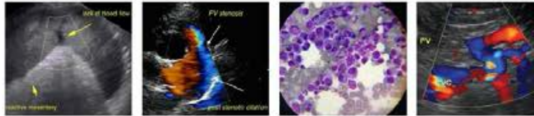

PATIENT

Dewey Bard

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

12 Years

WEIGHT

7 Pounds

INTERPRETED BY

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

IMAGING BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Donner Truckee VH

REFERRING VET

Dr. Vannini

INVOICE

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DATE

6/3/22

PRESENTING CLINICAL SIGNS

not eating a few weeks- currently on chemotherapy- vincristine- cytoxan- prednisolone- he's on the CHOP protocol- on anti nausea meds- AUS to see if there are improving or declining changes- was hospitalized at ER for anorexia- two nights ago

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is well distended with anechoic contents. The wall is smooth and regular. No abnormalities are noted with the trigone or proximal urethra, and there is no evidence of sediment, cystoliths, polyps or a mass.

Kidneys

The **left** kidney measures 3.38 cm (3.80-4.40 cm). The capsule is smooth. The cortex is mildly hyperechoic, i.e. it is isoechoic to the spleen. A mild to moderate loss of the normal definition of the cortico-medullary junction is present. Mineralizations of the diverticulae and pelvis are present, without evidence of nephroliths or pyelectasia. An accumulation of intrapelvic fat is noted. The surrounding mesentery is mildly to moderately hyperechoic (stable).

The **right** kidney measures 3.44 cm (3.80-4.40 cm). The capsule is smooth. A moderate loss of the normal definition of the cortico-medullary junction is present. Mineralizations of the diverticulae and pelvis are present, without evidence of nephroliths or pyelectasia. An accumulation of intrapelvic fat is noted. The surrounding mesentery is moderately hyperechoic (stable).

Aortic bifurcation/trifurcation

No abnormalities observed.

Adrenal Glands

The **left** adrenal gland measures 0.40 cm in diameter. No abnormalities are noted with the gland's overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

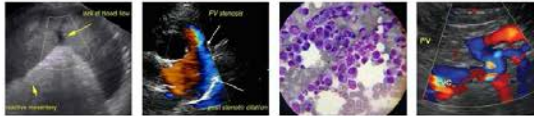
The right adrenal is 0.39 cm. Findings are similar to the left.

Spleen

The spleen is within normal limits in size 7.9 mm (normal = 10 mm). Its echotexture is diffusely "lacy" or miliary, with mildly scalloped margins. A hypoechoic nodule, measuring 2.9 mm in diameter x 3.03 mm in length, is present toward the tail. Subjectively, the spleen appears mildly, but diffusely hypoechoic. The hyperechoic punctate foci observed at the time of the last exam are hyperechoic walls of blood vessels. The latter may be due to fat, mineralization and/or fibrosis. The surrounding mesentery is hyperechoic. A possible thrombus or partial thrombus may be present in the splenic vein. The remaining splenic vasculature does not show any abnormalities.

Liver

There are no obvious signs of hepatomegaly. The liver's borders are smooth, but mildly rounded. It is homogeneous, but appears diffusely hypoechoic today. Focal lesions are not observed and no abnormalities are observed with the hepatic vessels. No obvious abnormalities are noted with the hepatic vessels.



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The gallbladder wall is stable in thickness at 1.5 mm, compared 1.6 mm. It remains hyperechoic. A trivial to small amount of echogenic material is present within the GB. The portions of the cystic and/or common bile ducts observed are not dilated or tortuous, i.e. there are no signs of an obstruction.

The duodenal papilla is stable at 0.59 cm in diameter.

Gastrointestinal

The gastric wall is within normal limits in thickness and the wall layers are well defined. The muscularis is prominent and mildly thickened. No obvious abnormalities are observed with its peristalsis.

The duodenum is 0.24 cm. A loss of detail of the architecture of the wall layers is noted today. A number of the small intestines are within normal limits in wall thickness, however others remain abnormal (up to 0.31 cm). The submucosa and muscularis are thicker than normal. Fogging of the muscularis is present, in addition to a loss of definition of the wall layers compared to Dewey's previous exam.

A large amount of fluid and gas are present within the lumen of the small intestines. Abnormally dilated loops of bowel are also present today. An obstruction is not visualized.

Region of the ileo-cecal-colic junction (ICC junction): The submucosa and muscularis layers of the small intestines are prominent to mildly thickened. No abnormalities are observed with the ICC junction per se and surrounding mesentery is not as hyperechoic today.

The colonic wall is not thickened and mural detail is considered normal. A large amount of fluid (liquid stools) and gas are present within the descending colon. An obvious obstruction is not observed.

Pancreas

The left limb is stable, i.e. it remains mildly hypoechoic, with a mildly coarse echotexture. Punctate, hyperechoic foci are scattered throughout the parenchyma. The surrounding mesentery is mildly to moderately hyperechoic, and are suggestive of active pancreatitis. Lateral to the left limb, multiple anechoic to hypoechoic nodules are observed surrounded by a hyperechoic mesentery. Metastatic lesions cannot be excluded. Nodular hyperplasia is less likely.

Other
Lymph nodes
The pancreatico-duodenal lymph node remains slightly enlarged at 0.78 cm. The mesentery surrounding the LN is severely hyperechoic.

A mesenteric LN is mildly to moderately enlarged, hypoechoic and has mildly irregular contours, 0.91 cm. The LN is not as round nor as enlarged today.

The two other mesenteric LNs measured are relatively stable in size, however, there is an improvement in their echogenicity and shape. They are no longer anechoic to hypoechoic and their contour is much smoother.

Abdominal effusion is not visualized today.

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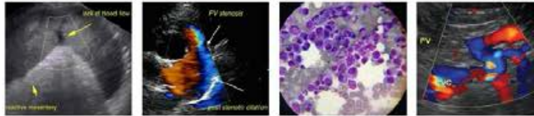

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pawsonography@gmail.com 530-786-8340

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ULTRASONOGRAPHIC FINDINGS

- **Gastrointestinal and lymphadenomegaly**: An ileus is present with gas and liquid stools in the colon. This may be causing cramps, discomfort and hyporexia. A loss of detail of the wall layers suggests the persistence of neoplasia and inflammation. The lymph nodes are not as large and irregular today, which suggests some response to chemotherapy.

- **Pancreas**: Active pancreatitis is still suspected, although infiltrative disease may be the underlying cause of edema and inflammation. There are possible signs of metastases of the adjacent mesentery are present today, however, evaluation with Doppler would be required before confirming this latter statement.

- **Liver**: Subjectively, the liver is diffusely hypoechoic. If it is truly hypoechoic, it is most consistent with infiltration of neoplastic cells within the liver.

- **Spleen**: Neoplasia is possible based on the scalloped borders and miliary echotexture, however, extramedullary hematopoiesis, splenitis and reactive hyperplasia remain viable differential diagnoses. A partial thrombus in the splenic vein cannot be excluded.

- **Gallbladder (GB)**: Cholecystitis remains a possible differential diagnosis, or this may be the normal appearance of Dewey's GB, including the mildly thickened and hyperechoic wall.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Some findings are suggestive of progression of Dewey's neoplasia, while other findings show complications, such as ileus and diarrhea, which could be causing his current side effects.

The following are suggested/recommended

- Metoclopramide at 0.15-0.25 mg/kg PO every 12 hours may help improve peristalsis. A low dose is suggested to avoid cramps and further discomfort.

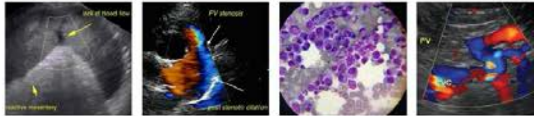
- A clay based montmorillonite paste may help diarrhea.

- Probiotics can cause gas and bloating. It may be worthwhile discontinuing the product or decreasing the dose by 50%. Some patients develop gas and bloating with psyllium depending on the source and concentration in the product.

- Appetite stimulant as needed

- Analgesia is strongly recommended

- Subcutaneous fluids at home, if possible



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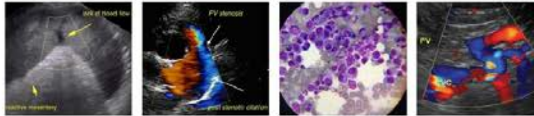

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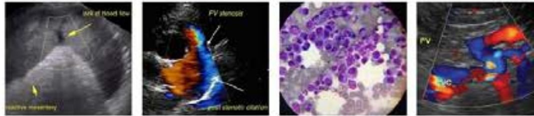

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Lisa Carioto, DVM, DVSc, Diplomate AVIM

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