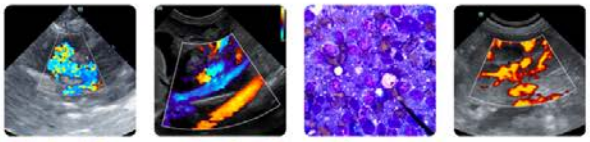


PATIENT

Fika Blevins

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

11 Years

WEIGHT

7.4 kg

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Dr. Gira

HOSPITAL NAME

Fish Creek Emergency

REFERRING VET

Dr. Brulotte

INVOICE

72957

DATE

2/13/26

PRESENTING CLINICAL SIGNS

Dental on Monday, not eating since. Lost fair amount of weight, is overweight. Has diarrhea.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder contains a mild amount of aggregating echogenic debris. The bladder wall is normal in appearance and thickness. No masses are seen.

The right kidney presents normal size (4.3 cm) with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis.

The left kidney presents normal size (4.4 cm) with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis.

Adrenal Glands

The right adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The right adrenal gland measures 4.0 mm in width.

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The left adrenal gland measures 4.5 mm in width.

Spleen

The spleen is normal in size, shape, margination and echogenicity. There is a 5.4 mm x 5.8 mm hyperechoic lesion in the body that is most likely a benign myelolipoma.

Liver

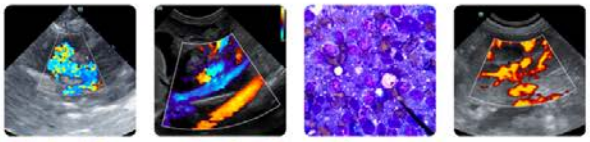
The liver presents normal size and shape with smooth lobar margins. The parenchyma has normal echogenicity with normal echotexture. No focal lesions are seen. Intrahepatic bile ducts are normal. Normal vascular pattern.

The gallbladder presents normal size with anechoic contents. Normal gallbladder wall. No evidence of bile duct distention or obstruction.

Gastrointestinal

The pylorus is visualized and contains a moderate amount of ingesta. No pyloric outflow tract obstruction is seen. Diffusely, the pylorus wall has a normal appearance and thickness. Pyloric wall measures 2.0 mm in width, which is normal.

Diffusely, the duodenum appears to have decrease in normal layering of the mucosal and submucosal layer. There appears to be decreased motility of the duodenum. There is a mild to moderate amount of fluid found throughout the duodenum. Duodenal wall measures 3.1 mm in width. The muscularis layer appears to be normal in thickness for the duodenum. The ileum has moderate loss of normal layering. It is difficult to assess the overall wall thickness, as the layering is decreased. There is a moderate amount of hyperechoic fat surrounding the ileum as well, consistent with infiltrative disease such as lymphoma or mast cell disease. Within what appears to be proximal jejunum, there are two areas that appear to have focal material within the lumen that is causing hard shadowing or complete shadowing. There are



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multiple segments of jejunum that are moderately distended with ingesta. These areas of shadowing within the jejunum are potentially concerning for small intestinal foreign bodies. Foreign bodies would explain the segments of distended jejunum and ingesta distended stomach as well.

Colon contains normal contents with normal wall thickness.

Pancreas

The pancreas is diffusely normal in appearance. It is isoechoic to the surrounding mesentery. There is no hyperechoic fat surrounded the pancreas.

Free Abdomen

Mild medial iliac lymphadenopathy is noted, with a representative node measuring 7.6 mm x 5.0 mm in width. These nodes are lobulated and hypoechoic in appearance.

In the area of the ileocolic junction there are enlarged mesenteric lymph nodes, with a representative node measuring 10.5 mm x 6.2 mm. There are approximately 4-5 enlarged lymph nodes in this region. There is hyperechoic fat surrounding the lymph nodes.

There are additional mesenteric lymph nodes present throughout the mesentery. One of the nodes measured 1.3 cm x 0.60 cm. These nodes also have hyperechoic fat surrounding them, consistent with inflammation.

No free abdominal fluid is seen.

ULTRASONOGRAPHIC FINDINGS

- Thickened small intestine with areas of loss of layering, specifically the ileum.
- Food distended stomach and small intestine, with two areas of complete shadowing with what appears to be the proximal duodenum.
- Enlarged mesenteric lymph nodes – Most likely round cell neoplasia such as lymphoma or mast cell disease, with the primary disease process most likely being the patient's small intestines. Less likely these lymph nodes are enlargement due to a reactive benign cause.
- Mild medial iliac lymphadenopathy – Likely reactive. Potential neoplasia such as round cell such as lymphoma or mast cell, or possibly metastatic neoplasia, although a primary tumor is not seen to be causing metastatic neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given that the patient does have concern for possible infiltrative disease, including mast cell disease, small cell lymphoma, less likely benign inflammatory bowel disease, it appears to be warranted to consider an exploratory laparotomy to evaluate the small intestines further for the possibility of a small intestinal mechanical obstruction. I would recommend during an exploratory laparotomy to evaluate the GI tract, and that GI biopsies of the small intestine and stomach are taken during this procedure and submitted for histopathology to determine underlying etiology of the changes to the GI tract causing the loss of layering to the ileum, and also we would recommend during this procedure if possible to extirpate one or several abdominal lymph nodes for histopathology as well.

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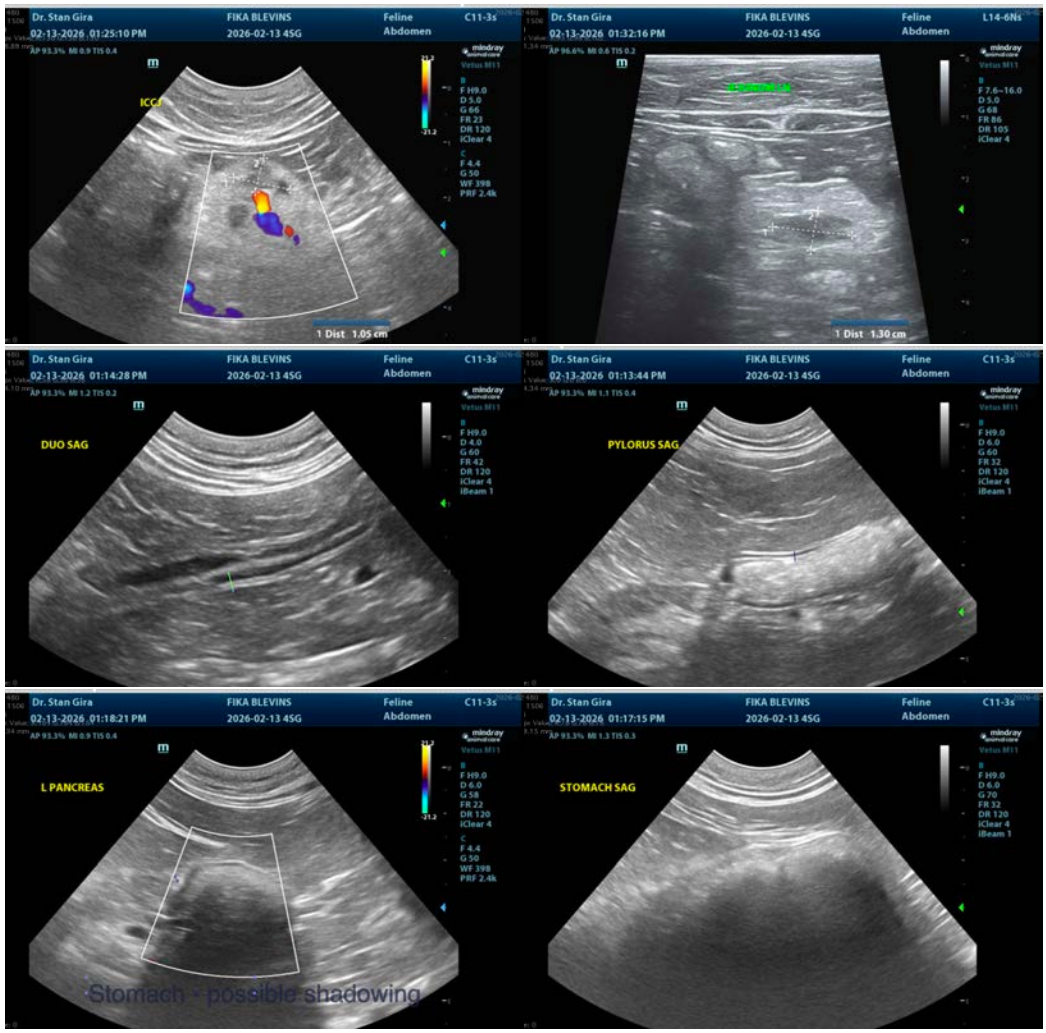
If possible, recommend sedating the patient and performing an ultrasound guided aspirate on one of the enlarged mesenteric lymph nodes and submitting cytology sample to Colorado State University for cytology, and if warranted, PCR for antigen receptor rearrangement assay (PARR).

If a urinalysis has not been performed, recommend submitting urinalysis, and if patient has an active urine sediment, then recommend submitting urine culture and antibiotic sensitivity.

Pancreatitis is not suspected as a cause of the patient's clinical signs. If pancreatitis is still a rule out for this patient, then recommend an fPLI to screen further for possible occult pancreatitis.

Prognosis is open pending results of exploratory laparotomy and the histopathology of the GI biopsides and lymph node biopsies.



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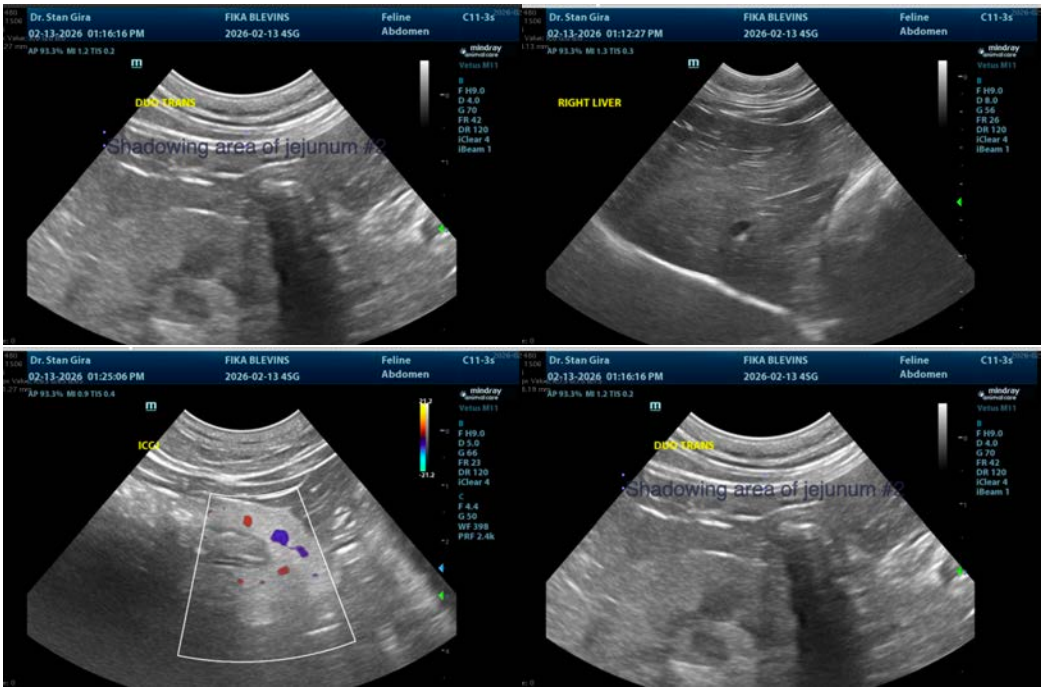

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Greg Kuhlman, DVM, DACVIM (SAIM)

Veterinary Internal Medicine Specialist
info@SonoPath.com