



**PATIENT**

Ziggy Bowen

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

13 years

**WEIGHT**

5.8

**INTERPRETED BY**

R. McKenzie Daniel,  
DVM, DABVP  
(Canine and Feline)

**IMAGING PERFORMED BY**

Dr. Nottingham

**HOSPITAL NAME**

All Creatures AH of  
South Hill, Inc.

**REFERRING VET**

Dr. Sig Nottingham

**INVOICE**

13523

**DATE**

1/20/22

**PRESENTING CLINICAL SIGNS**

Wt on 4/1/21 =15.4 -9/21=12.4 -12/21=7.8 -1/22=5.8. No vomiting, eating very little, pt not having bowel movements, water intake decreased and urine has decreased  
Abnormal PE/Chem/CBC/UA Results: Very Anemic in last month. auto agglutinating RBC. non regenerative. Normal chemistries. Bilateral renal lithiasis. urine culture - no growth but treated with veraflox for 1 month with continued wt loss.- see attached blood work from 01/20/22.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

The residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture measuring – cm in diameter.

The area of the aortic trifurcation was free of pathology.

Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. Areas of medullary renolithiasis were present. The left kidney measured 3.5 cm in length. Mild pyelectasia was present in the right kidney. The right kidney measured 3.3 cm in length.

**Adrenal Glands**

No overt pathology in the area of the left or right adrenal glands.

**Spleen**

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

**Liver/ Gallbladder**

The liver was mildly enlarged. The parenchyma of the liver was subjectively increased in echogenicity compared to the spleen and renal cortices. The echotexture of the liver parenchyma was uniform with a mild coarse echotexture. The capsule of the liver was symmetrical in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non-distended in size with primarily anechoic luminal content. The cystic and common bile ducts were normal.

**Gastrointestinal**



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The stomach exhibited generalized mural thickening, exhibiting decreased mural echogenicity and loss of discernable wall layering. Associated gastric stasis was present, exhibited by mild to moderate retained anechoic fluid. The gastric body wall measured 1.1 cm in width. The pylorus wall measured 0.82 cm width. Potential for ulceration associated with the gastric lumen possible. Regional perigastric reactive mesentery was noted.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction, or foreign material. The jejunum wall measured 0.20 cm.

Normal visible colon wall layers were present with apparent formed feces in lumen.

***Pancreas***

The parenchyma of the left limb, body, and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease were evident.

***Free Abdomen***

No overt lymphadenopathy or peritoneal effusion was present.

**ULTRASONOGRAPHIC FINDINGS**

- Moderate yet variable gastric mural thickening, exhibiting decreased mural echogenicity and loss of discernable wall layering
- Mild hepatomegaly, exhibiting generalized increased parenchyma echogenicity
- Sonographically unremarkable small bowel
- Bilateral chronic renal changes with medullary renolithiasis and mild right kidney pyelectasia

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Potential for emerging obstructive renolithiasis associated with the right kidney is possible, although the pyelectasia may be owing to chronic renal changes or potential pelvic scarring. Urine culture and sensitivity could be considered.

Although sampling is required for a definitive diagnosis, the thickened hypoechoic stomach walls with loss of discernable wall layer detail and potential for ulceration is strongly suggestive of infiltrative gastric neoplasia, specifically gastric lymphoma or possibly ulcerative gastric lymphoma. Potential for severe generalized inflammatory etiology (i.e., severe gastritis) possible yet considered less likely. Assuming normal clotting status, ultrasound guided FNA of the gastric wall could be considered for screening cytology with potential for oncology consult. The stomach does not appear to be surgical.

Potential for hepatic involvement cannot be excluded, with other considerations, including lipidosis, owing to anorexia, inflammation, early fibrosis or other hepatopathy. If gastric FNA is elected, concurrent hepatic FNA, assuming normal clotting status, could be considered for further clarification.

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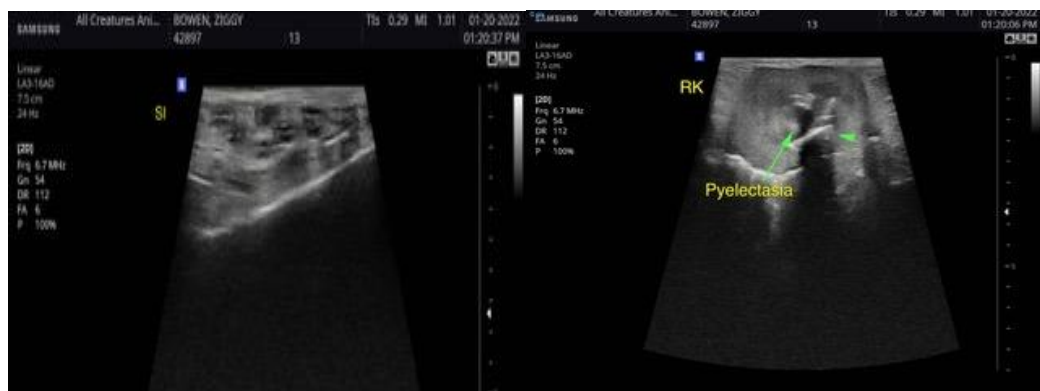
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The information and recommendations provided are based on the images presented by the



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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.

**R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)**  
info@SonoPath.com