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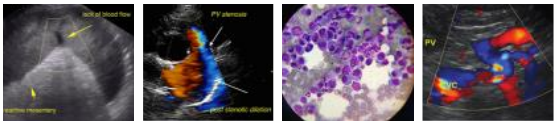

ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

Mia Holland

SPECIES

Feline

BREED

DLH

SEX

Spayed Female

AGE

11 Years

WEIGHT

13.13 Lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

Amazon Park AH

REFERRING VET

Dr. Jones

INVOICE

14557

DATE

3/28/22

PRESENTING CLINICAL SIGNS

History: Several day history of poor appetite, lethargy, straining to defecate. Exam reveals mass effect in caudal abdomen on right side, appears soft tissue in structure on radiographs.

Abnormal PE/Chem/CBC/UA Results: CBC shows PMN at 23,000, eosinophils at 93,000. Spec fPL is 2, normal is 0-3. Pathology review: "Overall, the microscopic evaluation agrees with the reported numerical data and the differential is verified. The red cell mass appears normal and the RBCs exhibit normal morphology. The platelet mass appears adequate and the platelets exhibit normal morphology. There is extreme leukocytosis consisting of extremely eosinophilia with a concurrent neutrophilia, monocytosis and basophilia also present. Eosinophilia is associated with hypersensitivity/allergic disorders including flea bite hypersensitivity, asthma, parasitism, idiopathic eosinophilic conditions (eosinophilic granuloma complex, eosinophilic enteritis or hypereosinophilic syndrome), mast cell degranulation caused by inflammation in the skin, respiratory or intestinal tracts, mast cell tumors, and eosinophilic leukemia. The eosinophils are morphologically normal and eosinophilic leukemia is considered less likely. A splenic mast cell tumor should be considered as a differential. An abdominal ultrasound with aspiration of the spleen and/or liver may be helpful in identifying the underlying cause of the eosinophilia. The concurrent neutrophilia and monocytosis suggests inflammation."

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 were noted. Aortic trifurcation was normal.

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 4.4 cm in length. The right kidney measured 4.4 cm in length.

Adrenal Glands

The left adrenal gland was mildly prominent in size yet without overt evidence of neoplastic criteria, measuring 0.7 cm in diameter.

The right adrenal gland was mildly prominent in size yet without overt evidence of neoplastic criteria, measuring 0.50 cm in diameter.

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 or benign parenchyma changes were not noted. The spleen measured 1.0 cm in width. No overt evidence of splenic neoplastic criteria.

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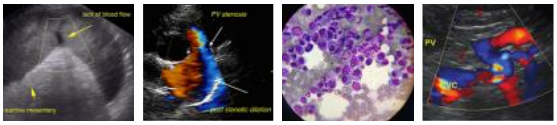

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Liver

The liver exhibited subjective mild enlargement. 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 congestion.

The gallbladder was non-distended in size with 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 measured 0.25 cm.

The intestinal walls demonstrated intact wall layers with diffusely thickened walls and intact yet altered 1:3 muscularis / mucosa ratio noted generally throughout the small intestine with secondary to variable muscularis layer hypertrophy with segmental areas of marked hypoechoic small intestinal mural hypertrophy, suggestive of emerging mural masses. Intestinal wall width ranged from 0.36 cm-0.68 cm.

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

Pancreas

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.

Free Abdomen

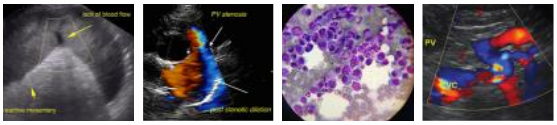
A large, midabdominal mesenteric to mesenteric root lymphadenopathy to lymphatic mass, which was not associated with a specific organ, specifically the gastrointestinal tract, was present. The mass exhibited a hypoechoic to heterogeneous echogenicity and primarily symmetrical margination. The mass measured approximately 6.0 cm x 4.7 cm. Regional periintestinal to perilymphatic reactive mesentery was present. No overt free fluid noted.

ULTRASONOGRAPHIC FINDINGS

- Diffuse enteropathy, exhibiting generalized to variable altered wall layering, segmental emerging small intestinal mural mass to masses
- Marked mid abdominal mesenteric to mesenteric root lymphadenopathy/lymphatic mass
- Associated perilymphatic to periintestinal reactive mesentery
- Probable concurrent mild chronic active pancreatitis
- Mild nonspecific hepatomegaly

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

General considerations for the small intestine may include inflammatory versus neoplastic infiltrative



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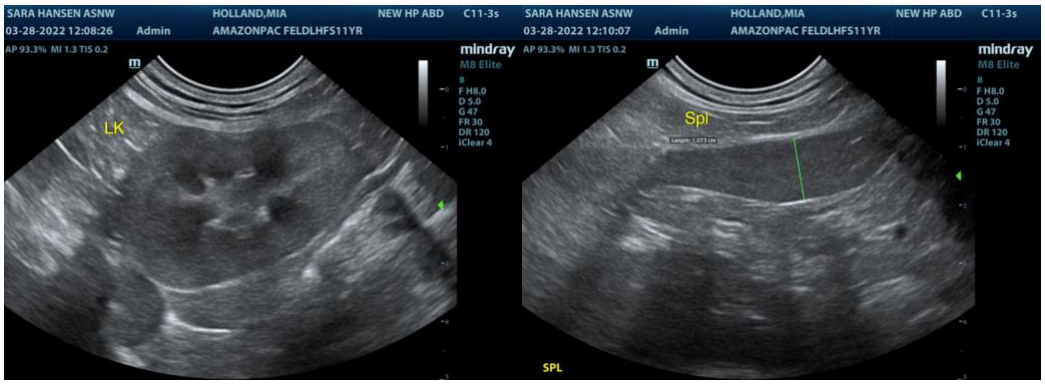
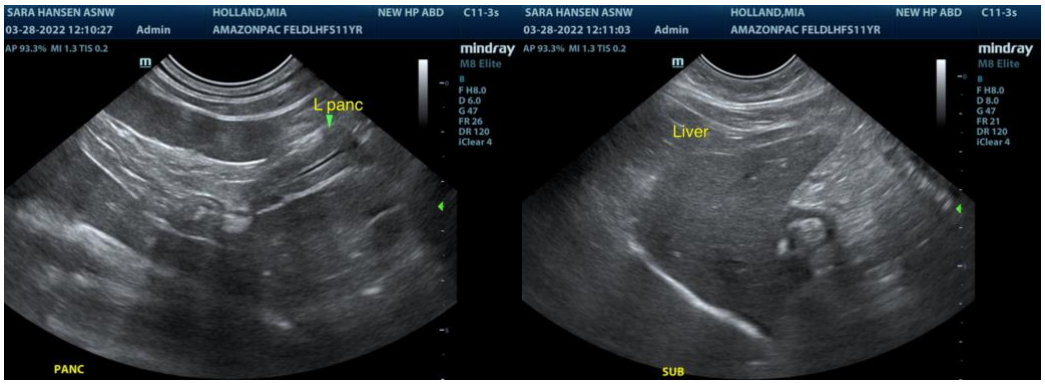
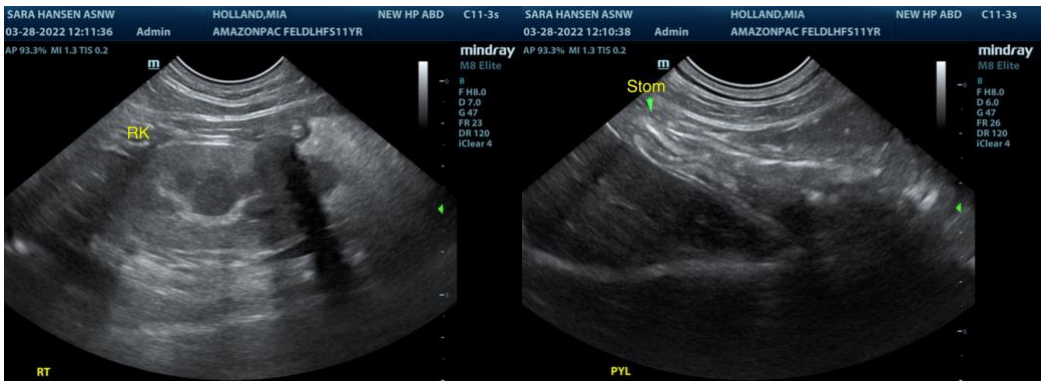
enteropathy. However, given the eosinophilia in this patient, along with marked mid abdominal mesenteric lymphadenopathy to lymphatic mass, neoplastic infiltrative enteropathy with round cells (which is lymphoma), mast cell neoplasia with concurrent neoplastic to metastatic mesenteric lymphadenopathy is considered most likely.

Assuming normal clotting status and with Benadryl pretreatment, ultrasound guided FNA of the marked lymphadenopathy to lymphatic mass +/- screening hepatosplenic FNA, using a 25-gauge needle is warranted for screening cytology and potential for oncology consult. Full thickness small intestinal and lymphatic biopsies maybe required for a definitive diagnosis, however, primary concern for diffuse round cell neoplasia is suspected in this case.







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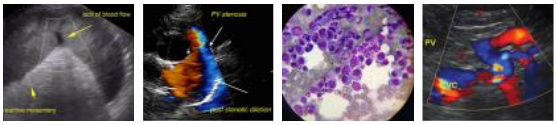

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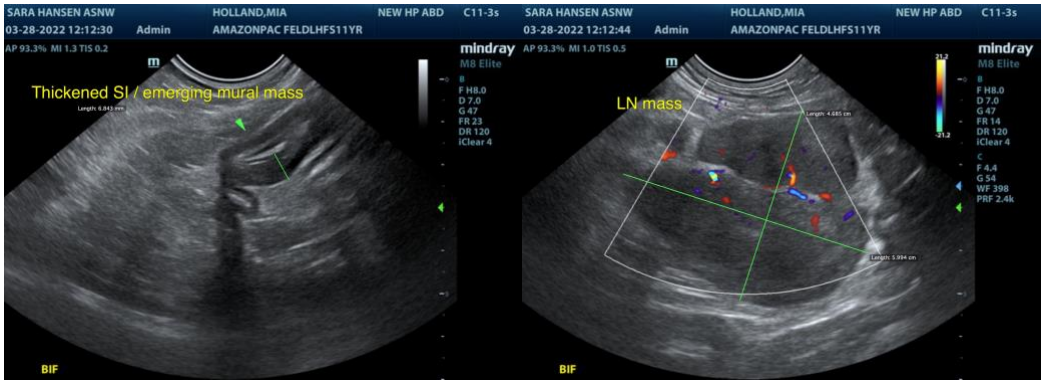

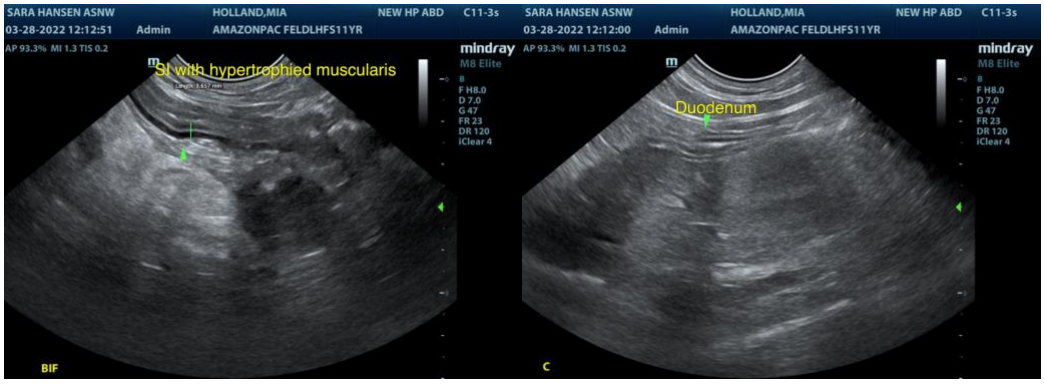

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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