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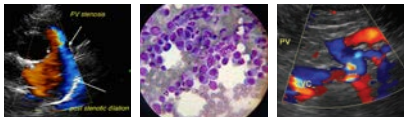

SonoPath

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DATE

8/13/21

PATIENT

Cookie Monster Frye

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

4/8/12

WEIGHT

8.16 Pounds

INTERPRETED BY

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

HOSPITAL NAME

BPH of Abingdon

REFERRING VET

Dr. Durastanti

INVOICE

24680

PRESENTING CLINICAL SIGNS

History: Cookie Monster, 9Y/3M Feline DSH, presents as drop off for ADR and loss of appetite. Usually very food motivated, loves treats, wants to eat wet food immediately in the AM - not eating normal wet food or treats right now. Would eat some tuna juice and some other new wet foods that were offered. Very soft, mucousy stool in very small amounts. Infrequent vomiting. Not typically the type to eat things he isn't supposed to in the house. Owner recalls only 1 episode of vomiting recently, which was mucous and some of his food.

Current Medications: Mirtazapine transdermal ointment: Use as directed on package - gave 1st dose in hospital; Cerenia 16 mg (4 pack): 0.5 tab PO SID for 8 days - gave 1st dose in hospital; Hills i/d.
Lab Results: cbc/chem- WBC 21.33 H, LYM 0.97 L, NEU 19.23 H, PLT 249 L // BUN 14 mg/dL Low, TP 10.3 g/dL, GLOB 7.7 g/dL High.
Radiographs: cranial abdomen up under rib cage multilobulated, firm mass-like structure.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: not needed
Stat Report: not requested / declined

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 (3.85 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 (4.07 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 region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.38 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. Jejunum wall measures 0.2 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 severe bowel wall thickening, primarily in the colon (possibly some ileum) with complete loss of layering extending for more than 6-7 cm. The colon wall measured 0.78 cm. There is a cluster of large, hypoechoic lymph nodes in the area of the ileocecal junction.

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 severe lymphadenopathy in the area of the ileocecal junction measuring 0.9, 0.47, 1.1, and 1.2 cm. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is generally of increased echogenicity in the area of the ileocecal junction and colon.

ULTRASONOGRAPHIC FINDINGS

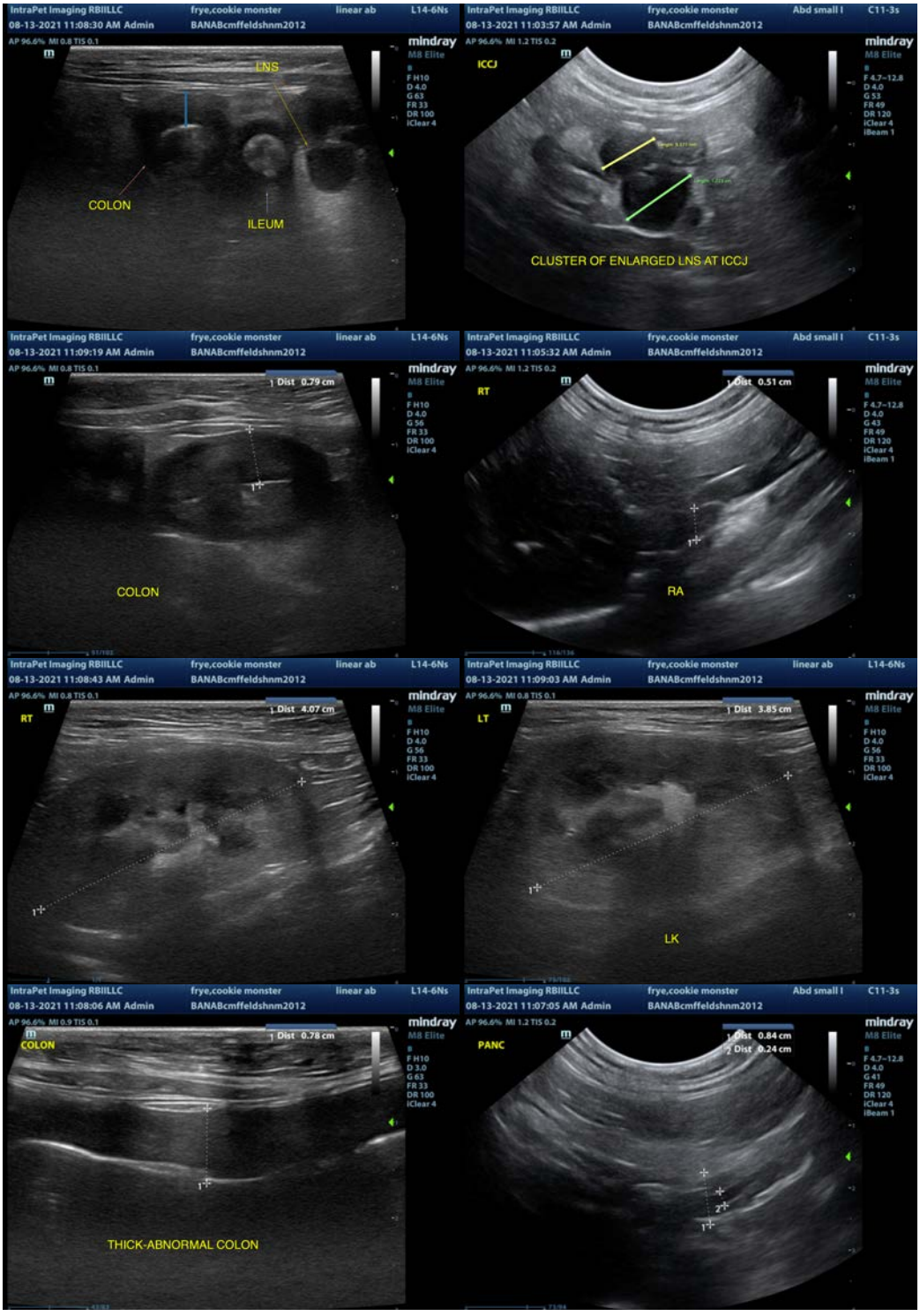
- Severe colonic wall thickening and loss of layering – Colonic wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia. A reduction in the detail of wall layering favors either severe colonic disease or neoplastic infiltration. Biopsies recommended.

- Severe lymphadenopathy in the area of the ileocecal junction – The severe mesenteric lymphadenopathy is most 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.

- Prominent muscularis layer of 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The colon wall is severely thickened with a complete loss of layering. Additionally, there is a large cluster of lymph nodes observed at the ileocecal junction. This is very concerning for possible round cell neoplasia, although other differentials such as FIP, granulomatous disease, etc. exist. Recommend fine needle aspirate of colon wall and mesenteric lymph node. If this is not diagnostic, recommend biopsies of the colon and lymph nodes. Recommend 3-view thoracic radiographs.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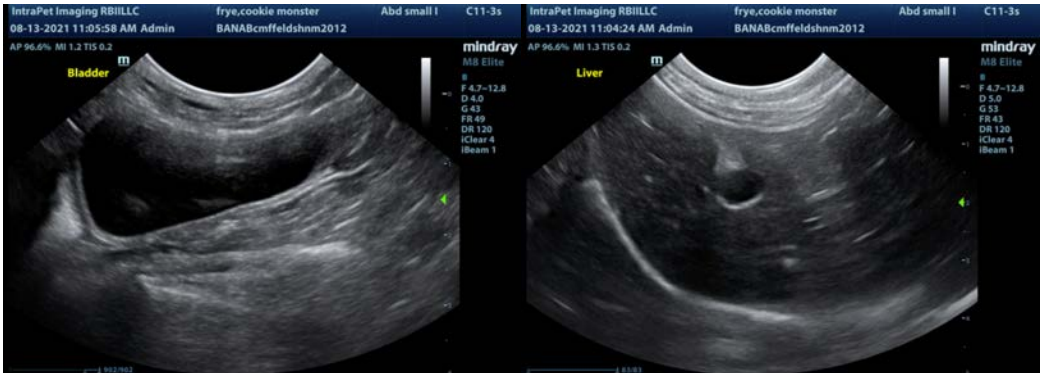
1 Dist 0.84 cm
2 Dist 0.24 cm



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)
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