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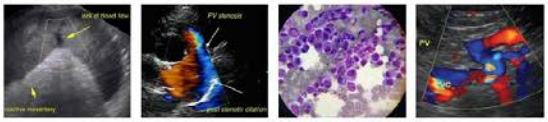

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Charlie Ella

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

3 Years

WEIGHT

6.9 Pounds

INTERPRETED BY

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

IMAGING BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Brighton Greens VH

REFERRING VET

Dr. Robin Janeway

INVOICE

39006

DATE

6/22/22

PRESENTING CLINICAL SIGNS

WEight loss 6.9 lb from 8.2 lbs in April Adopted from SF shelter ~ 6 weeks ago. Dental in April O states decreased appetite x 2 weeks PE June 17th- significantly dehydrated, gas and thickening sm intestine in the cranial abdomen. FAST u/s- Extremely thickened loop of small intestine noted- possible duodenum. Mesenteric lymphadenopathy. Radiographic Findings The partially visible cardiopulmonary structures are without defined abnormalities. Abdominal detail is diminished as the patient is thin and there is little intra-abdominal fat, however, some wispy densities in the mesenteric region may suggest scant ascites.. The stomach is suspected empty and contracted with margins are poorly defined.. Small bowel segments contain scattered somewhat disorganized gas with no abnormal distention. The colon contains scant semi-formed fecal content proximally and distally. The one visible kidney in the cranial dorsal abdomen on the lateral view appears of likely normal size and shape. The opposite kidney is not well seen. The urinary bladder is empty and not defined. The partially visible spleen appears normal. Conclusion Near emaciation, however, there is the impression of possible scant ascites as well. Empty gastric character may suggest gastritis. Impression of an enteritis but without evidence of obstructive disease. Evidence of a colitis with impending soft character feces suspected. Radiopaque G.I. foreign material is not defined. Suboptimal urinary tract evaluation. Recommend detailed abdominal ultrasound as additional diagnostics. BLood panel - amyl 1116, TP 9.6, glob 6.7, Cytology mesenteric LN to pathologist= lymphoid hyperplasia, cannot rule out small cell lymphoma, consider biopsy/flow cytometry or PARR assay Pt has been on prednisolone since 6/17/22, gauge response as well as determine if lesion may be resectable or if there is an impression from specialist of IBD vs lymphoma vs other.

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 is normal/borderline large at 4.12 cm and is hyperechoic 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 is large (4.28 cm) and hyperechoic 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 0.42 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 0.24 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.

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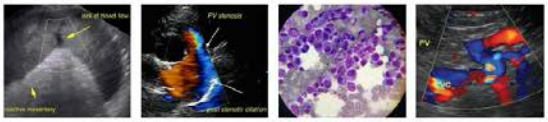

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Spleen

The spleen is subjectively normal/borderline large in size (1.0 cm in width 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 gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a mild amount of non-organized echogenic debris. 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 measured 0.18 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized. Wall layering appears diminished, and there is severe wall thickening with asymmetrical hypoechoic thickening measuring up to 0.51 cm with non-progressive fluid visualized in the lumen. Findings are concerning for infiltrative disease to the colon wall.

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

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a significant mesenteric lymphadenopathy present with clusters of lymph nodes visualized, two of which measure 1.45 cm and 1.29 cm in diameter. The sublumbar lymph nodes are also prominent, measuring 0.40 cm in diameter. The omentum is of increased echogenicity around the abnormal colon and lymph nodes.

PRIMARY FINDINGS

- Severely thickened colon wall with reduced detail of wall layering – could be consistent with infection, inflammation, or infiltrative neoplasia.

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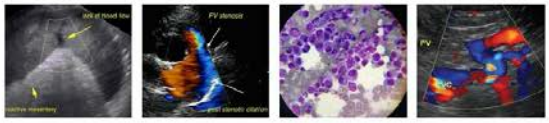

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- Moderate mesenteric lymphadenopathy – The moderate mesenteric lymphadenopathy could be consistent with a neoplastic process, although you can see significant lymphadenopathy in some cases of autoimmune/inflammatory disease, infectious disease(tick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

SECONDARY FINDINGS

- Borderline bilateral renomegaly – could be consistent with acute renal disease, infiltrative disease, a portosystemic shunt, or could be within normal limits for this individual.

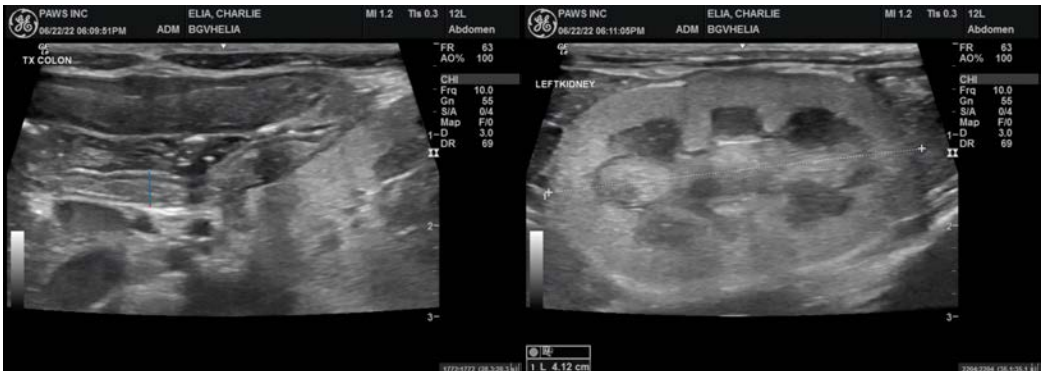
- Borderline large spleen – The spleen appears relatively normal, but measures as borderline enlarged. This could be consistent with infiltrative disease. Consider a fine needle aspirate.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The descending colon wall is severely thickened with a reduction in the detail of wall layering. This lesion is asymmetrical and irregular. These findings could be consistent with severe inflammatory colitis, infectious colitis (fungal, etc.), or neoplastic disease. A fine needle aspirate of the colon wall could be considered. Additionally, there is a significant mesenteric lymphadenopathy. A previous fine needle aspirate was performed and was hyperplastic.

You could consider lowering the steroid dose to a physiologic dose for about one week, then resampling spleen, colon and lymph nodes, and submitting these samples together with a possibility of adding PARR testing or flow cytometry. Of primary concern would be lymphoma, FIP, or severe inflammatory/infectious disease. A lack of significant response to steroids is concerning, as it may be suppressing some of the illness and the ability to obtain a diagnosis without fixing the problem. If a diagnosis cannot be obtained based on cytology, consider surgical biopsies.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.



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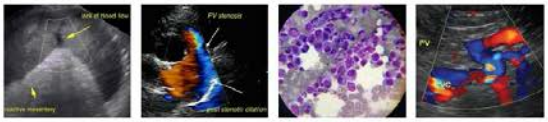

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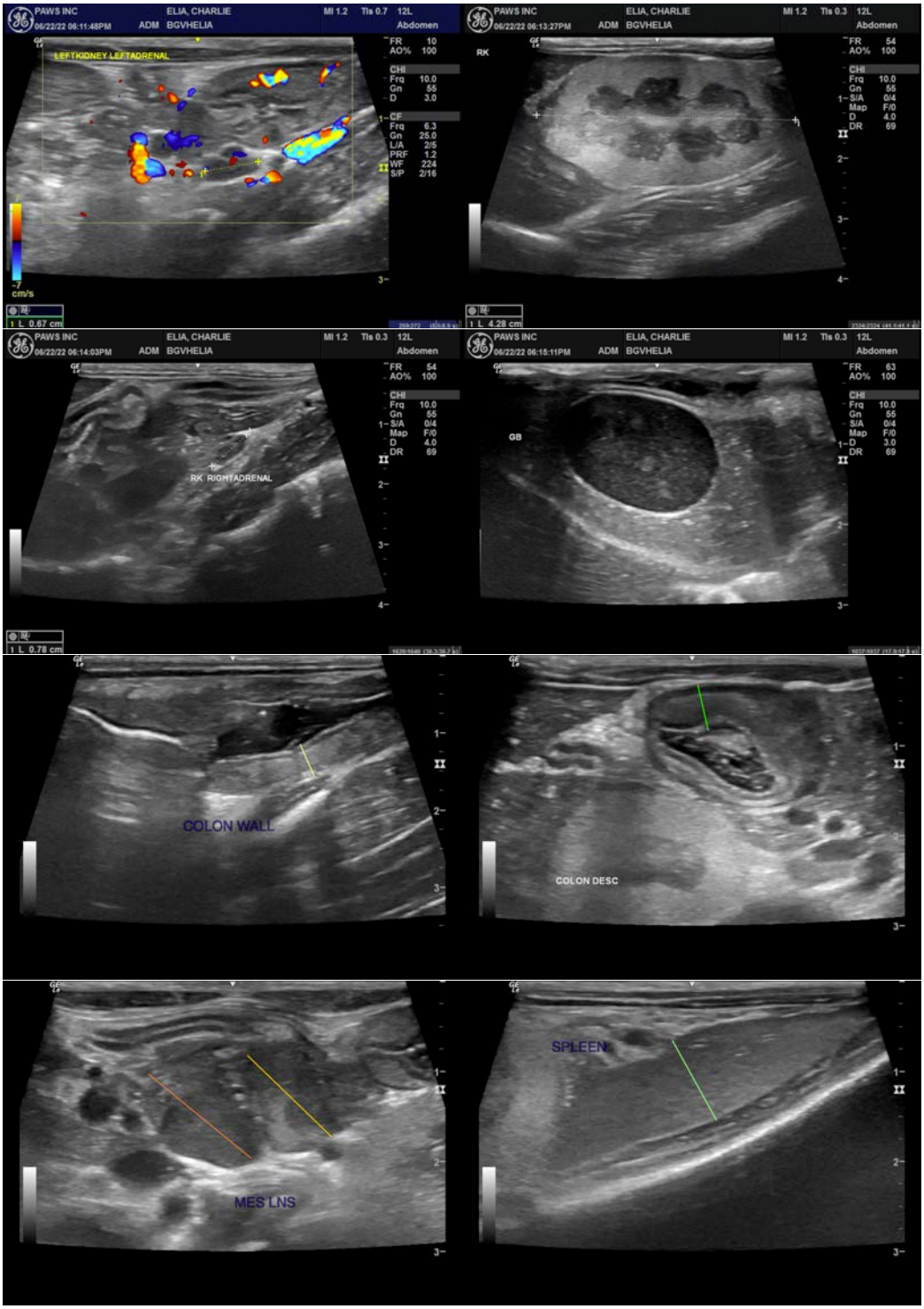

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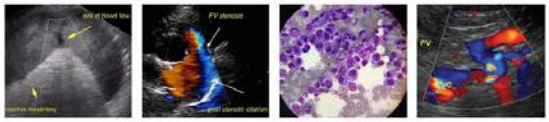

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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