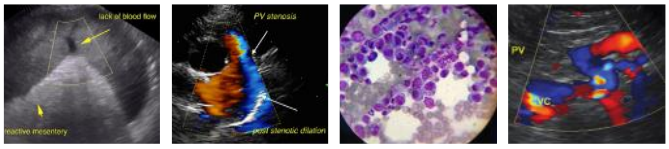
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Blacky Cohen

SPECIES
Feline

BREED
DSH

SEX
MN

AGE
3 years

WEIGHT
11.2 lbs.

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

IMAGING PERFORMED BY
Dr. Couser

HOSPITAL NAME
Willamette Vet Hospital

REFERRING VET
Dr. Couser

INVOICE
13478

DATE
3/15/22

PRESENTING CLINICAL SIGNS

Pt presented for acute vomiting. O left for week-long trip, pt left at home with automatic feeder, minimal monitoring. O returned to food in feeder bowl and multiple piles of vomit around the house. O offered wet food today, pt vomited after eating. O reports pt had intermittent vomiting over last few months. Hx chronic intermittent URI signs (mucoid nasal discharge, sneezing, wheezing), no resp signs currently.
Abnormal PE/Chem/CBC/UA Results: Exam - QAR. MM light pink, normothermic. Palpable mid-abdominal mass approx 3-4 cm diameter. Small intestine gassy. CBC: WBC 16.4k, Neut 13.6k, Mono 0.82k, rest wnl. Chem, lytes: all wnl. TT4 = 2.2 wnl USG 1.076, sediment NSF.

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 without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were present in the left kidney. 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 4.6 cm in length.

Normal size and margination were present in the right kidney. 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. A hyperechoic corticomedullary band, consistent with a medullary rim sign, was present. This is a nonspecific finding seen in both normal and abnormal kidneys. It may be associated interstitial renal disease, hypercalcemia, tubular necrosis, lymphoma, and FIP. However, it is a nonspecific finding. 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 0.4 cm width. The right adrenal gland was not definitively visualized. No overt pathology was noted in the area of the right adrenal gland.

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 0.93 cm in width.

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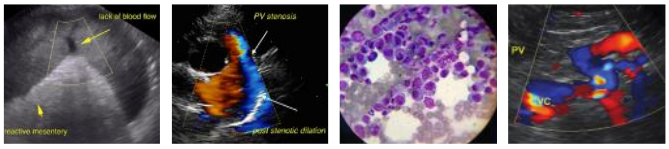

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Liver/ Gallbladder

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 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 revealed a moderately sized Intestinal mural mass likely jejunal in location present in the mid to cranial abdomen measuring approximately 3.0-4.0 cm in diameter with wall width up to 1.5 cm. The mass exhibited moderate hypoechoic mural hypertrophy with loss of discernable wall layering. Concurrent, non-associated smaller to emerging mural mass was noted in the subjective cranial small intestine likely jejunal in location with wall width measuring 0.8 cm. Regional intestinal segments adjacent to the mural masses exhibited intact yet subjective mild altered muscularis/mucosa ratio owing to mild to variably prominent muscularis layer. Additional small intestine exhibited Intact wall layering and maintained 1:3 muscularis / mucosa ratio. An example of subjective normal-appearing small intestine measured 0.23 cm wall width. The Ileocolic junction was not definitively visualized.

The visualized segments of the colon were sonographically unremarkable.

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 were evident.

Free Abdomen

Mid abdominal mesenteric lymph nodes were present. The lymph nodes exhibited symmetrical to rounded margination with abnormal width: length ratio (>0.5). An example of the lymph nodes measured 1.4 cm x 0.75 cm. Regional perilymphatic to mild peri intestinal reactive mesentery was present. No free fluid was noted.

ULTRASONOGRAPHIC FINDINGS

- Segmental enteropathy exhibiting at least 2 variably sized mural masses
- Associated mildly prominent to hypoechoic mesenteric lymphadenopathy with mild regional perilymphatic to peri intestinal reactive mesentery
- Nonspecific right kidney medullary rim sign
- Mild urinary bladder sediment - likely minor cellular or crystalline debris, potential for mild mucus

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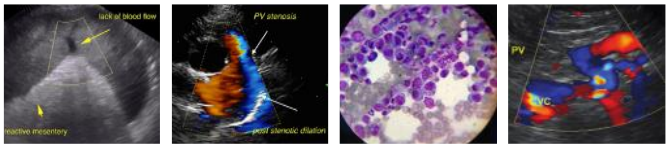

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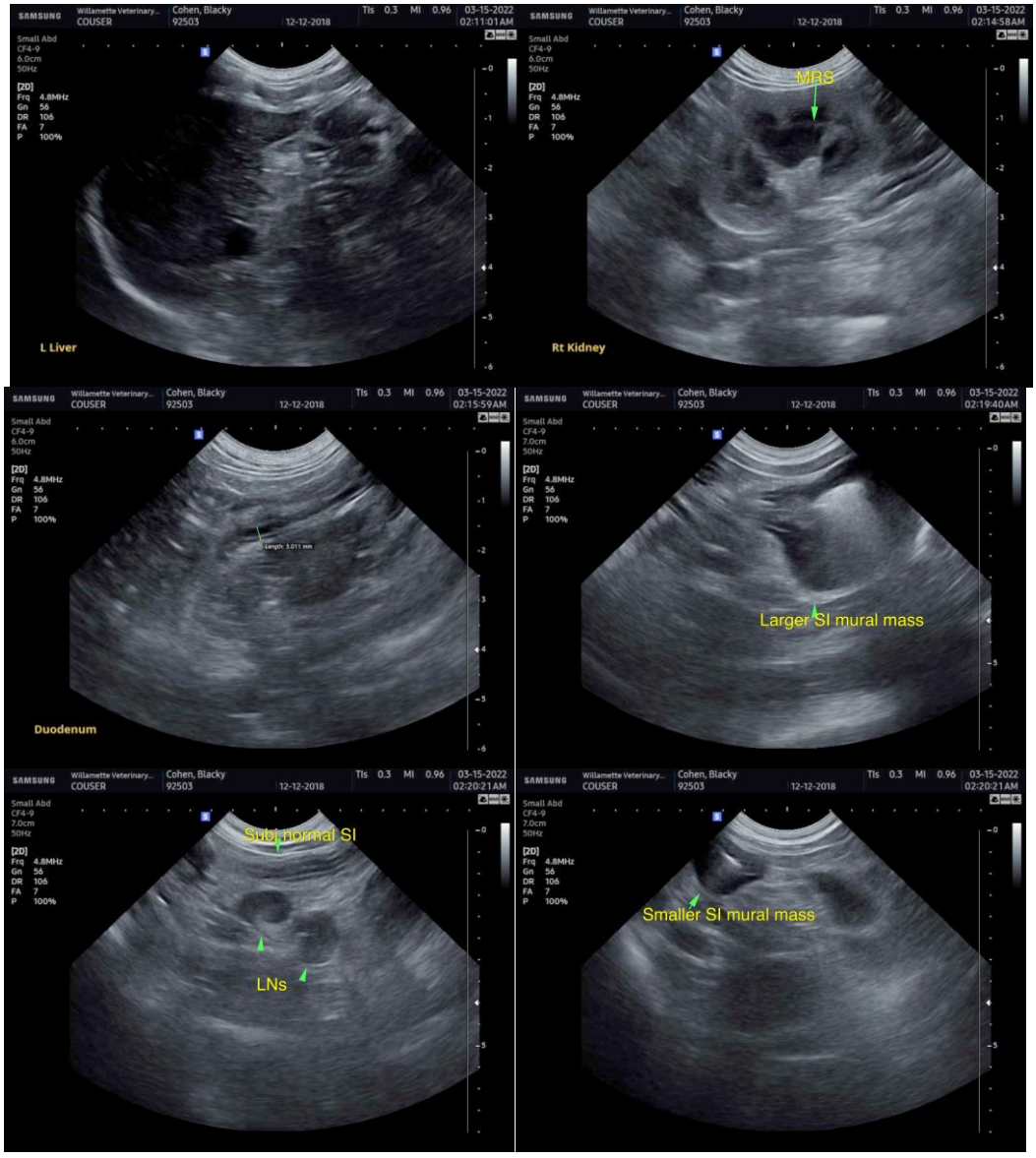
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The Intestinal mural masses along with potential regional small intestinal intact to altered wall layering may Indicate inflammatory (IBD / eosinophilic enteritis), neoplastic (lymphoma, mast cell neoplasia, or other), or granulomatous (dry form FIP), etiologies. The associated lymphadenopathy may indicate secondary hyperplasia, reactive lymphadenitis, or early neoplastic to metastatic lymphadenopathy.

Assuming no evidence of thoracic pathology on three view chest radiographs, laparotomy with gross inspection of the Intestinal mural masses and regional small intestine with potential for Intestinal mass biopsy +/- resection anastomosis, as well as additional small intestinal biopsies of the regional small intestine and lymphatic biopsies would be warranted.

Based on Intestinal and lymphatic histopathology, oncology consultation may be indicated.



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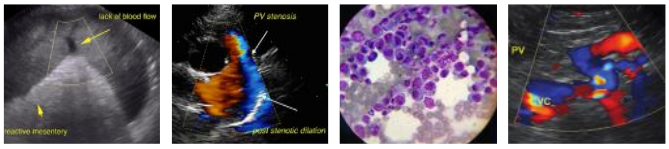

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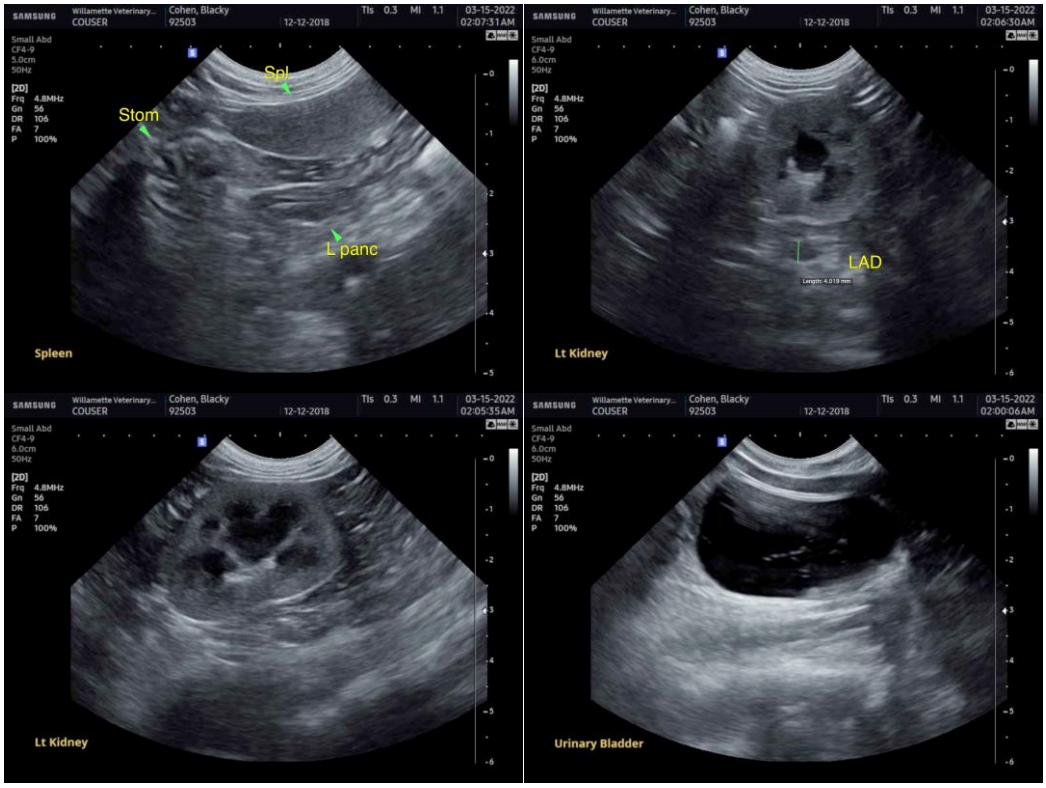

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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