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Clinical Sonography & Telecytology
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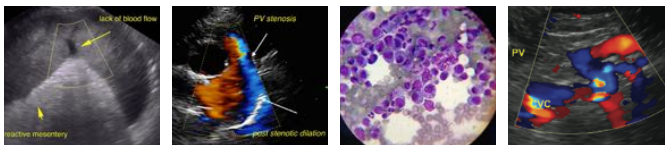

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1-800-838-4268 info@sonopath.com

PATIENT
Lily Fischer

SPECIES
Feline

BREED
Domestic Shorthair

SEX
Spayed female

AGE
15 years

WEIGHT
7.5 lbs

INTERPRETED BY
Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY
Heather

HOSPITAL NAME
Animal Care Center of Flanders

REFERRING VET
Dr. Hallihan

INVOICE
44992

DATE
6/27/23

PRESENTING CLINICAL SIGNS

History: ADR- Hasnt been eating well for a couple weeks and has been lethargic was given gabapentin 0.5ml 1 hour before scan - needed 0.11mL torbugesic IV for further sedation taking amlodipine 1.25mg/ml transdermal

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 his age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. Mineralization was noted in the kidneys. The left kidney measured 3.2 cm. The right kidney revealed a cortical infarct at the cranial pole. The right kidney measured 3.0 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.

Spleen

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 was noted.

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.

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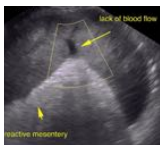

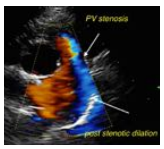

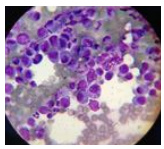
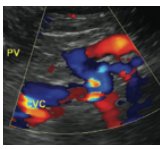

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Gastrointestinal

The **gastric** fundus in this patient revealed a mural thickening that measured 1.0 cm with loss of mural detail. There is a strong concern for round cell neoplasia. The pyloric outflow was mildly thickened. The small intestine and colon were unremarkable. The epigastric lymph node was mildly enlarged. The epigastric lymph node measured 1.0 x 0.5 cm. The mesenteric lymph nodes were slightly enlarged as well.

Pancreas

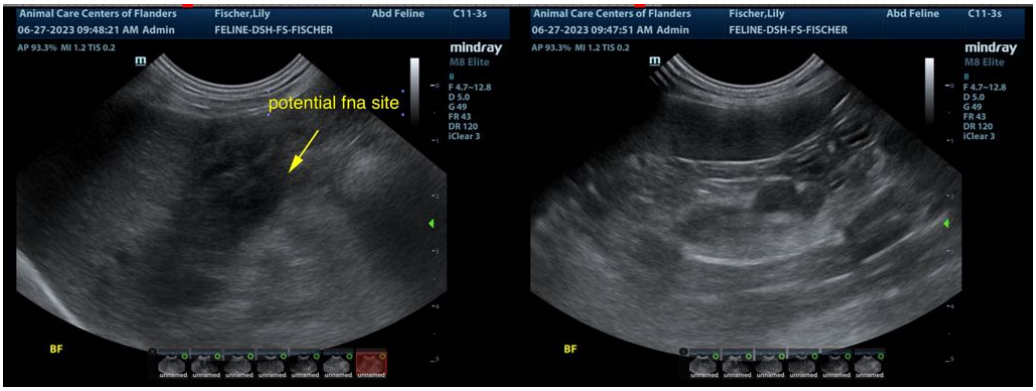
The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxiphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

ULTRASONOGRAPHIC FINDINGS

Variable upper gastrointestinal thickening with regional lymphadenopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a strong concern for emerging lymphoma. None of the lesion at the time of the sonogram are overtly available for ultrasound-guided FNA. However, minor portions of the gastric wall thickening and potentially mesenteric lymph node could be utilized for FNA. However, exfoliation may be difficult. Full thickness pyloric and upper gastric biopsies as well as lymph node biopsies would be ideal in this patient. The prognosis is very guarded. Chest radiographs are warranted to assess for metastatic disease. There is a strong concern for emerging GI lymphoma with micrometastasis possible in other organs, yet no structural changes were noted at this time.



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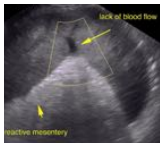
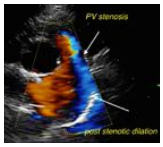
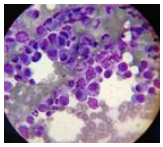
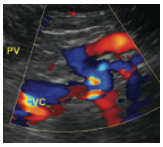

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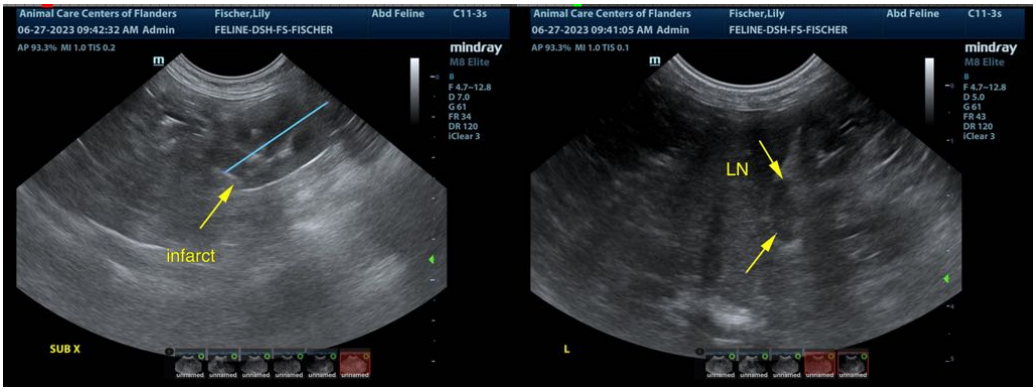

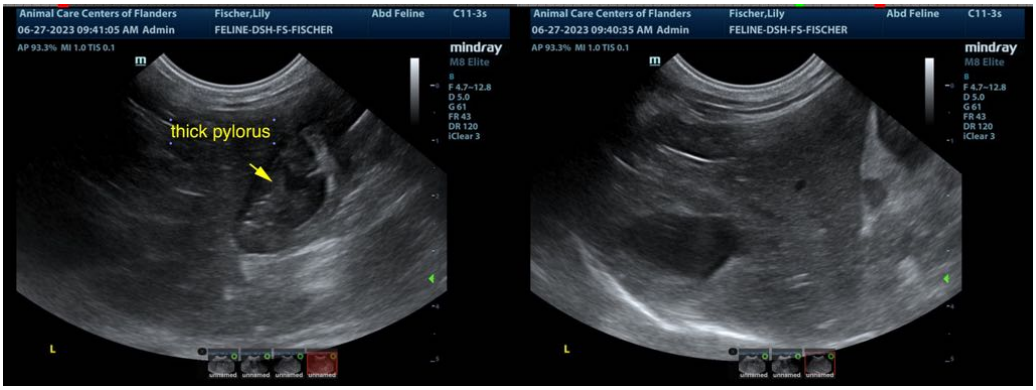

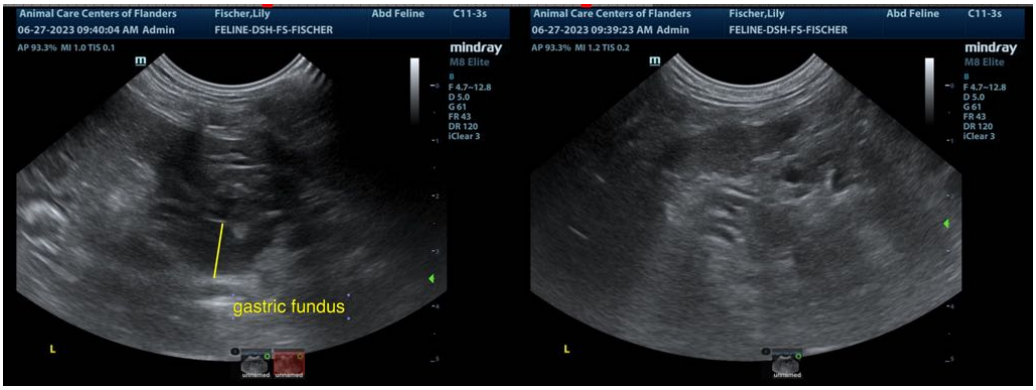

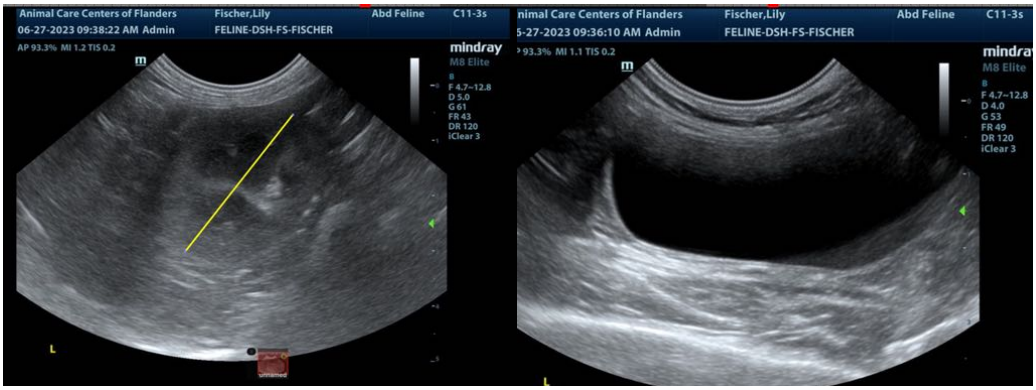

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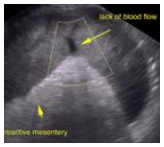

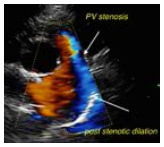

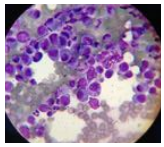
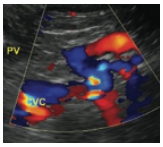

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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