



PATIENT

Ricky Schwarz

SPECIES

Feline

BREED

DLH

SEX

MN

AGE

18

WEIGHT

3.49

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Massa

HOSPITAL NAME

Animal Emergency
Hospital Volusia

REFERRING VET

Dr. Massa

INVOICE

11974ag

DATE

10/24/2022

PRESENTING CLINICAL SIGNS

Acutely lethargic today, not eating. Normally vomits ~1-2x daily but today vomited ~5x. No diarrhea per O. Indoor only. Does like to eat things off the floor. No change in diet/treats. Chronic mucoid nasal discharge per O

Abnormal PE/Chem/CBC/UA Results: PE: nasal discharge L nare, dehydration BW: mild anemia with leukocytosis/neutrophilia/lymphopenia, elevated globulins Rad report: There is repeatable region of increased soft tissue opacity within the caudal dorsal thorax, the left of midline in the ventral dorsal view. There is potential esophageal luminal gas. No cardiovascular abnormalities are seen. No other thoracic abnormalities are seen. There is a moderate amount of gas in the colon. The stomach and small intestinal tract are unremarkable. The liver, spleen, visible portions of the kidneys, urinary bladder, and abdominal serosal detail are all within normal limits. There is multifocal spondylosis deformans. Conclusion Left caudal dorsal thoracic soft tissue opacity. This is concerning for a potential mediastinal location such as esophageal or paraesophageal, with differentials including foreign body or a granulomatous/neoplastic lesion. A left caudal pulmonary lesion is not ruled out.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 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 were noted.

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. The left kidney measured 3.8 cm in length. The right kidney measured 3.9 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

No obvious pathology was present in the area of the bilateral adrenal glands.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. 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. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age-related remodeling with minor potential for inflammatory or neoplastic disease. The spleen measured 1.0 cm in width at the level of the hilus.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion.



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The gallbladder was divided into two compartments and was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild to moderate non to focal progressively shadowing ingesta with no signs of ileus, obstruction or overt foreign material.

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The intestinal walls demonstrated intact wall layers with diffusely thickened walls and altered 1:3 muscularis / mucosa ratio primarily consisting of muscularis hypertrophy. The small intestine wall measured 0.3 cm in width. No overt evidence of loss of wall layering detail or intestinal masses.

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

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Pancreas

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The let pancreas exhibited potential for mild enlargement with hypoechoic parenchyma and subtle evidence of peripancreatic hyperechoic mesentery. The visible pancreatic duct was normal.

AGE

Free Abdomen

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No omental masses or peritoneal effusion was present.

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Multiple focally enlarged mid abdominal mesenteric lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation and hyperechoic mesentery was evident. An example of lymph node size was 1.5 cm diameter.

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ULTRASONOGRAPHIC FINDINGS

- Infiltrative enteropathy pattern with associated midabdominal mesenteric lymphadenopathy-inflammatory vs neoplastic, IBD/eosinophilic enteritis or round cell neoplasia possible
- Possible concurrent pancreatitis
- Overtly normal stomach containing ingesta
- Nonspecific mild chronic renal changes

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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An FNA cytology of an enlarged lymph node if accessible is warranted for screening cytology. Full thickness intestinal biopsy +/- LN biopsies are likely required for a definitive diagnosis. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. The presence of gastric ingesta may indicate some degree some of gastric hypomotility or metabolic stasis if documented NPO. The sonographic presentation of the ingesta was most consistent with food, without evidence of overt foreign material. Empirically IBD protocol +/- as needed GI support and therapy for pancreatitis if suspected would be reasonable.

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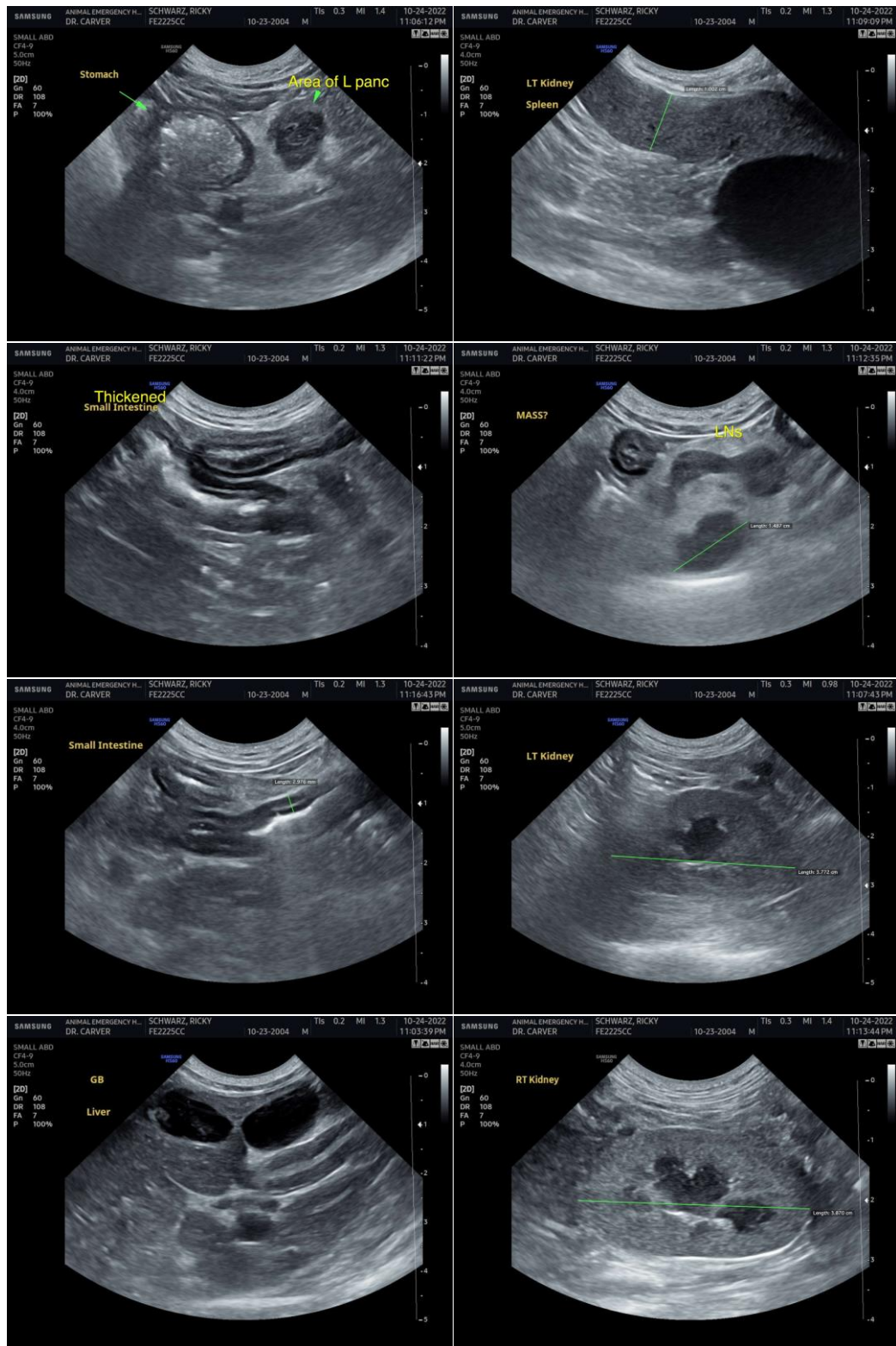
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.



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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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