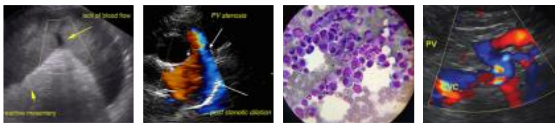


PATIENT

Coco Hill

SPECIES

Feline

BREED

DLH

SEX

FS

AGE

9 years

WEIGHT

6.7 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

West Salem AC

REFERRING VET

Dr. Crane

INVOICE

16276

DATE

2/22/23

PRESENTING CLINICAL SIGNS

P has been quickly losing weight, occasional vomiting of undigested food, not eating as much for 1 to 2 week duration. On PE, P underweight, generalized muscle atrophy, dehydrated, greasy unkempt hair coat. Ping pong ball sized firm mass palpated in the mid ventral abdomen.

Abnormal PE/Chem/CBC/UA Results: TP: 5.4 ALP 349 GGT 14 Tbili: 8.7 CBC unremarkable lipase: normal TT4, U/A, and Pt/PTT pending Current Medications Cerenia (10mg/ml) 0.3ml SQ, LRS SQF 100ml

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Mild, primarily nondependent, particulate sediment was present without evidence of calculus formation. This is likely incidental unless evidence of inflammatory urinary bladder sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted. The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S if evidence of inflammatory cells is recommended.

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 and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 3.6 cm in length. The right kidney measured 3.9 cm in length.

Adrenal Glands

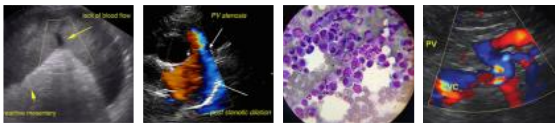
The bilateral adrenal glands were overtly normal in size, position, and shape. The left adrenal gland measured 0.29 cm width. The right adrenal gland measured 0.26 cm width.

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.

Liver/ Gallbladder

The liver presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of



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congestion. The gallbladder was non-distended in size containing primarily anechoic content with mild, nonorganized, echogenic gallbladder debris. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. Minor retained anechoic pyloric fluid was noted.

The small intestine presented generalized intact wall layering exhibiting generalized propensity for mildly prominent to variable muscularis layer. Segments of midabdominal jejunum exhibited mild to moderate mural hypertrophy exhibiting decreased mural echogenicity and loss of discernable wall layer detail. Thickened segments of jejunum measured up to 0.27 cm wall width. By comparison, intact jejunal wall layering measured 0.24 cm. Minor segmental nonobstructive intestinal ileus was present without evidence of a mechanical obstructive pattern.

Normal visible colon wall layers were present with non-formed fecal matter present in the proximal colon and cecum.

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

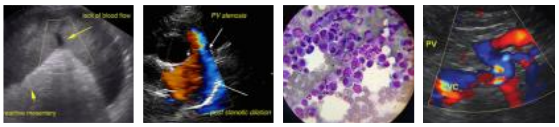
Midabdominal mesenteric / mesenteric root lymph nodes were present. The lymph nodes exhibited symmetrical to rounded margination with abnormal width: length ratio (>0.5). The enlarged lymph nodes were bordered by echogenic to reactive mesentery. An example of a mesenteric root lymph nodes measured 2.4 cm length and 1.3 cm width. Regional peri lymphatic to peri intestinal hyperechoic omentum was noted. Scant peritoneal free fluid was present.

ULTRASONOGRAPHIC FINDINGS

- Generalized infiltrative enteropathy pattern exhibiting segmental thickened jejunum with indistinct / loss of discernable wall layering
- Associated hypoechoic to swollen midabdominal mesenteric lymphadenopathy, scant peritoneal free fluid
- Hepatomegaly
- Nondistended gallbladder with mild luminal debris
- Subtle heterogeneous left pancreas
- Mild age-related kidneys

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Primary considerations for the intestinal presentation combined with mesenteric lymphadenopathy may include inflammatory vs. neoplastic infiltrative enteropathy i.e., IBD /eosinophilic enteritis vs.



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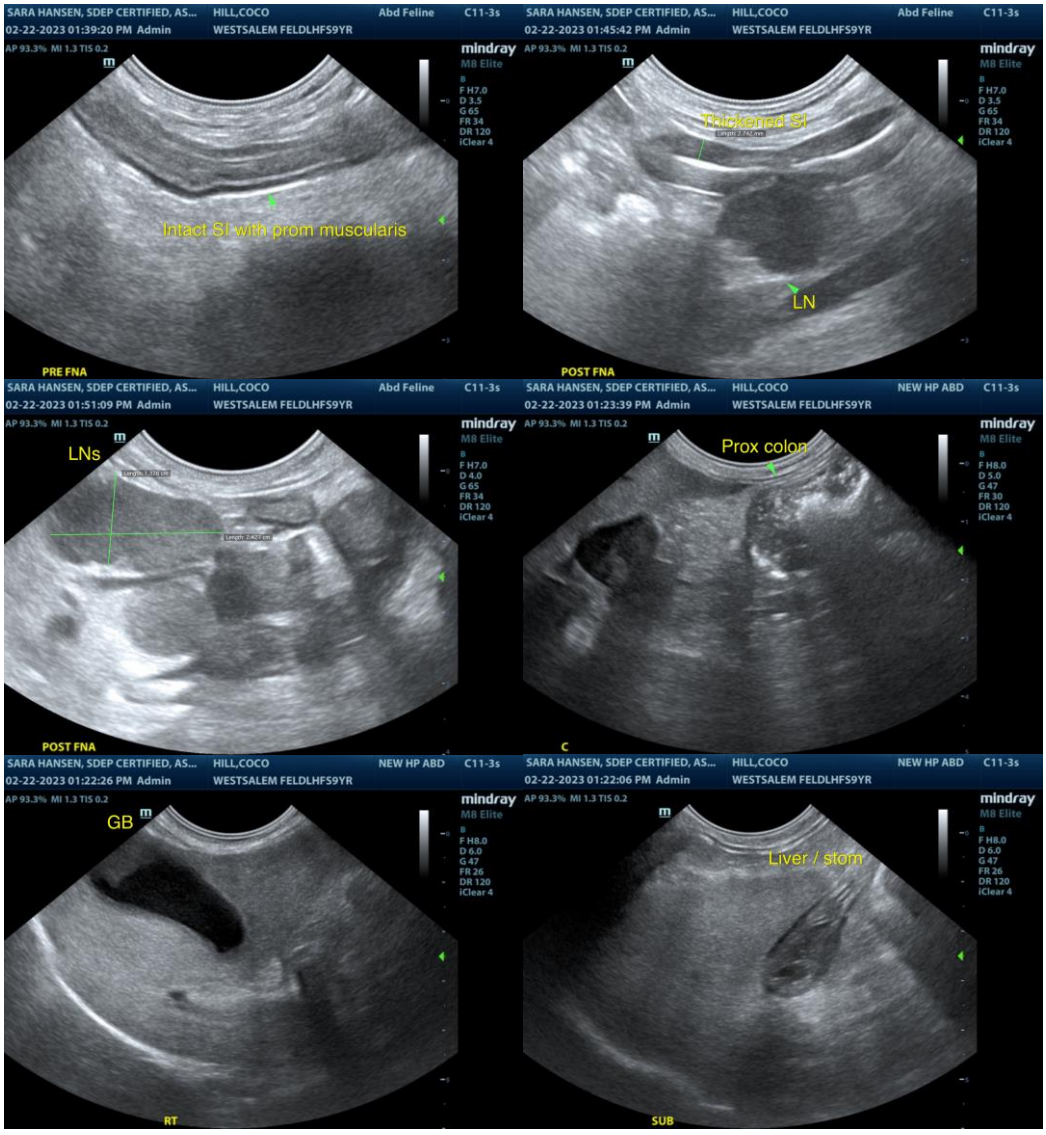
lymphoma mast cell neoplasia or other with associated mesenteric hyperplasia, lymphadenitis, or neoplastic lymphadenopathy. Dry form FIP and granulomatous mesenteric lymphadenopathy are considered a less likely differential diagnosis with higher suspicion for neoplastic criteria. The possibility of multicentric neoplasia potentially involving the liver vs. inflammatory hepatopathy and/or Triad Disease are all potentials.

Correlation with pending cytology is recommended. If neoplastic process is confirmed, or if not done, screening hepatic FNA cytology for further staging would be recommended. Intestinal and lymphatic +/- hepatic biopsies may be required for a definitive diagnosis. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended.



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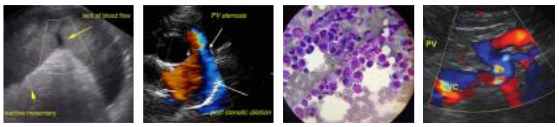

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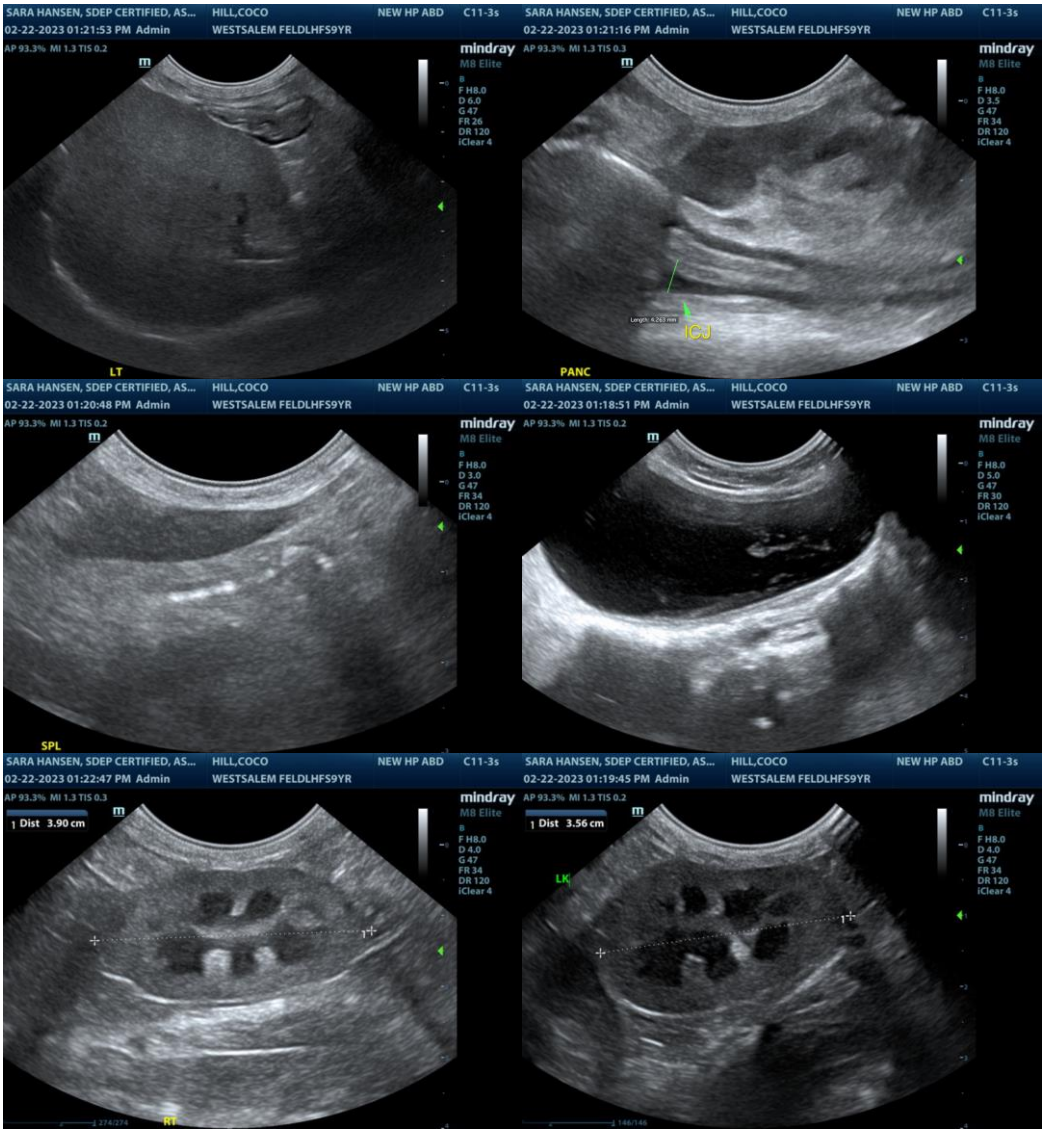

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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