



PATIENT

Dickel Neumann

SPECIES

Feline

BREED

Ragdoll

SEX

M/N

AGE

10

WEIGHT

3kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Belan

HOSPITAL NAME

Glamorgan AH

REFERRING VET

Dr. Falk

INVOICE

15066

DATE

10/4/22

PRESENTING CLINICAL SIGNS

Weight loss and chronic diarrhea

Abnormal PE/Chem/CBC/UA Results: Fecal PCR negative blood work non diagnostic.

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 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 3.6 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 0.36 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.49 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 0.6 cm width at the level of the hilus.

Liver/ Gallbladder

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. The gallbladder was non-distended in size with mild, nondependent, echogenic debris. The cystic and common bile ducts were normal. No evidence of gallbladder or peripheral gallbladder inflammation was noted.

Gastrointestinal

The stomach fundus and body exhibited intact and sonographically unremarkable wall layering. The ventral gastric body wall width measured 0.24 cm. Prominent to mildly thickened wall layering in the area of the pylorus to upper duodenum exhibiting intact yet indistinct wall layer detail was present



PATIENT	along with mild retained pyloric and upper duodenal chyme. Pyloric to upper duodenal wall width measured 0.33 cm.
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SPECIES	The small intestine presented intact wall layering and primarily maintained a 1:3 muscularis/mucosa ratio. A segmental intestinal mural mass was present in the subjective mid abdomen suggestive of jejunal location exhibiting segmental, variable yet moderate mural hypertrophy, decreased mural echogenicity, and loss of discernable wall layering with associated mild metabolic to paralytic intestinal ileus, measuring approximately 3.0-4.0 cm length with wall width up to 1.4 cm. By comparison, normal-appearing jejunum measured 0.20 cm.
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SEX	Normal visible colon wall layers were present with apparent formed feces in lumen.
M/N	
AGE	Pancreas
10	The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia.
WEIGHT	Free Abdomen
3kg	Several, likely regional mesenteric lymph nodes were present. The lymph nodes exhibited symmetrical to rounded margination with abnormal width: length ratio (>0.5). The enlarged lymph nodes were bordered by echogenic to reactive mesentery. An example of a mesenteric lymph node measured 1.0 cm in diameter. Regional peri intestinal hyperechoic mesentery was noted around the abnormal segmental intestine. No evidence of peritoneal free fluid was noted.
INTERPRETED BY	ULTRASONOGRAPHIC FINDINGS
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)	<ul style="list-style-type: none"> • Segmental intestinal mural mass with associated mild regional peritonitis and likely mesenteric lymphadenopathy • Subjective mildly thickened pylorus, upper duodenal walls with minor retained pyloric chyme • Concurrent pancreatitis pattern • Mild chronic renal changes • Minor hepatic parenchymal remodeling with mild gallbladder debris - gallbladder debris suspected to be secondary to fasting, given no evidence of reported cholestasis
IMAGING PERFORMED BY	INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS
Dr. Belan	Although sampling is required for a definitive diagnosis, the segmental intestinal mural mass is suspected to be jejunal in location, suggestive of neoplastic criteria, i.e., lymphoma, mast cell neoplasia, or other, with inflammatory or granulomatous etiologies (dry FIP), possible. Potential for regional mesenteric lymphoid hyperplasia, reactive lymphadenitis, or early neoplastic lymphadenopathy is possible. Likewise, possible early involvement of the upper gastrointestinal tract cannot be definitively excluded.
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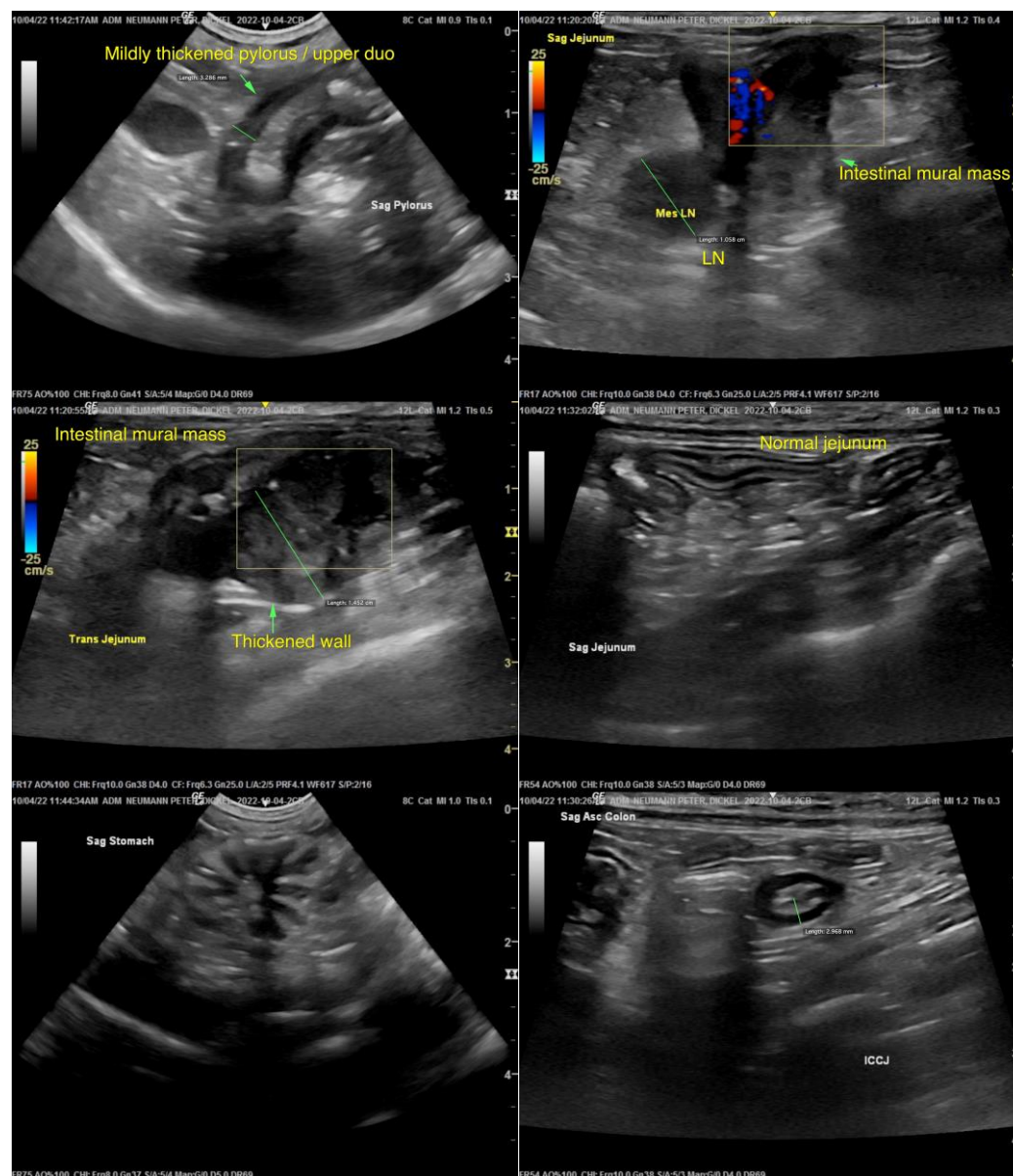
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Assuming normal clotting status, ultrasound-guided FNA of the intestinal mural mass +/- regional lymph node for screening cytology and further clarification may be considered. Oncology and/or surgical consult would be ideal. Three-view chest radiographs are recommended if not done.





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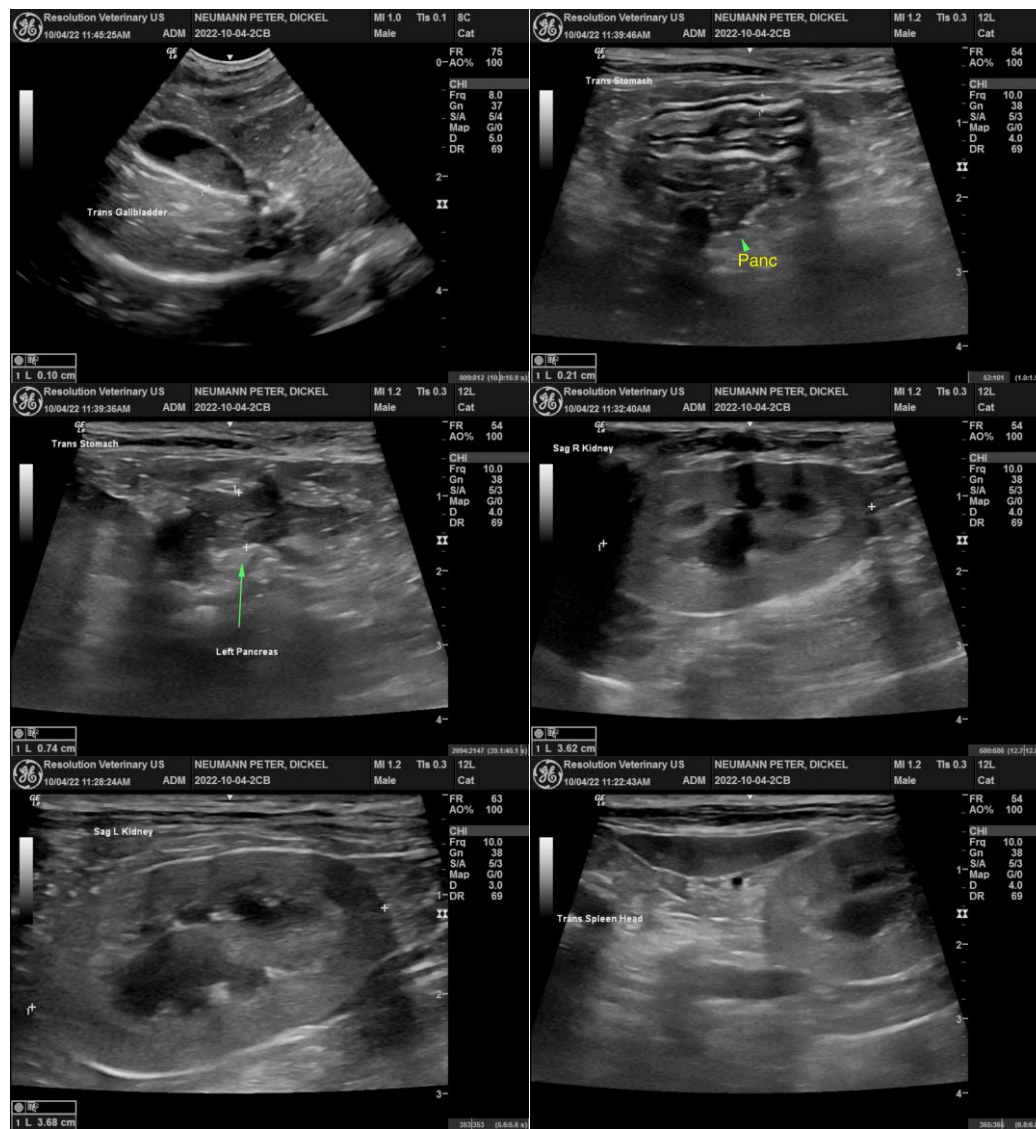
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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