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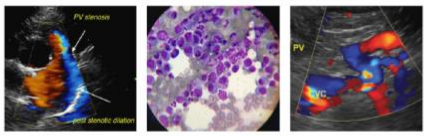
fredgromalak@gmail.com



SonoPath
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PATIENT

Harry Cantrell

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

6 Years 11 Months

WEIGHT

4.92 kg

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Dr. Patton

INVOICE

20785

DATE

PRESENTING CLINICAL SIGNS

History: Harry presented to the MVS Emergency Service on Jan 26, 2023, at 5:15pm, for evaluation of inappetence. Yesterday owners noted that patient had formed black stool (not tarry, normal consistency just black) and he wasn't eating. He is still drinking. Today he ate very little so they brought him to pcDVM and they advised to come here due to possible mass or intussusception. He has a history of protein allergy and is on a Rx diet for it. No v/d/c/s noted. No past medical issues other than the allergies. He is an indoor only cat with one feline housemate.

Abnormal PE/Chem/CBC/UA Results: AFAST: No free fluid; large mass effect noted cranial to the urinary bladder

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. Primarily anechoic urine was present in the lumen. Mild nondependent particulate sediment was present, which may indicate minor cellular debris/protein, crystalline debris, lipid or mucus. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted. Aortic trifurcation was normal.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. Mild increased cortex echogenicity was noted, suspect patient variant. No evidence of renal nodular or neoplastic criteria. No evidence of pelvic dilation. The left kidney measured 3.7 cm in length. The right kidney measured 4.0 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.38 cm.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.40 cm.

Spleen

Mild splenomegaly with minor asymmetrical medial capsule contour was noted. Mild heterogenous to discrete micronodular splenic parenchyma was noted. No splenic masses were present. The spleen measured 1.1 cm in width.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non-distended with primarily anechoic content with mild incidental echogenic luminal debris. No evidence of gallbladder or peripheral gallbladder inflammation. The cystic and common bile ducts were normal.

Gastrointestinal

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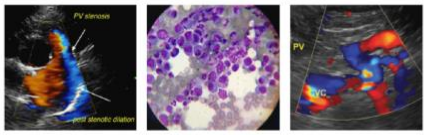

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The stomach presented primarily intact wall layering with regional indistinct variably thickened to nodular ventral gastric body walls, primarily owing to variably prominent gastric mucosa. Intact stomach wall measured 0.25 cm, whereas variably thickened stomach wall measured up to 0.65 cm wall width. The stomach contained a moderate amount of progressively shadowing ingesta, without evidence of mechanical pyloric outflow obstruction.

A moderately sized to large jejunal mural mass was present in the mid to caudal abdomen, exhibiting marked mural hypertrophy, decreased mural echogenicity, and loss of discernable wall layering, potentially measuring 5-7 cm in length with wall width up to 2.0 cm. Associated segmental jejunal paralytic ileus or potential impacted ingesta was present, without overt evidence of obstruction. Adjacent jejunum exhibited intact to indistinct variably thickened wall layering, both oral and aborally, extending into normal appearing jejunum, exhibiting 1:3 muscularis to mucosa ratio and intact wall layering. The adjacent thickened jejunum measured 0.34 cm wall width. Normal appearing jejunum measured 0.22 cm wall width. No evidence of pathology at the level of the ileocolic junction, measuring 0.29 cm wall width. Regional hyperechoic perijejunal omentum was present.

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 was evident.

Free Abdomen

A solitary mid abdominal mesenteric lymph node was present. The lymph node exhibited symmetrical to rounded margination with abnormal width: length ratio (>0.5). The enlarged lymph node was bordered by echogenic to reactive mesentery. The mesenteric lymph node measured 3.2 cm x 2.0 cm. Intermittent small pockets of scant free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Jejunal mural mass with associated adjacent hypoechoic to swollen mesenteric lymphadenopathy, regional perilymphatic to periintestinal hyperechoic mesentery and scant free fluid
- Concurrent thickened adjacent jejunum, exhibiting intact indistinct wall layering
- Discrete, variably thickened ventral gastric body walls with moderate shadowing gastric ingesta
- Mild splenomegaly, exhibiting discrete micronodular parenchyma

Secondary Findings

- Nonspecific mild increased renal cortex echogenicity with mild urinary bladder sediment- suspect renal patient variant, no overt renal neoplastic/metastatic criteria

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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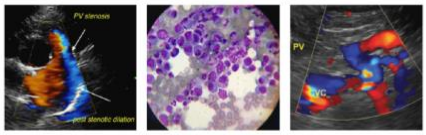

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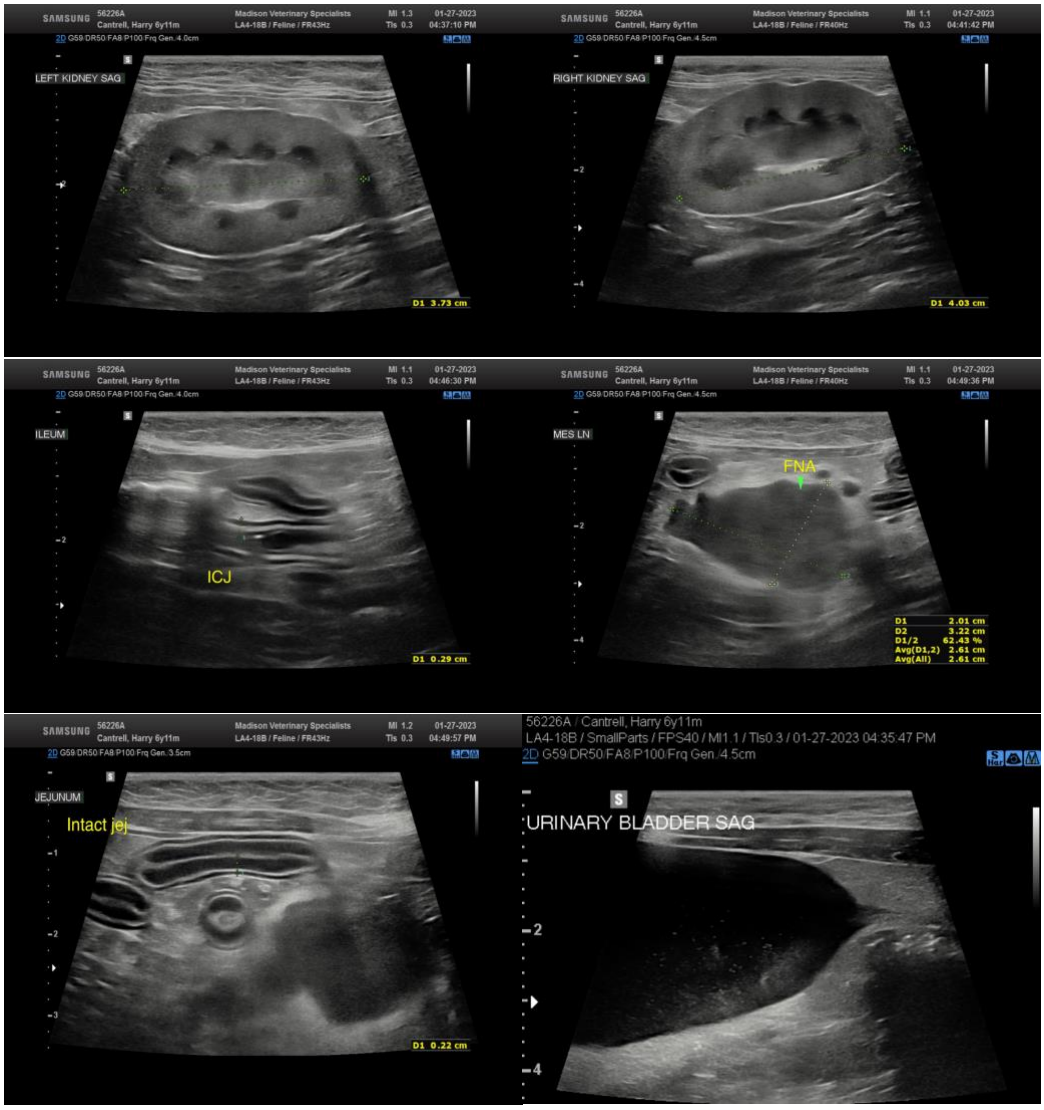
Although sampling is required for further assessment, primary concern for high-grade jejunal and lymphatic neoplastic process, such as high-grade lymphoma or similar. Potential for nonneoplastic etiologies, i.e., significant inflammatory or granulomatous (dry FIP) etiologies possible yet though less likely. Concern for possible early splenic or regional gastric mural metastasis is warranted. Further assessment may include FNA cytology of the jejunal mural mass, mesenteric lymph node, and spleen, assuming normal clotting status, and using a 25-gauge needle and with potential Benadryl pretreatment. Three view chest radiographs are recommended if not done. Oncology and/or surgical consult could be considered pending recommended sampling and staging.



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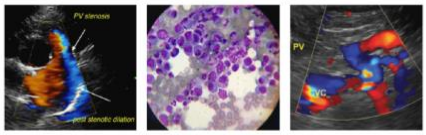

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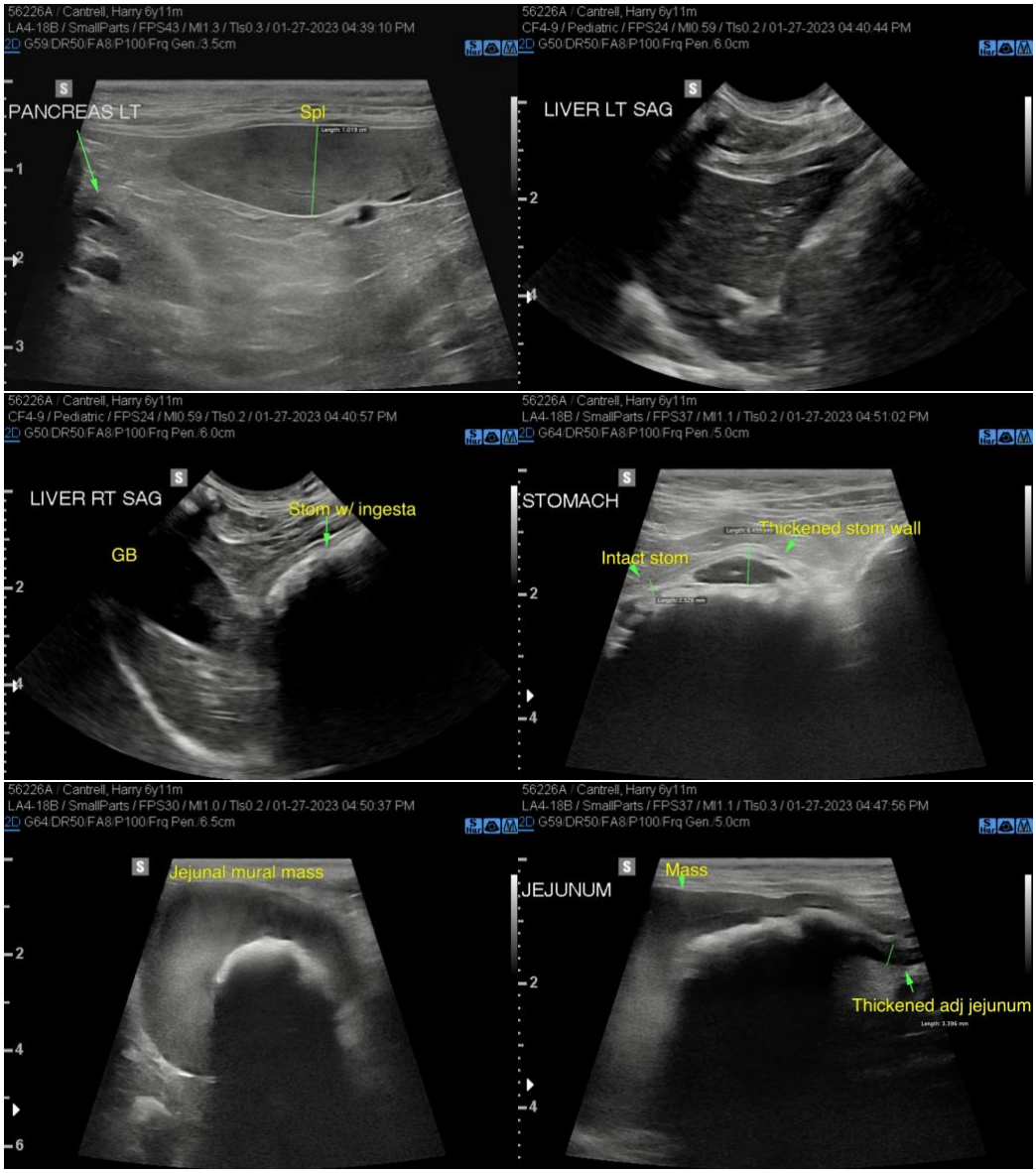

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

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