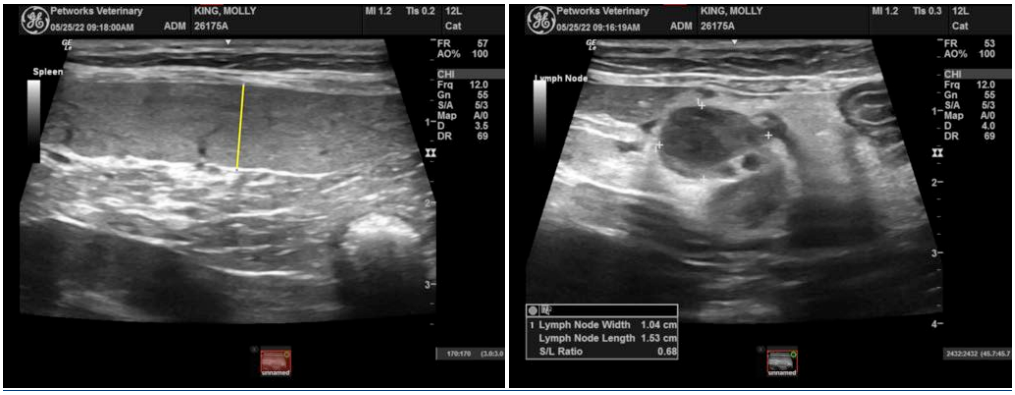

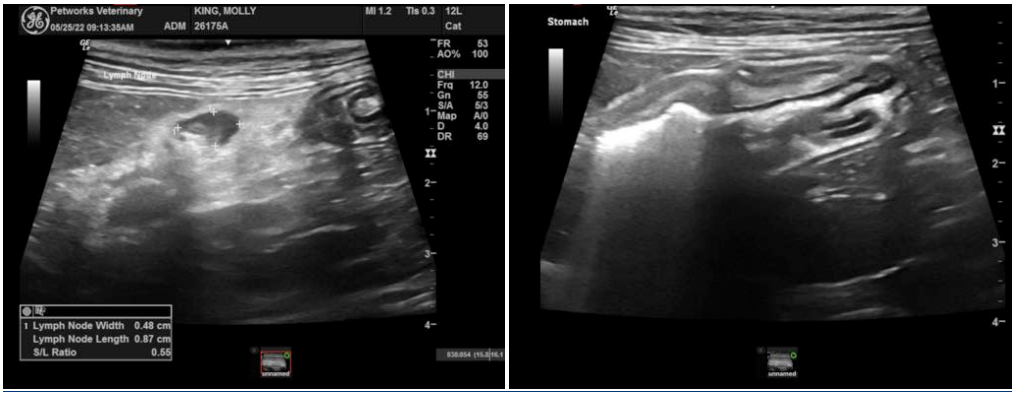

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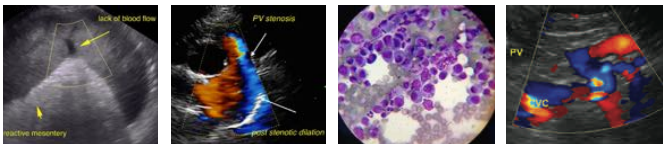

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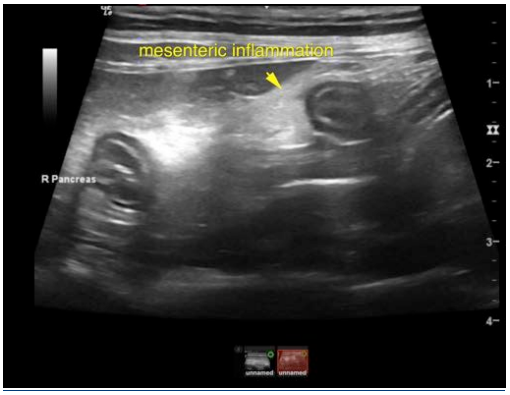

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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