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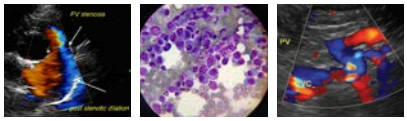

SonoPath
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DATE

3/31/23

PATIENT

Emmeline Long

SPECIES

Feline

BREED

Ragdoll

SEX

Spayed Female

AGE

3/4/22

WEIGHT

9 Pounds

INTERPRETED BY

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

HOSPITAL NAME

Cat Sense Feline Hospital

REFERRING VET

Dr. Sinclair

INVOICE

46312

PRESENTING CLINICAL SIGNS

Presented today for a decrease in appetite and activity in the last 2 weeks with the possibility that she may have swallowed part of a cat toy a few weeks ago. She has not been vomiting. She had lost ¼ pound since we saw her in October and possibly 1.5 pounds since earlier this year. The PE was unremarkable otherwise. Bloodwork is pending. X-rays were taken and no foreign bodies were noted but she has a possible thickened stomach wall, hepatomegaly, possible small amount of pleural
effusion and ascites. The right kidney may have a slight bulge. The pancreas might be visible. Concern would be for FIP, neoplasia or pancreatitis.

Current Medications: Starting on Cerenia 4mg SID.
Radiographs: See attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: STAT requested.
Imaging Performed By: Rachel Brilhart, RDMS.

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 (4.14 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 (4.0 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 0.31 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 0.40 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 (0.73 cm), echotexture is homogenous and hypoechoic, 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 hypoechoic with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. 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.

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 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. Jejunum wall measures 0.24 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and appeared enlarged with a thickened hypoechoic irregular wall with complete loss of layering, creating a mass effect measuring approximately 2.88 cm in diameter, and with a bowel wall measuring 0.71 cm. Additionally, the descending colon appears severely thickened and irregular with complete loss of layering, with a bowel wall varying in size from 0.40-0.65 cm with severe surrounding inflammation and prominent lymph nodes.

Pancreas

The pancreas is large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild pancreatitis. Prominent pancreatic duct noted.

Free Abdomen

There is free abdominal fluid with a diffuse moderate lymphadenopathy with large, round hypoechoic lymph nodes clustered around the ileocecal junction and the colon. Examples of these lymph nodes measure 0.44, 0.43, and 0.71 cm in diameter. The omentum is diffusely severely hyperechoic.

Other

The right auricle and pericardium were visualized and were unremarkable. No obvious pathology is visualized. If cardiac function evaluation is desired a full echocardiogram is warranted.

There is a small soft tissue structure visualized on the right side, possibly consistent with a prominent intrathoracic lymph node, and scant pleural effusion visualized on the right.

ULTRASONOGRAPHIC FINDINGS

- Hypoechoic, prominent pancreas with prominent pancreatic duct and surrounding hyperechoic mesentery – The pancreatic changes are most consistent with mild pancreatitis/pancreatic inflammation. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.

- Hypoechoic, heterogeneous liver – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.

- Severe thickening of the colon wall with complete loss of layering – This involves the ileocecal junction, which creates somewhat of a mass effect. Possible differentials include infiltrative neoplasia (lymphoma, carcinoma, etc.), FIP, inflammatory disease, etc.

- Moderate diffuse lymphadenopathy – The moderate mesenteric lymphadenopathy could be concerning for a neoplastic process, although you can see significant lymphadenopathy in some cases of autoimmune/inflammatory disease, infectious disease(tick born disease-such as bartonella, fungal infections, FIP (cats)) etc. A fine needle aspirate with cytology is recommended for further evaluation.

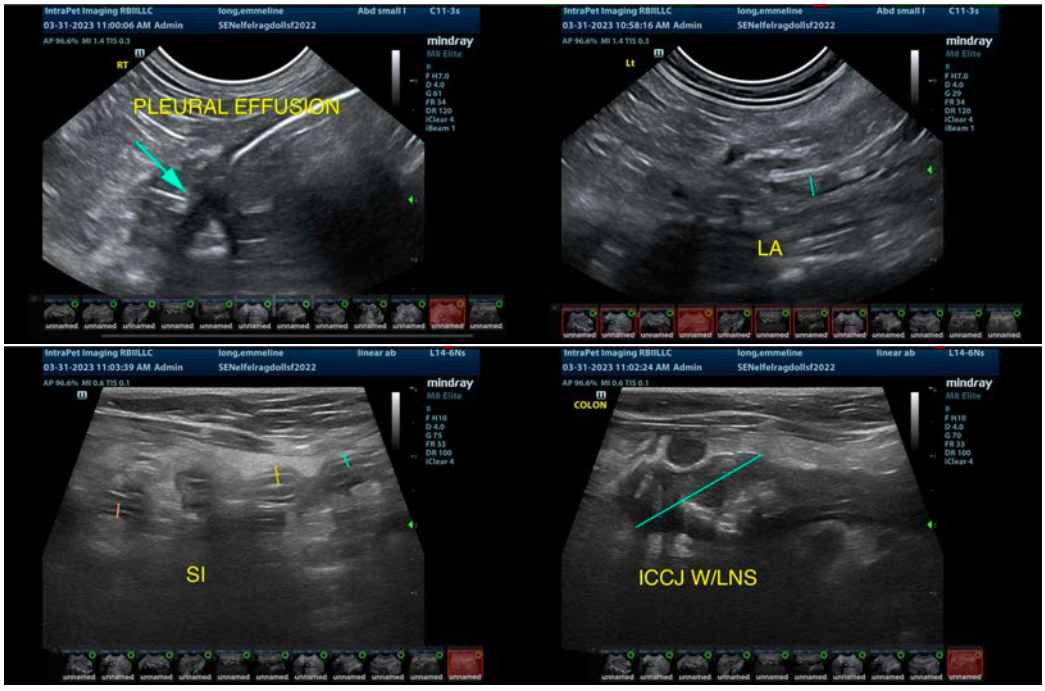
- Scant right-sided pleural effusion.

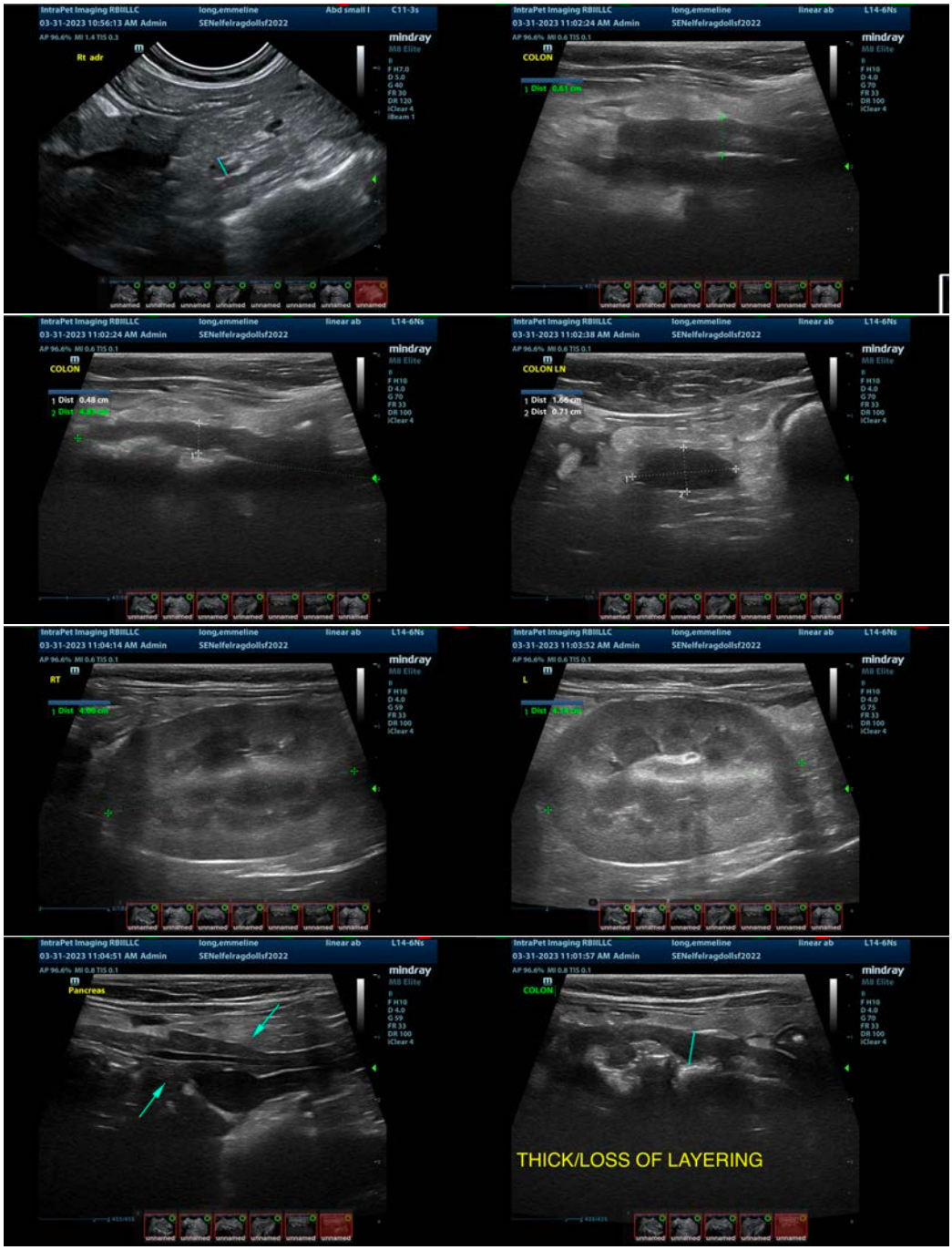
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The general impression is of a severely inflamed/hyperechic abdomen with diffusely hypoechoic lymph node and moderate lymph node enlargement. The large bowel is severely thickened with a complete loss of layering, creating a mass effect at the level of the ileocecal junction. Clusters of large lymph nodes are surrounding the ileocecal junction and the distal colon. Findings are highly concerning for possible round cell neoplasia, less likely FIP due to the more diffuse nature.

Recommend a fine needle aspirate of colon wall (at the ileocecal junction is a good option) and a fine needle aspirate of a mesenteric lymph node. If cytologic diagnosis cannot be obtained based on these samples, you could consider an aspirate of the liver or spleen, which also appear hypoechoic and abnormal. The pancreas is similarly hypoechoic but appears more prominent and subjectively inflamed.

There is scant free pleural effusion visualized on the right side and evidence of intrathoracic inflammation.

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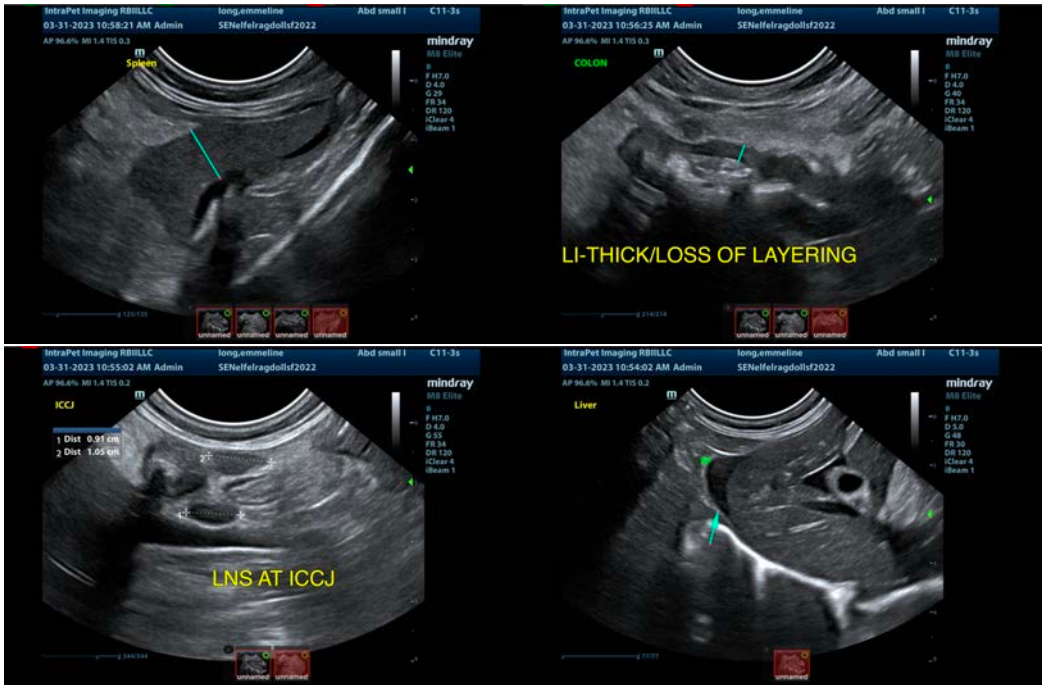
COLON
THICK/LOSS OF LAYERING



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.

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