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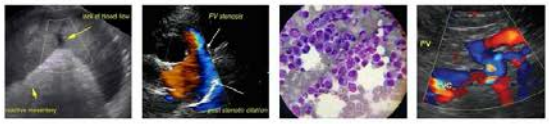


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Lucille Kalivoda
Dr Pet

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

13 Years 2 Months

WEIGHT

8.4 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

MountainView AH

REFERRING VET

Dr. Sarah Kalivoda

INVOICE

29768

DATE

11/11/21

PRESENTING CLINICAL SIGNS

PAWS Request Form: Chief Concern / Provisional Diagnosis: Hx of chronic IBD for over 8+ years with progressive malodorous diarrhea and extensive vomiting. Treated with EOD prednisolone/metronidazole/sulfasalazine (moderate control with this), cerenia and ondansetron for several years. Last year (2020) became diabetic w/ chronic prednisolone usage. Stopped prednisolone and started leukaran and continued ondansetron and cerenia PRN usage, in addition started glargine 1 unit BID. Very well controlled IBD with leukaran and well control diabetes with glargine. After stopping pred and starting on Purina DM, Lucille is almost in complete diabetic remission (glucose typically around 250) without insulin (initially placed on glargine). 6 months ago, while still on glargine, went into a hypoglycemic crisis with glucose too low to read. Recovered with intenstive oxygen and critical care therapy however at that time on abdominal ultrasound there was a large mesenteric lymph node noted that was suspected at the time to be large cell lymphoma however aspirates were inconclusive. Relevant Medical History and Physical Exam findings: Non painful abdomen. Pendulous abdomen. Recent Diagnostics: Relevant Labratory Results / Abnormalities: SDMA 16 April 2021; No azotemia; No protein in urine; BUN/Creat normal. This was when she was initially diagnosed as diabetic. More current blood work pending at lab. Current medications (include full name, dosage and frequency): Leukaran 2mg every other third day; Cerenia EOD; Ondansetron daily; Vitamin B12 supplementation 0.25mls monthly; Prednisolone 2mg/Metro/Sulfasalazine once weekly/PRN usage if excessive vomiting noted. Relevant Radiograph Findings(email radiographs if available): Previous Ultrasound Report in March 2021. Liver: WNL; Gall Bladder: WNL; Spleen: Mildly thickened measuring up to 14 mm Left Kidney: 3.62 x 1.99 cm Left Adrenal: 0.59 x 0.43 cm Right Kidney: 3.57 x 1.96 cm Right Adrenal: 1.25 x 0.42 cm Urinary Bladder: WNL Pancreas: Multiple hypoechoic nodules in the left pancreas Stomach: Mildy thickened wall Bowel: Mildly thickened wall with a thickening of the muscularis Lymph Nodes: Jejunal node markedly enlarged, measuring ~ 2 cm in diameter with hyperechoic mesentery surrounding it Mildly enlarged splenic nodes Comments: No effusion present
Abnormal PE/Chem/CBC/UA Results: ECHO sent and pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

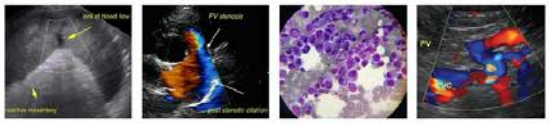
The urinary bladder is moderately distended with echogenic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (3.3 cm). Overall echogenicity is normal with adequate 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 (3.6 cm). Overall echogenicity is normal with adequate 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 0.34 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.



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The right adrenal gland is normal in size measuring 0.36 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 gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. Bowel loops follow a typical curvilinear path with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measured 0.28 cm. Jejunum wall measured 0.25 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 are numerous hypoechoic small nodules visualized throughout the parenchyma. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a severely enlarged mesenteric lymph node visualized measuring 1.91 cm x 2.3 cm. Adjacent to this lymph node is another cystic lymph node measuring 1.42 cm. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of increased echogenicity around these enlarged lymph nodes.

Other

A brief view of the thorax was provided, and there is evidence of both pericardial and pleural effusion. Recommend cardiac ultrasound.

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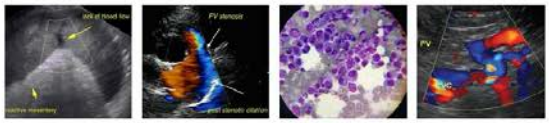

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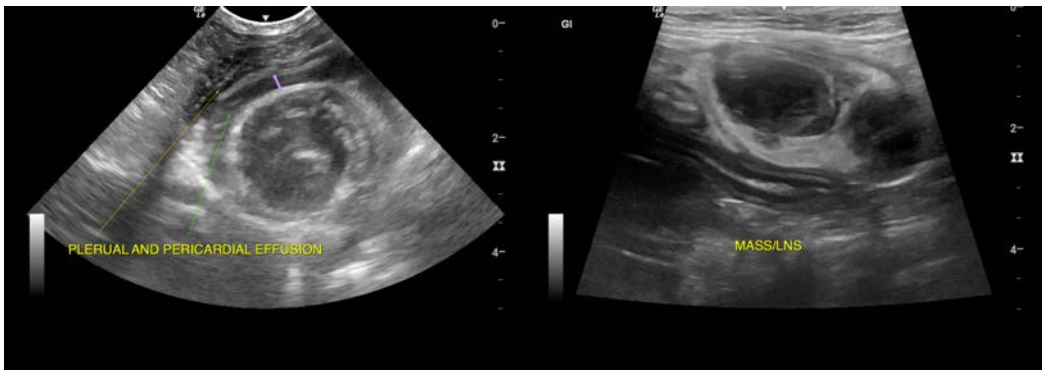
ULTRASONOGRAPHIC FINDINGS

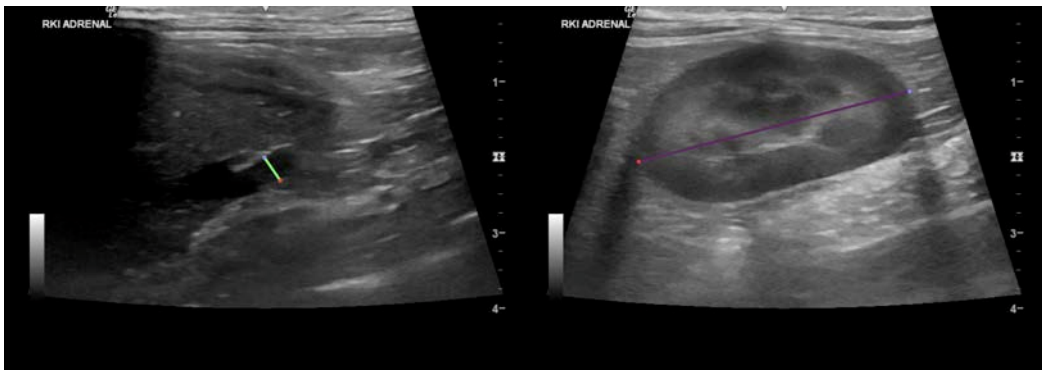
- Large abdominal mass/lymph node – This sounds like the previous lesion noted on 3/21. Measurements are similar. Consider reaspiration.
- Prominent nodular pancreas – These changes are stable and likely benign.
- Echogenic debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.
- Prominent muscularis layer to the small intestine – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.
- Suspect pleural and pericardial effusion – Recommend 3-view thoracic radiographs and cardiac ultrasound.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The previously visualized abdominal mass/lymph node is present and prominent. It appears to measure roughly the same size, but there is an additional cystic lymph node adjacent to the primary lymph node. Consider reaspiration. Additionally, the bowel remains prominent with an increased muscularis layer. Consider a GI panel and GI biopsies for further diagnostics.

Unfortunately, there was pleural and pericardial effusion evident on today's scan. Consider 3-view thoracic radiographs and a cardiac ultrasound to further evaluate this issue.





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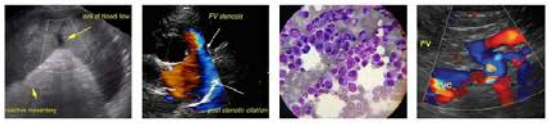

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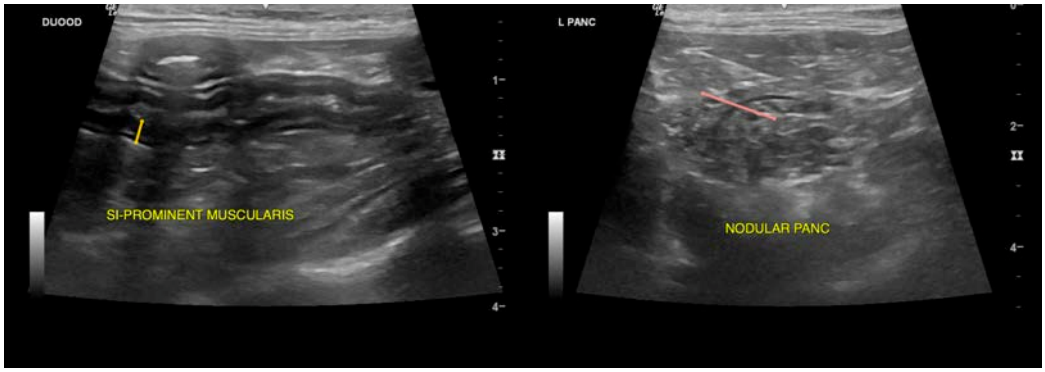

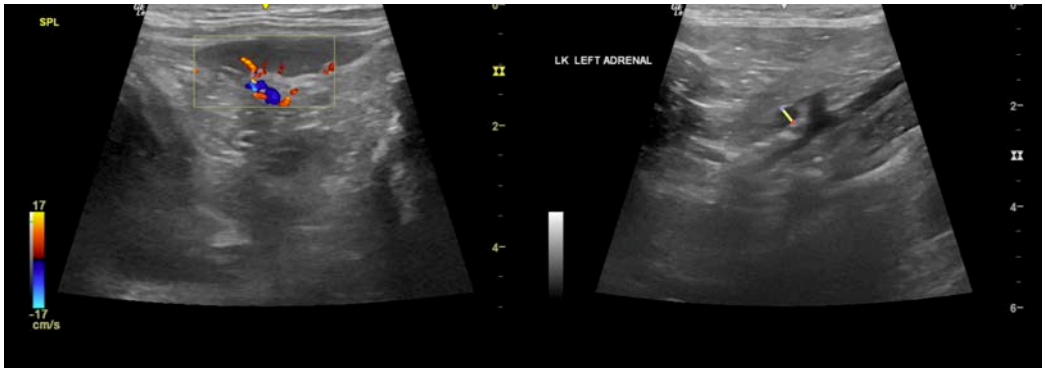

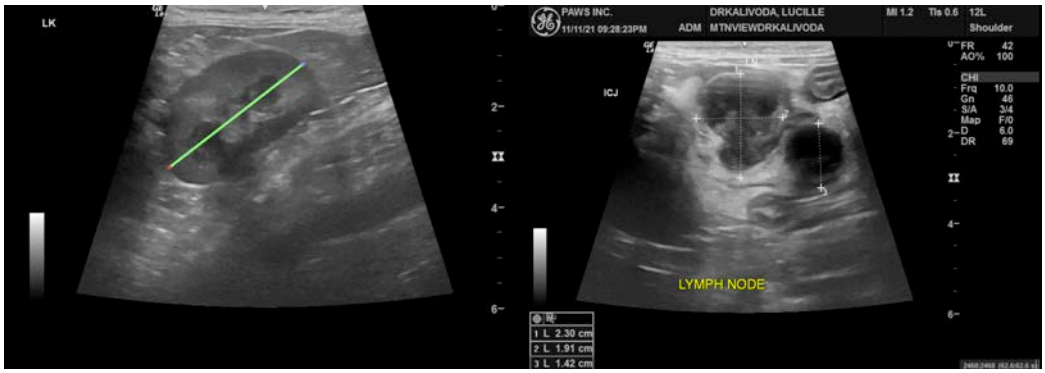

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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