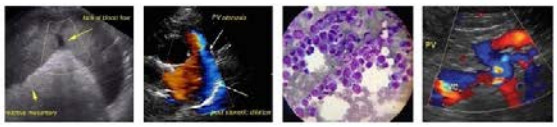

PATIENT

Jace Quinn

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

8 Years

WEIGHT

4.1 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Nelson Animal Hospital

REFERRING VET

Dr. Quinn

INVOICE

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DATE

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PRESENTING CLINICAL SIGNS

Acute weight loss, Intermittent vomiting. Will not eat kibble but eats canned food with enthusiasm. Normal stool. Moderate to profound weakness. Behavioral changes e.g. constant purring, eating voraciously in exam room when is normally a very shy and anxious cat. Dilated pupils RR 36, difficult to auscult due to purring. Monocytosis, elevated SDMA. Anemia, Hct 0.18 - nonregenerative. History of cutaneous MCT 4 months ago, cranial to ear.

Abnormal PE/Chem/CBC/UA Results: HR 180 RR 36 BP 84 No murmur heard but difficult to assess due to purring please see attached BW

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 (4.32 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal 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 (4.86 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal 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 0.53 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 0.42 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 large and hypoechoic, measuring 1.06 cm in with at the level of the hilus. 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 mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

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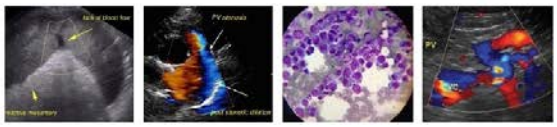

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Gastrointestinal

The stomach contains moderate fluid. 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. Jejunun wall measures 0.35 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 normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

There is a small amount of free abdominal fluid. There are occasional hypoechoic prominent mesenteric lymph nodes, one of which is measured at 0.37 cm. The omentum is generally mildly hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- Borderline large spleen – Differentials include congestion, sedation, anatomic variant, and infiltrative disease. Consider a fine needle aspirate.
- Diffusely thickened small bowel with prominent muscularis layer – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia.
- Small volume free abdominal fluid
- Prominent mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is the general impression of diffuse small bowel thickening with a very prominent muscularis layer, some free fluid, some prominent lymph nodes, and a large spleen. These changes could be consistent with severe inflammatory type changes, but there is a concern for possible underlying neoplastic disease (round cell neoplasia). Consider a fine needle aspirate of the spleen and 3-view thoracic radiographs. If a cytologic diagnosis cannot be obtained, then consider pathologist review of a blood smear, looking for possible cause of the anemia (regenerative response secondary to the anemia would be another differential for the possibly enlarged spleen).

Recommend supportive care including the possibility of a blood transfusion, correction of the electrolytes, etc., and if diagnostic testing at this point is not helpful, you could consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to obtain more information regarding the GI tract, and consider obtaining GI biopsies.

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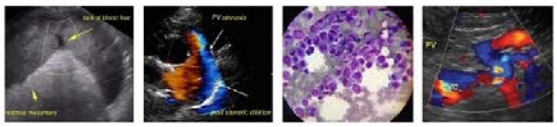

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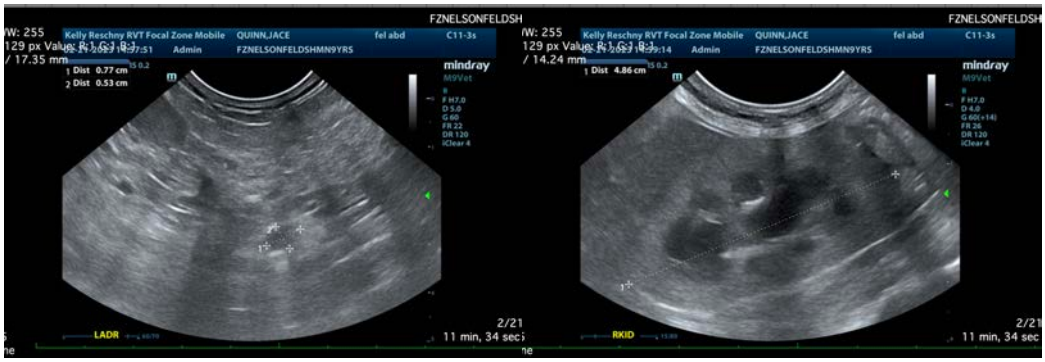

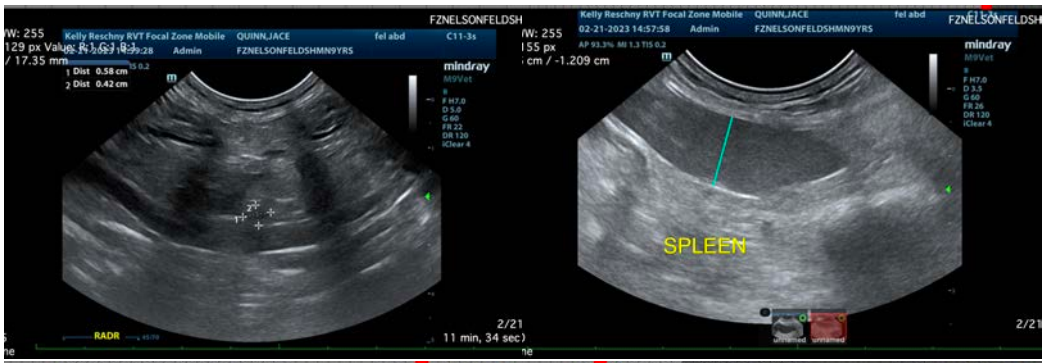

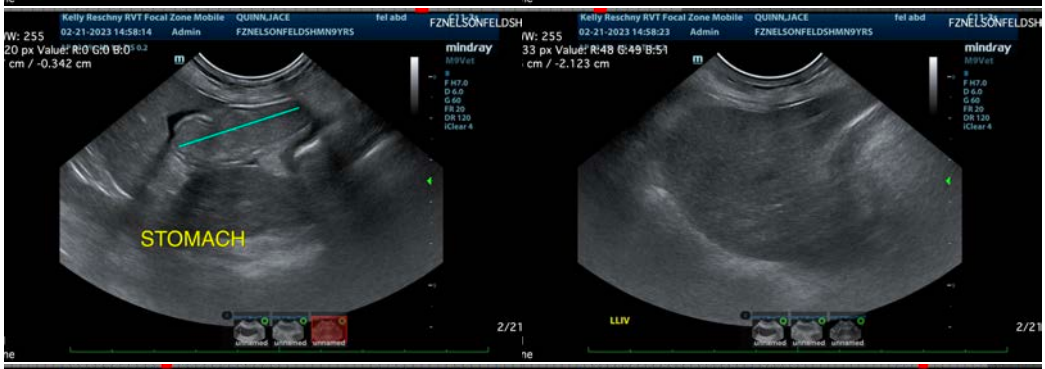

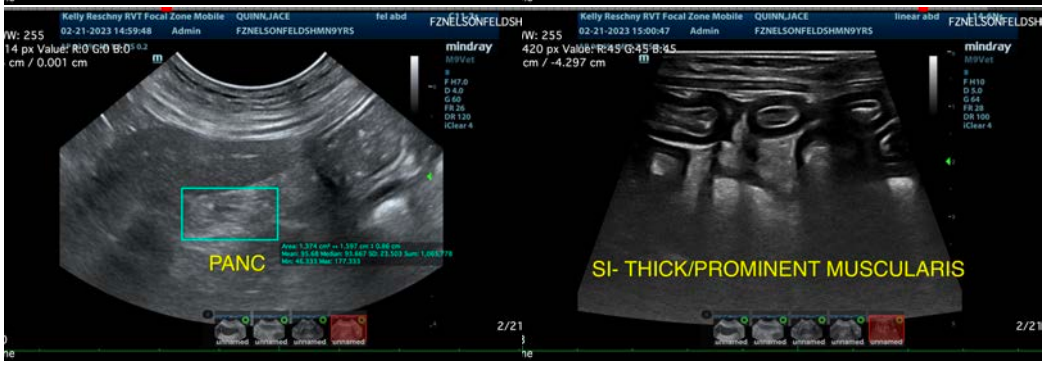

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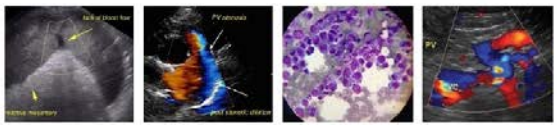

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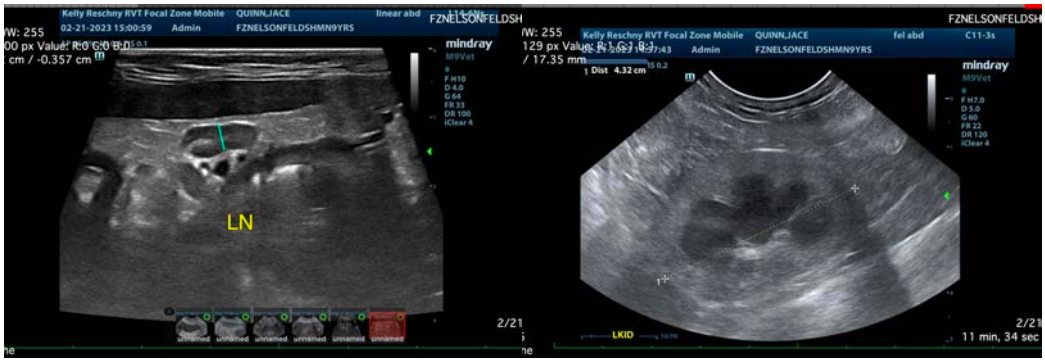

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

kathleen.sennello@sonopath.com