



PATIENT

Bella Salgado

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

12 Years

WEIGHT

8.56 Pounds

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Michaleen

HOSPITAL NAME

DPC Veterinary
Hospital

REFERRING VET

Dr. Oldenhoff

INVOICE

16659

DATE

8/2/22

PRESENTING CLINICAL SIGNS

History: Reason for Visit: Not eating as much. History: 12yr old SF shorthair kitty is presented today because since AVCC visit (anorexia and vomiting ~1week) on June 26th 2022, P's eating has been declining/become nonexistent. Owner reports P has not done well with any medications at home: cerenia, famotidine, prednisolone, appetite stimulant, gabapentin.

Abnormal PE/Chem/CBC/UA Results: Mentation: BAR EENT: OU NS. AU clear, no debris. Oral cavity: Mild calculus, no string under tongue Lymph Nodes: Submandibular, prescapular and popliteal lymph nodes normal size, shape and consistency Skin: Healthy hair coat. No ectoparasites seen, skin clean dry and intact. CV/Respiratory: Normal heart rate and rhythm, no murmur, pulses strong and synchronous, normal bronchovesicular sounds. Abd/GI: Tenses on palpation, unable to fully palpate organs well. Uro/Perineum: No lesions or abnormalities. Musculoskeletal: BCS = 5/9. Ambulatory x 4, normal gait, normal palpation all 4 limbs. Neurological: Alert and appropriate. No deficits noted. 6/25/22 bloodwork Diagnostics: CBC: thrombocytopenia (plt 31 K/uL) Cytology: manual plt 151 K/uL Chem: BUN 14 mg/dL, T4/SDMA: 1.2 ug/dL / 13 ug/dl NOVA: pCO2 23.3 mmHg, pO2 203.5 mmHg, SO2 110%, iMg 0.79 mmol/L, Glu 138 mg/dL, BUN15 mg/dL, HCO3- 13.5 mmol/L UA: USG 1.036, suspect cocci bacteria (none present on direct) Radiographs: Findings The gastrointestinal tract contains a mild to moderate volume of fluid and gas, and is normal in size, position and orientation, consistent with a nonspecific gastroenteropathy or pancreatitis. Subjectively the gastric and intestinal walls have a turgid/thickened appearance, however radiographic assessment of gastrointestinal mural is inaccurate and nonspecific, and ultrasonography is recommended for further evaluation of the gastrointestinal tract. In the right cranial to mid abdomen, in the mesentery, at the level of the 13th rib on the lateral views, a small (0.4 cm) partially mineralized crescentic structure is present. This most likely represents incidental nodular fat necrosis (Bate's body) or less likely non-obstructive intestinal mineral material. In the mid abdomen, there is poor peritoneal serosal detail. The liver, spleen, left kidney and region of right kidney, urinary bladder, and retroperitoneal space are normal. Conclusion 1. Poor peritoneal serosal detail differential diagnosis includes septic or sterile peritonitis, pancreatitis, steatitis, carcinomatosis/lymphomatosis and/or mild peritoneal effusion Discussion: A definitive cause for reported vomiting and pyrexia is not determined during this evaluation. Differential diagnosis for the reported clinical history and radiographic findings includes infiltrative gastrointestinal neoplasia, immune-mediated enteropathy, or pancreatitis.

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** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The kidneys measured 3.0 cm each.

Adrenal Glands



PATIENT

The regions of the **adrenal glands** revealed no evident pathology.

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Spleen

SPECIES

The **spleen** was mildly enlarged 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.

Feline

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Liver

DSH

The **liver** was swollen and irregular in contour with minor regional lymphadenopathy. The gallbladder and common bile duct were unremarkable.

SEX

Gastrointestinal

Spayed Female

The **upper gastrointestinal tract** revealed variable thickening with loss of mural detail and an overt intestinal mass, measuring approximately 3.0 cm x 2.0 cm.

AGE

Pancreas

12 Years

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some mild 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 subxyphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

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Free Abdomen

Eric Lindquist, DMV
DABVP, Cert. IVUSS

Reactive **mesentery** was noted throughout the mid abdomen. Regional lymphadenopathy noted with disruptive lymph nodes.

IMAGING PERFORMED BY

ULTRASONOGRAPHIC FINDINGS

Michaleen

- Multicentric lymphoma pattern, involving the intestine and lymph nodes with probable splenic and hepatic involvement
- Free fluid is suggestive for lymphomatosis
- Age-related pancreatic changes
- Scalloping spleen
- Variable intestinal thickening

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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FNA of the intestinal mass, accessible lymph nodes, spleen and liver indicated.

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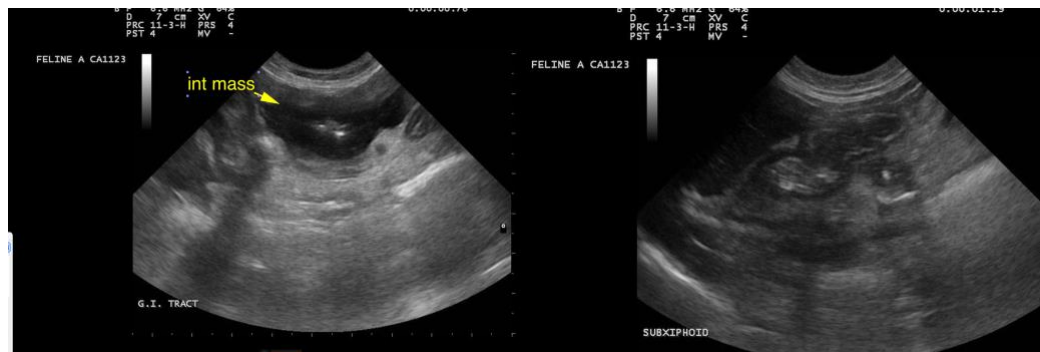
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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info@SonoPath.com