



**PATIENT**

Bond Granitzki

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

4.5 Years

**WEIGHT**

8.6 Pounds

**INTERPRETED BY**

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

**IMAGING PERFORMED BY**

Shari Reffi, CVT

**HOSPITAL NAME**

Tranquility VC

**REFERRING VET**

Dr. Antonelli

**INVOICE**

12866

**DATE**

8/30/21

**PRESENTING CLINICAL SIGNS**

History: Vomiting 2x per week + weight loss. No current meds. R/O IBD vs Neoplasia vs other  
Abnormal PE/Chem/CBC/UA Results: ALB 4.1, ALT 101, T4/FT4-wnl

**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 pelvic urethra was imaged 2.0 cm beyond the cystourethral junction.

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 right kidney measured 3.95 cm. The left kidney measured 3.84 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 0.33 cm. The right adrenal gland measured 0.37 cm.

**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 were noted. The spleen measured 0.7 cm.

**Liver**

The **liver** was mildly swollen. A trace amount of free fluid was noted between the liver lobes and gallbladder. The gallbladder itself was unremarkable.

**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. No concerning lymphadenopathy was visible. No evidence of obstruction was present. Chronic inflammatory bowel disease is likely with a low possibility of an early neoplastic event such as lymphoma. Full thickness tissue biopsies via open laparotomy, ideally guided by intraoperative ultrasound in order to obtain the most representative mural sample, would be necessary to rule out this possibility.

**Pancreas**



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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.

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**Free Abdomen**

The mesenteric **lymph node** (2.46 cm x 0.6 cm) presented normal length to width ratio with slight, swollen contour. There was no loss of parenchymal detail. This is most consistent with reactive lymphadenitis or lymphatic hyperplasia.

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DSH

**ULTRASONOGRAPHIC FINDINGS**

**SEX**

Neutered Male

- Minor mesenteric lymphadenopathy
- Mild hepatic swelling with trace fluid
- Hypertrophied muscularis in variable areas of the small intestine

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

**AGE**

4.5 Years

If liver enzyme elevations occur, then FNA of the liver indicated. Emerging round cell neoplasia is a potential in this patient; however, no neoplastic criteria are met at the time of the sonogram. Mesenteric lymph nodes have a reactive pattern, FNA could be considered, however, they are not excessively large, therefore, exfoliation may be difficult for a definitive diagnosis. The free fluid may be owing to lymphatic congestion or possible early infiltrative disease. Treatment for inflammatory bowel warranted such as the following protocol. Screening FNA of the liver, mesenteric lymph nodes and spleen would be ideal given the patient history as an occult emerging round cell neoplastic event may be in play in this patient.

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**Triaditis/Pancreatitis protocol**

Part or all of this protocol may be considered based on your clinical impression of the patient:

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Recommend pain management when anorexic with **Buprenorphine** (0.01-0.02 mg/kg IM or SC), clinical trial of **Zithromax** (50 mg sid/cat x 10 days, 3 weeks if bartonella +), **Prednisolone** (0.5-2 mg/kg tapering over 1 week to minimal effective dose), and **B12 injections** if weight loss (Cyanobalamine 250 mcg sub-q once-weekly x six weeks, then every other week for six weeks and then once-monthly, long-term if necessary), **novel-protein or hydrolyzed diet** (*Hydrolyzed diets have been shown to be more effective in dietary intolerance case management compared to hypoallergenic diets*) or the **magical Purina DM** (changing protein source is crucial and may need rotation every 6 months if clinical signs recur) Diet trials is a whatever works phenomenon. If vomiting becomes a persistent issue then endoscopy would be warranted and/or recheck sonogram to assess more emerging disease. One diet does not work for all patients so different trials may be necessary or protein source rotation every 6 months as new sensitivities develop.

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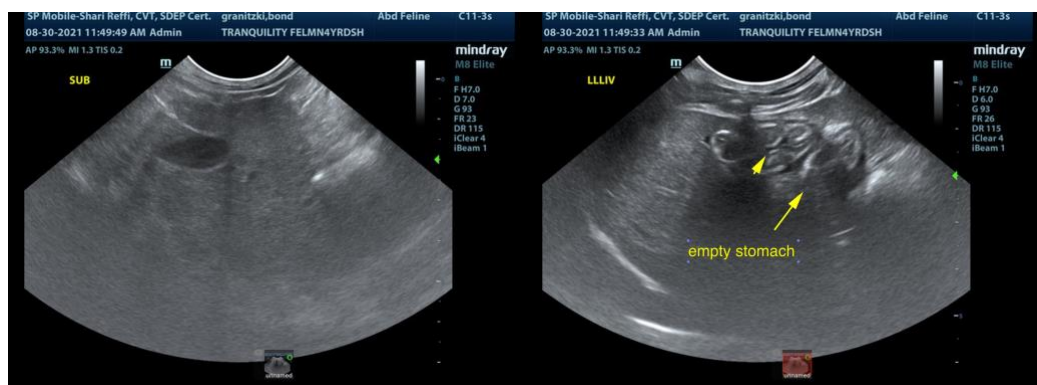
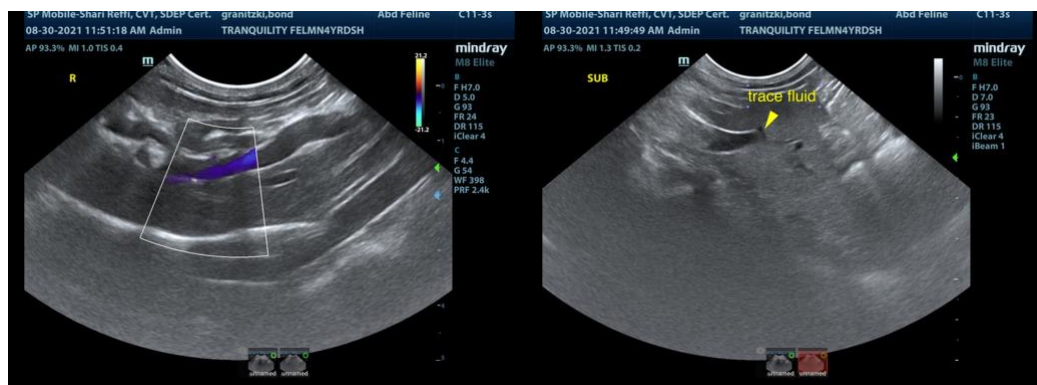
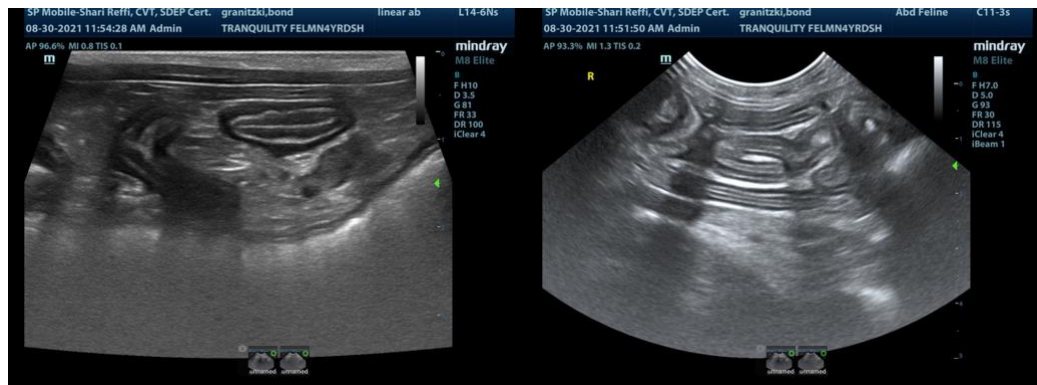
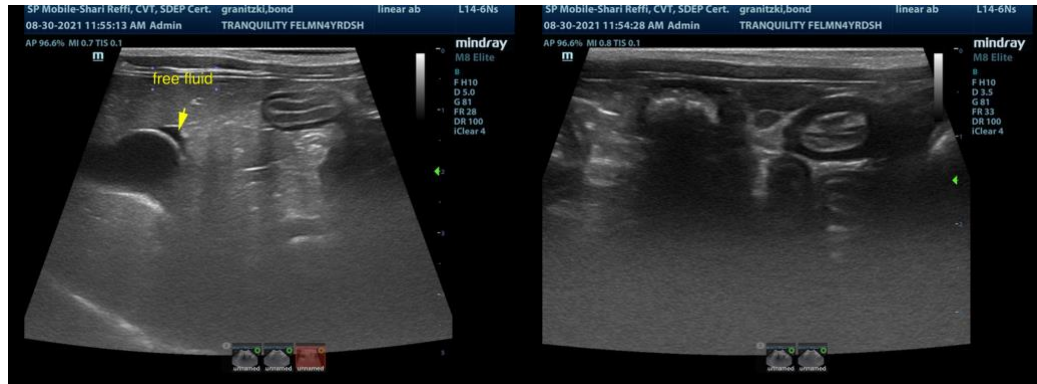
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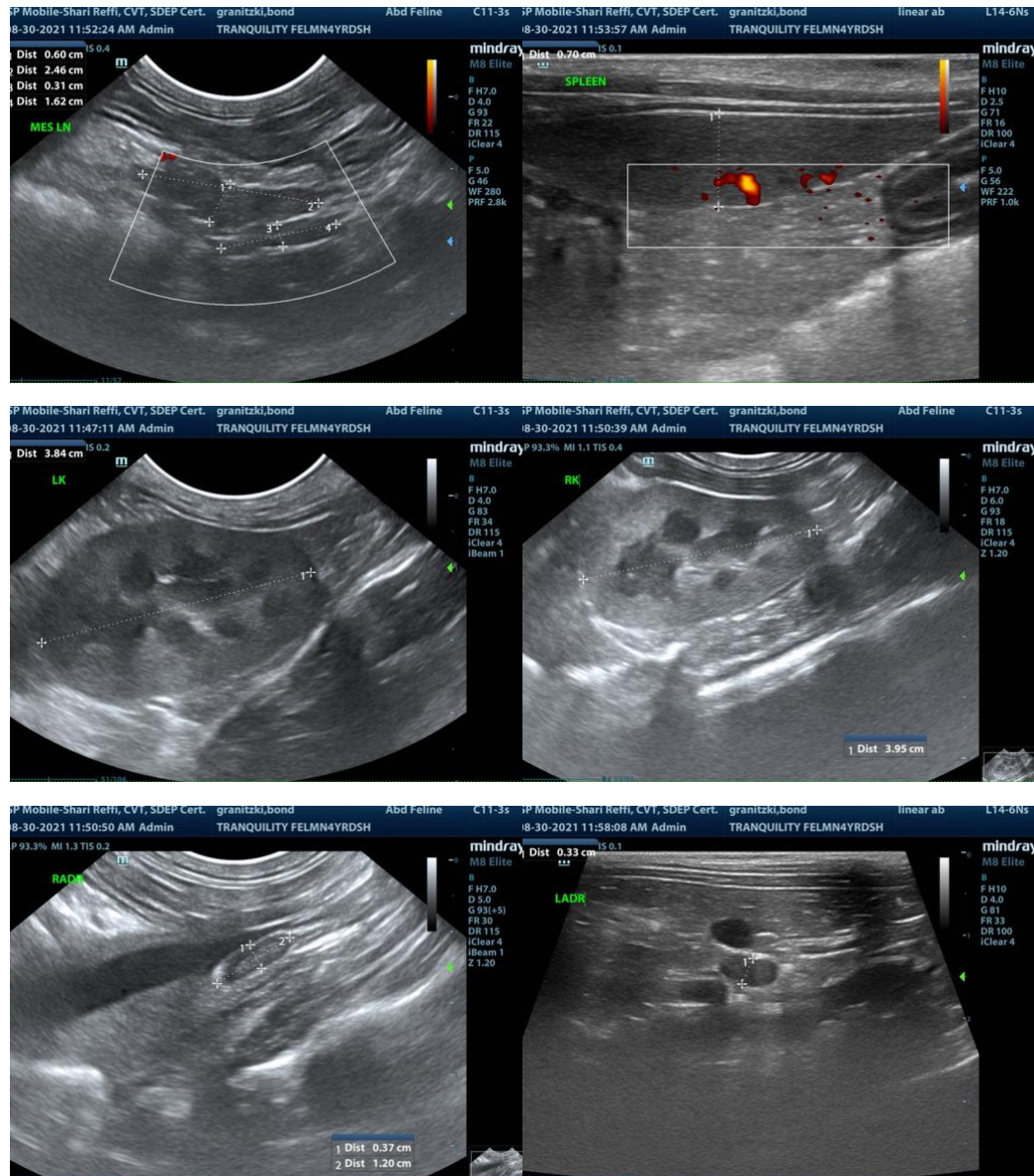
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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