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Clinical Sonography & Telecytology
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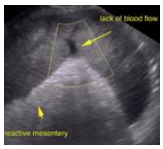
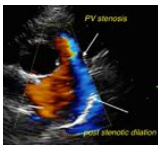
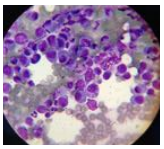
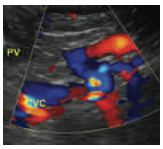





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Midnight Wood

SPECIES
Feline

BREED
Domestic Shorthair

SEX
Spayed Female

AGE
17 years

WEIGHT
16.9 lbs

INTERPRETED BY
Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY
Kelly Vazquez , CVT

HOSPITAL NAME
Bergen County VC

REFERRING VET
Dr. Gess

INVOICE
92234

DATE
10/7/21

PRESENTING CLINICAL SIGNS

History: Weight loss, intermittent anorexia, and vomiting.
Abnormal PE/Chem/CBC/UA Results: SDMA 14, USPG 1.016/inactive, T4 2.5.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (3.58 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.46 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.42 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

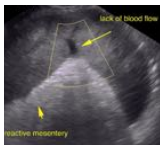
The right adrenal gland is normal in size measuring 0.43 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

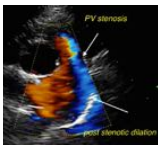
Spleen

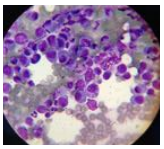
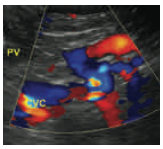
The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed. The gallbladder lumen is moderately distended. The wall of the gallbladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.





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Gastrointestinal

The stomach contains minimal luminal contents. It subjectively appears normal with normal layering, but measures as thick at <0.52 cm (normal is less than 0.36 cm). In the cranial abdomen adjacent to the enlarged gastric lymph node the wall appears thicker and measures at 1.0 cm in thickness with loss of detail of layering. There is no focal mass effect in this area. There is variability in wall thickness due to rugal folds.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. The duodenum measured as normal and the jejunum measured as normal (0.17 cm). Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is prominent and hypoechoic as compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. Surrounding hyperechoic mesentery was noted.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a significant cranial abdominal lymphadenomegaly present. The gastric lymph node is prominent and measured 1.29 x 0.86 cm with surrounding hyperechoic mesentery. The omentum is of normal uniform echogenicity, but hyperechoic in the cranial abdomen.

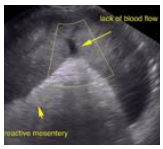
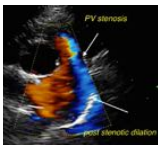
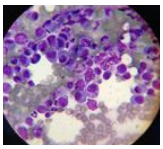
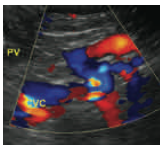
ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

- Enlarged gastric lymph node with cranial abdominal inflammation. The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Subjective gastric wall thickening. The stomach wall thickening could be consistent with inflammation, edema, infiltrative neoplasia, imaging artifact due to rugal folds, other.
- Hypoechoic, prominent pancreas surrounded by hyperechoic mesentery. The pancreatic changes are most consistent with mild pancreatitis/pancreatic infiltration. I recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider FNA if not improving.

SECONDARY FINDINGS:

- Decreased corticomedullary distinction in both kidneys. Mild loss of corticomedullary

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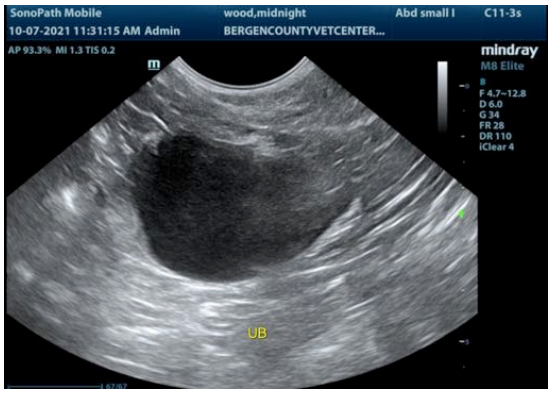
distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is clearly cranial abdominal inflammation with a large lymph node and a reactive looking pancreas. It is not clear if this is due to a primary source of inflammation from the GI tract causing a reactive lymph node and irritation of the pancreas or if this is pancreatitis causing cranial abdominal inflammation and secondary gastritis. I recommend a GI panel with an fPLI, TLI, cobalamin and folate to further evaluate for pancreatic and small intestinal disease. I recommend symptomatic treatment for pancreatitis and gastritis. If you can find an angle to aspirate the gastric lymph node that information may be helpful, but it is in a difficult area.

If the patient's symptoms are not improving or progressing then consider reevaluation with ultrasound as surgical biopsies may be necessary. I recommend three view thoracic radiographs.



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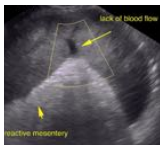
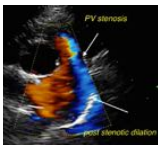
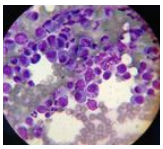
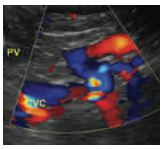

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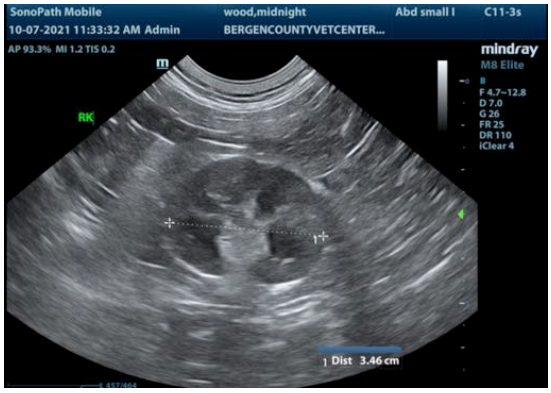

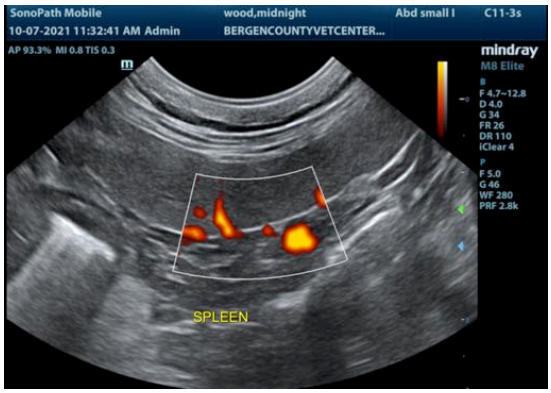

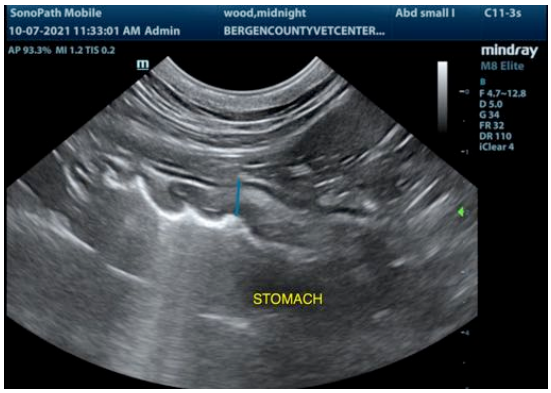

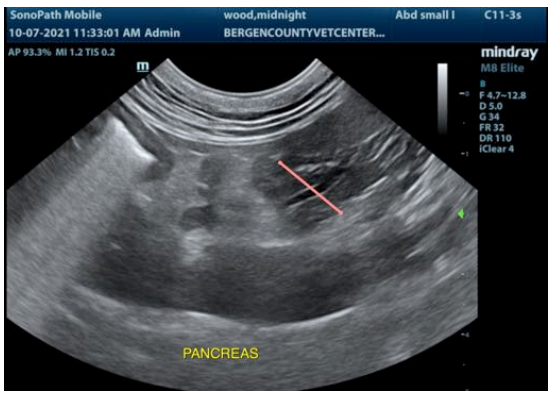

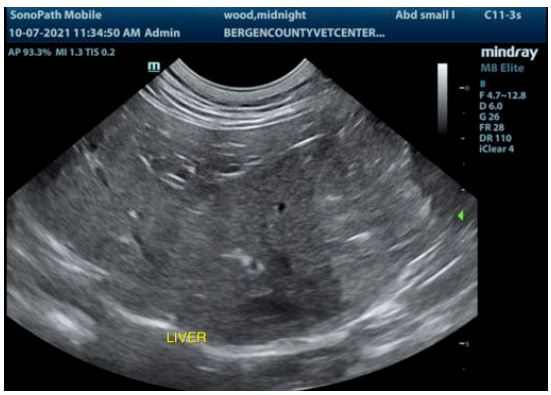

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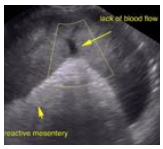
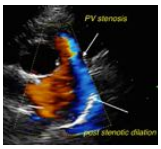
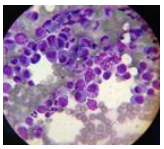
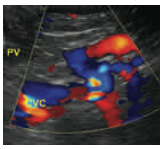

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

kathleen.sennello@sonopath.com