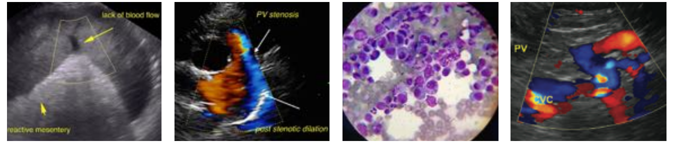

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PATIENT

Teddy Cline

SPECIES

Feline

BREED

DLH

SEX

M/C

AGE

11 years

WEIGHT

9lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Jessica Bailes

HOSPITAL NAME

All Creatures Great & Small Veterinary Clinic, Corvallis OR

REFERRING VET

Justin Vaughn

INVOICE

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DATE

3/9/2023

PRESENTING CLINICAL SIGNS

Hx of progressive weight loss, lethargy, and decreased appetite. Hx of hyperthyroidism - well-regulated on BW but progressive weight loss noted. No hx of vomiting recently; no diarrhea.

Abnormal PE/Chem/CBC/UA Results: Weight loss, unkempt haircoat, generalized sarcopenia, otherwise NSF on PE SC: Creat 1.3. All other UR. CBC: Hgb 8.9. Hct 29. All other UR. T4: < 0.5 UA: USG = 1.041, otherwise NSF Thyroid dose decreased; weight loss persisted. Thoracic rads taken today; NSF

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mild primarily suspended echogenic debris present. 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 calculi. Echogenic debris of this type can be associated with small crystals, cellular debris, and proteinaceous debris.

The left kidney has a normal shape and size (3.81 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 (4.35 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 0.38 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 0.23 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.

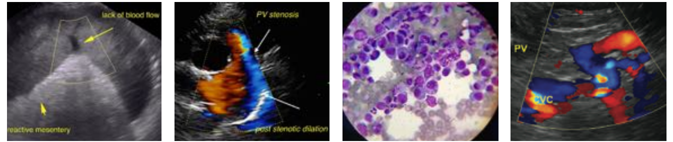
Spleen

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 mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.



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Gastrointestinal

The stomach contains minimal luminal contents. Some areas of the gastric wall appear relatively normal with intact wall layering and normal rugal folding. In this region, the stomach wall measures at 0.28 cm but there are other areas which appear focally thickened measuring approximately 1.02 cm in diameter, with reduced detail of wall layering.

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. The duodenum measured 0.27 cm in diameter and the jejunum measured 0.22 cm in diameter. Visualized peristalsis appears appropriate. There are several areas of small bowel which have irregular thickening with reduced detail of layering. In this area of the bowel wall measures up to 0.77 cm in thickness. There is a focal area of abnormal bowel with irregular thickened hypoechoic wall, complete loss of layering and what appears to be trapped intraluminal foreign material. Alternately but less likely this could be a foreign body with severely inflamed bowel surrounding. The shadowing foreign material measures approximately 1.37 cm in diameter and the bowel wall in this region measures 0.75 cm.

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

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a severe mesenteric lymphadenopathy at the mesenteric root with large hypoechoic lymph nodes measuring 0.76 cm, 0.70 cm, and 0.77 cm in diameter. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is hyperechoic around the abnormal bowel and lymph nodes.

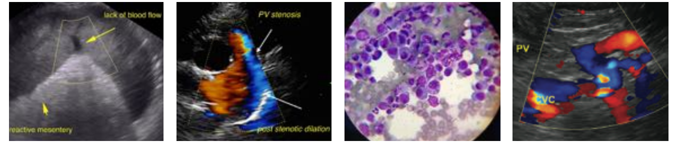
ULTRASONOGRAPHIC FINDINGS

- Echogenic debris urinary bladder. The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus. Recommend urinalysis and culture.

- Focal gastric wall thickening with reduced detail of wall layering. Findings could be consistent with severe gastritis, but infiltrative disease is a primary concern. Consider a fine needle aspirate of the thickened area of gastric wall.

- Focal bowel wall thickening with loss of layering and a suspected intraluminal foreign body. Findings are concerning for possible infiltrative disease (round cell neoplasia, carcinoma, etc.) and secondary foreign material.

- Severe mesenteric 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.



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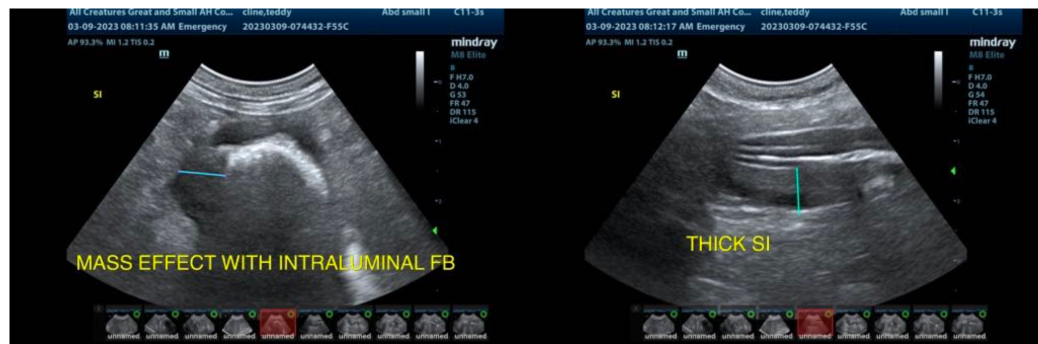
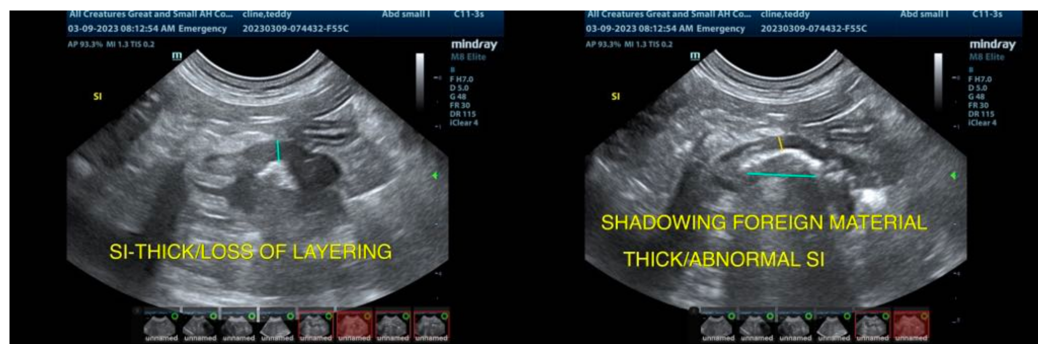
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gastric wall appears asymmetrically thickened with reduced detailed of wall layering. This could be consistent with severe focal gastritis etc. but given the bowel changes and the severe lymphadenopathy this is concerning for possible infiltrative disease. There is a section of small intestine in the mid bowel which appears severely thickened and irregular with complete loss of layering. There is a large focal area of shadowing material visualized within this abnormal bowel, most consistent with bowel mass entrapping foreign material. Although, a primary foreign body with secondary bowel wall thickening cannot be completely ruled out. Consider fine needle aspirate of the bowel wall. There are additional areas of small intestine which appear asymmetrically thickened with reduced detailed wall layering, and there is a severe mesenteric lymphadenopathy. Recommend a fine needle aspirate of an enlarged mesenteric lymph node.

My suspicion for round cell neoplasia here is high, if a cytologic diagnosis cannot be obtained then consider surgical biopsies.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.





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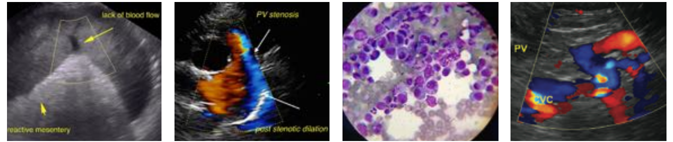

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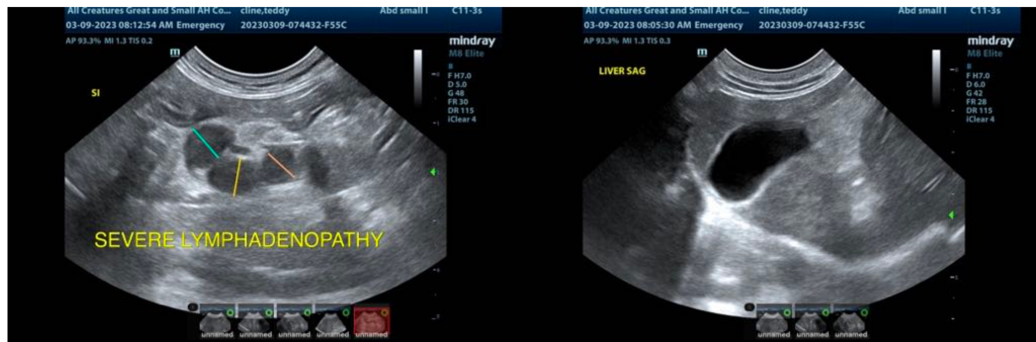

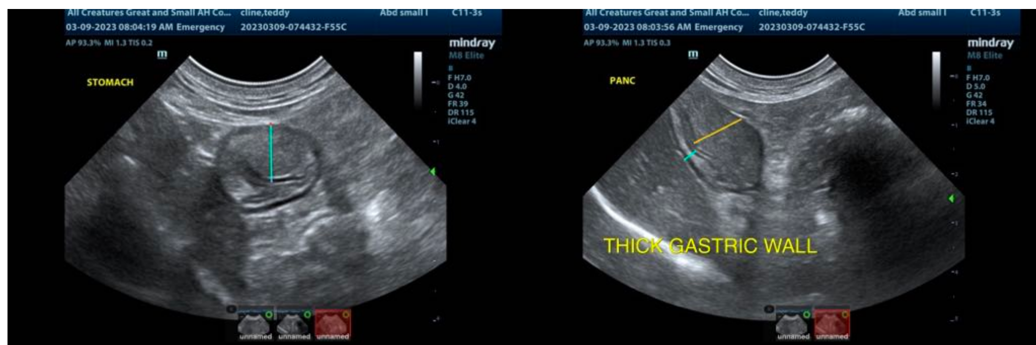

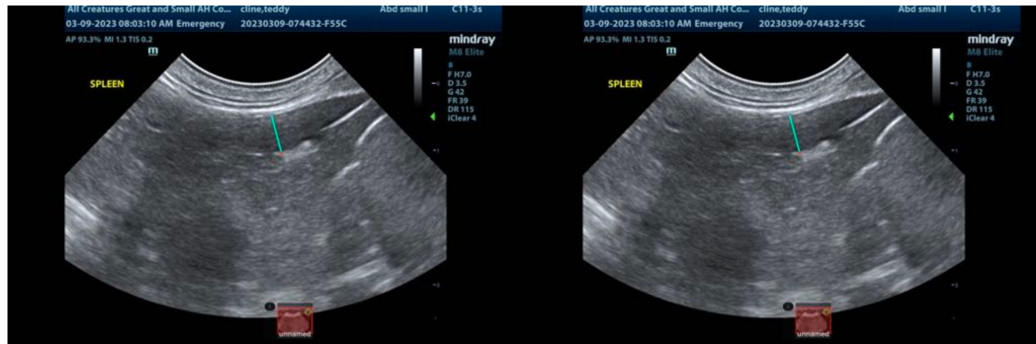

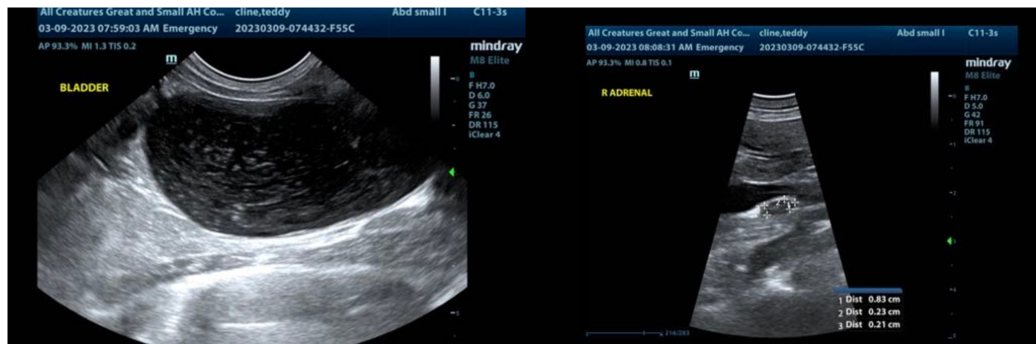

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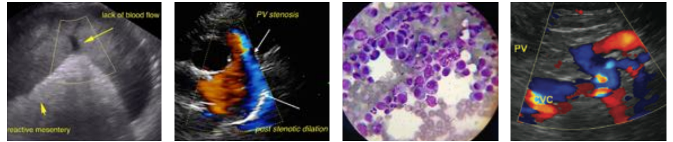

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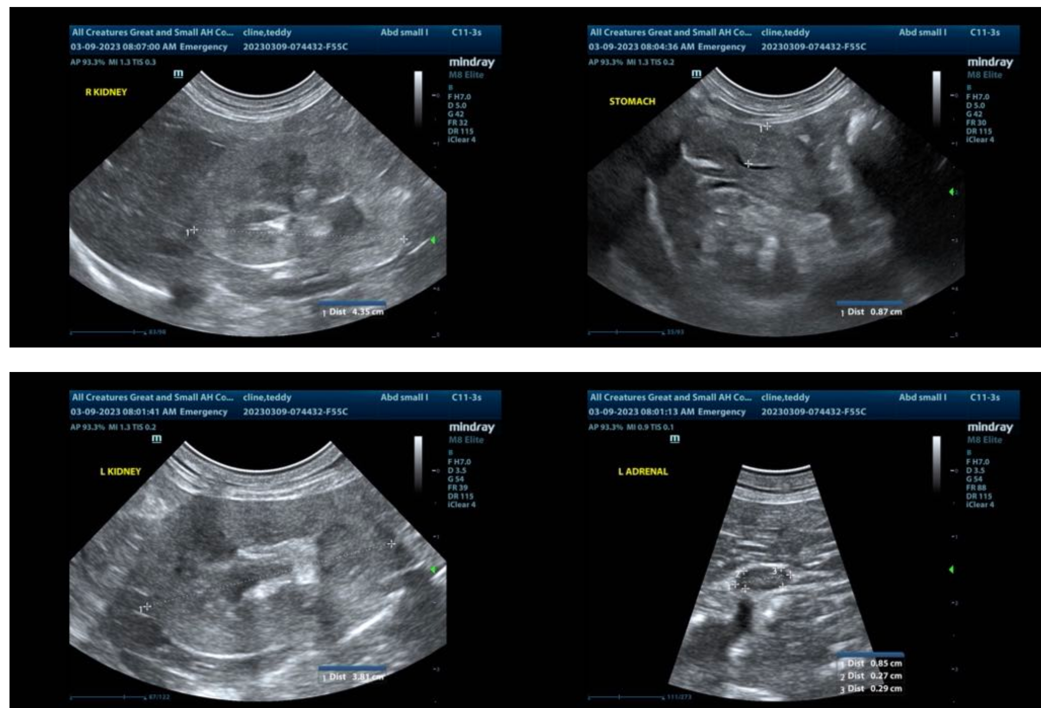

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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