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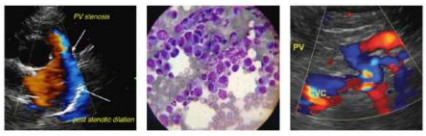

SonoPath
Clinical Sonography & Telecytology
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PATIENT
Lucy Vaughn

SPECIES
Feline

BREED
DSH

SEX
FS

AGE
12 years

WEIGHT
12.6 lbs.

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

IMAGING PERFORMED BY
Amy Mayhew LVT

HOSPITAL NAME
SVS Imaging MI

REFERRING VET
Cat Care of Rochester Hills

INVOICE
15220

DATE
10/13/22

PRESENTING CLINICAL SIGNS

Weight loss, occ hairball, leukocytosis, pancreatitis

Abnormal PE/Chem/CBC/UA Results: Mild dental disease, soft heart murmur/tachycardic. 8-31-22: CBC: WBC 24,400 H - r/o infection, inflammation, neoplasia (not expected to see this) Neut 19,276 H r/o infection, inflammation Monos 732 H r/o chronic inflammation Chem: Glu 242 H - chronic stress hyperglycemia (no glucosuria) TP 6.1 L - r/o PLE, PLN (only renal insufficiency, no proteinuria). AST 12 L not significant T4 2.2 Blood pressure - 168 UA - No evidence of UTI Add on fPL - 4.3 - slightly high, possible pancreatitis 10-6-22: CBC: Retics 62, rest of RBCs wnl WBC: 28,500 H (24,400) Neutro: 18,639 H (19,276) Lymph: 6,555 H (3,904) Monos: 2,109 H (732) Basos: 143 H (0) Chem: TP 5.9 L (6.1) r/o PLE (or PLN) ALT: 178 H AST: 72 H ALP: 61 H fPL: 5.8 (4.1) - still suggestive of pancreatitis. Add on BNP - 45 **Chest rads taken today.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and cystourethral junction exhibited normal thickness and tone. Anechoic urine was present in the lumen with minor, non-dependent, particulate sediment which may indicate 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 changes was noted.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 3.7 cm in length. The right kidney measured 3.9 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 0.39 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.51 cm width.

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. The spleen measured 0.67 cm width at the level of the hilus.

Liver/ Gallbladder

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

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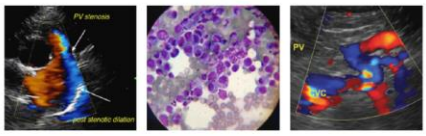

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normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction, or foreign material. The gastric body wall width measured 0.25 cm.

The small intestine presented primarily intact wall layering and maintained a 1:3 muscularis/mucosa ratio with no evidence of a mechanical obstructive pattern. A solitary, segmental, intestinal mural mass in the subjective area of the distal jejunum or proximal ileum was present. The mural mass exhibited segmental moderate mural hypertrophy, decreased mural echogenicity, and loss of discernable wall layering, measuring approximately 4.6 cm length x 2.6 cm diameter. Wall width within the intestinal mural mass measured up to 1.6 cm. By comparison, normal-appearing duodenum wall measured 0.31 cm width. Normal-appearing jejunum wall measured 0.25 cm width. No evidence pathology was noted at the level of the ileocolic junction. The ileocolic junction wall measured 0.34 cm width. Separate mildly thickened yet intact ileum wall distal to the intestinal mural mass was present measuring 0.5 cm ileum wall width.

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

Pancreas

The left limb of the pancreas was mildly prominent in size with areas of mild capsule asymmetry and heterogeneous isoechoic parenchyma compared to adjacent omentum. Minor pancreatic duct dilation was noted. No signs of active inflammation or neoplasia.

Free Abdomen

Regional peri intestinal hyperechoic mesentery was noted around the intestinal mural mass. No obvious evidence of lymphadenopathy or peritoneal free fluid was present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Small intestinal mural mass with associated mild peri intestinal peritonitis - subjectively distal jejunum or proximal ileum in location
- Concurrent subjective mild yet intact ileum walls distal to the intestinal mural mass, no evidence of neoplastic criteria at the level of the ileocolic junction
- Mild chronic pancreatitis pattern

Secondary Findings

- Mild chronic renal changes
- Mild urinary bladder sediment

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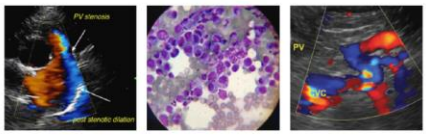

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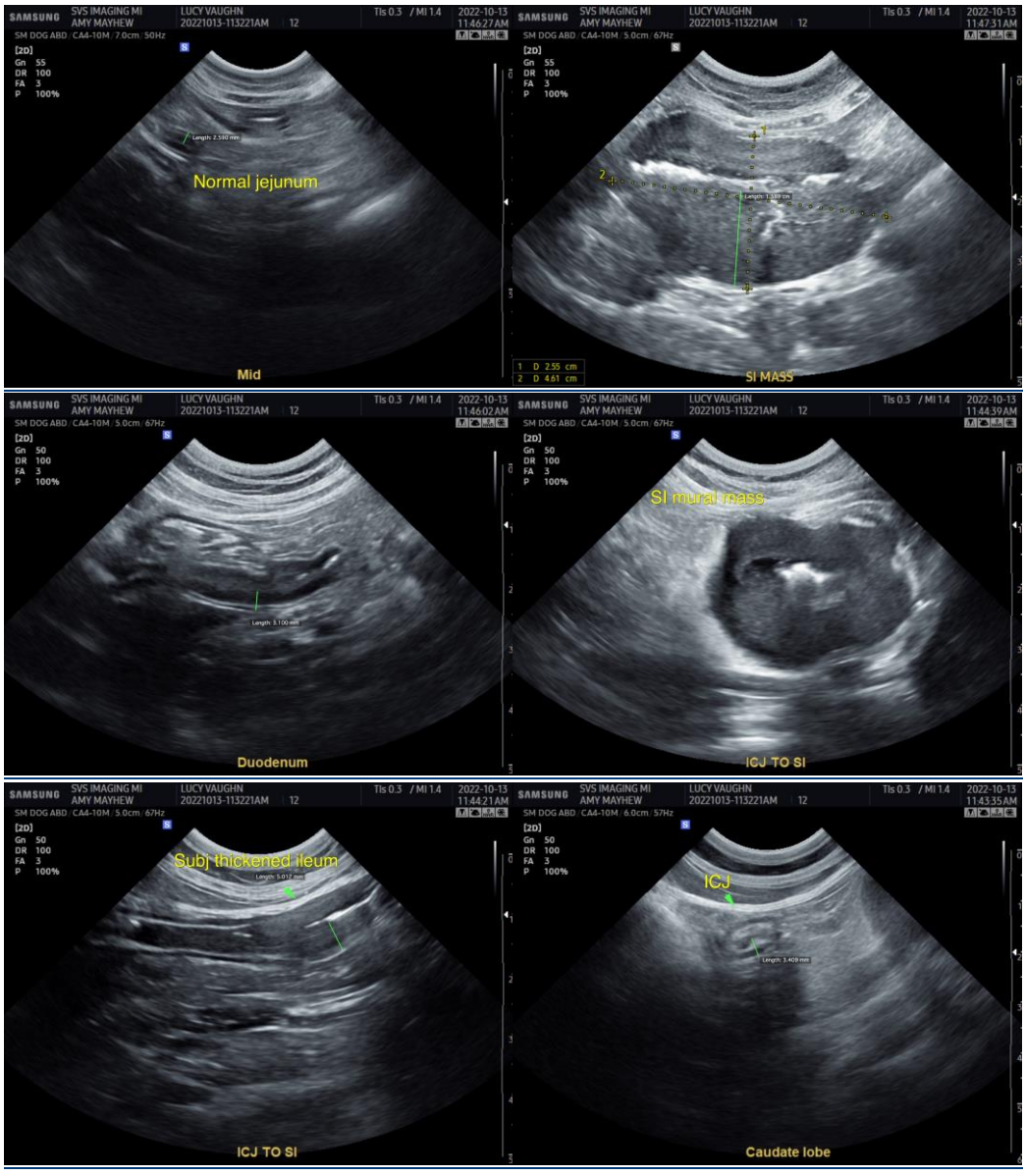
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Inflammatory neoplastic or possible granulomatous (Dry FIP), etiologies are possible for the intestinal mural mass, although neoplastic criteria is favored. Correlation with pending cytology is recommended. Subjectively, the intestinal mural mass appears to be amendable to surgical resection, although possible early adjacent ileal involvement is of concern. Intestinal biopsies are recommended at the time of surgery if surgery is elected. Pending cytology, an oncology consult may be considered.



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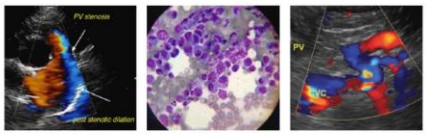

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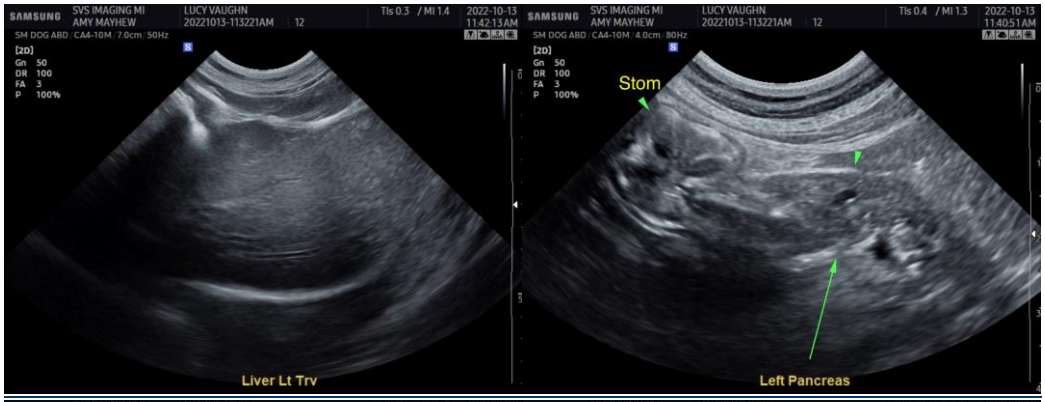

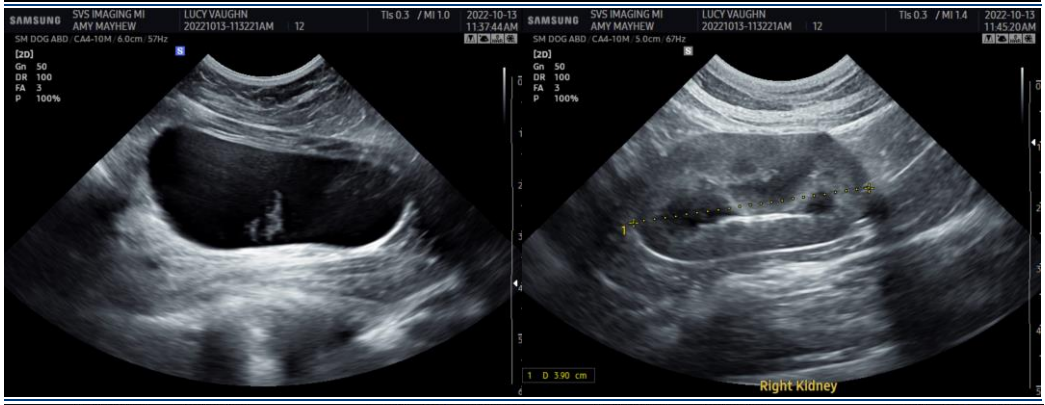

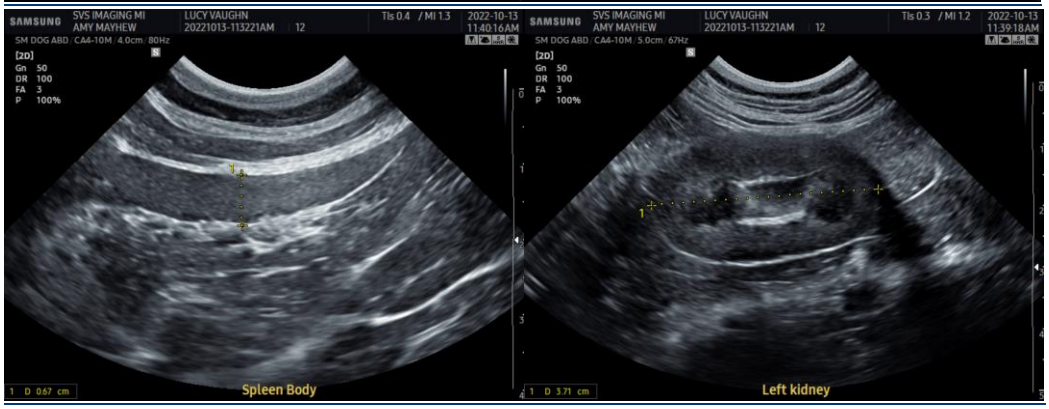

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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