



PATIENT

Snickers Pitt

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

13 years

WEIGHT

Unknown

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

VCA Salem AH

REFERRING VET

Dr. Hallden

INVOICE

13675

DATE

4/15/22

PRESENTING CLINICAL SIGNS

Anorexia x 4 days. Has vomited once a day most of the past 10 days. No diarrhea. Gradual weight loss in the past 6 months; has lost 3 pounds since a year ago. Thickened small bowel per palpation. Dental disease, otherwise unremarkable PE. Indoor only cat in multi-cat household originally obtained in Florida as an outdoor cat. Current Medications Transdermal mirtazapine, 250 mcg B-12 sc Primary Question/Differential to Be Answered in This Exam Primary differentials LSA vs IBD. Screening for cause of acute anorexia & vomiting and chronic weight loss.

Abnormal PE/Chem/CBC/UA Results: Marginal neutropenia (2304) and eosinophilia (1856) of tWBC 6400. Unremarkable chemistry, with tT4=2.4 ug/dL . FeLV negative on current panel. Panel sent via email. Previously tested negative for both FeLV and FIV in 2011.

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. Minor, non-dependent, 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 kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild to moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Pinpoint medullary mineral was present. No evidence of pelvic dilation was present. The left kidney measured 3.8 cm in length. The right kidney measured 4.3 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 0.21 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.30 cm width.

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 0.7 cm width at the level of the hilus.



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Liver/ Gallbladder

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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 normal in size yet subjectively divided into two compartments containing anechoic content with mild luminal debris. The proximal common bile duct was dilated and tortuous without overt post hepatic obstruction.

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Gastrointestinal

The stomach exhibited regionally thickened, mildly nonhomogeneous wall layering subjectively in the area of the mid-gastric body extending into the antrum and pylorus. Indiscernible wall layer detail was noted within the area of the regional gastric wall thickening. The stomach was primarily empty with minor retained anechoic fluid. Gastric wall width measured 0.7-0.8 cm.

The small intestine presented intact wall layering with segmental to generalized propensity for mildly prominent muscularis layer. No evidence of loss of intestinal wall layering or intestinal masses was noted. The jejunum wall width measured up to 0.29 cm. The ileocolic wall width measured 0.35 cm.

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

Pancreas

The pancreas was normal in size and contour with heterogeneous to mildly hypoechoic parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia. Mild pancreatic duct dilation was noted.

Free Abdomen

Multiple, mildly prominent to hypoechoic gastric and pancreaticoduodenal lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly margined. A normal width:length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. An example of lymph node size was 0.5 cm diameter. No free fluid was noted.

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ULTRASONOGRAPHIC FINDINGS

- Regionally thickened stomach exhibiting indistinct wall layering
- Enteropathy exhibiting intact yet mildly altered wall layering
- Intermittent mildly prominent to hypoechoic gastric and likely pancreaticoduodenal lymph nodes
- Potential concurrent low-grade chronic to chronic active pancreatitis
- Bilateral chronic renal changes



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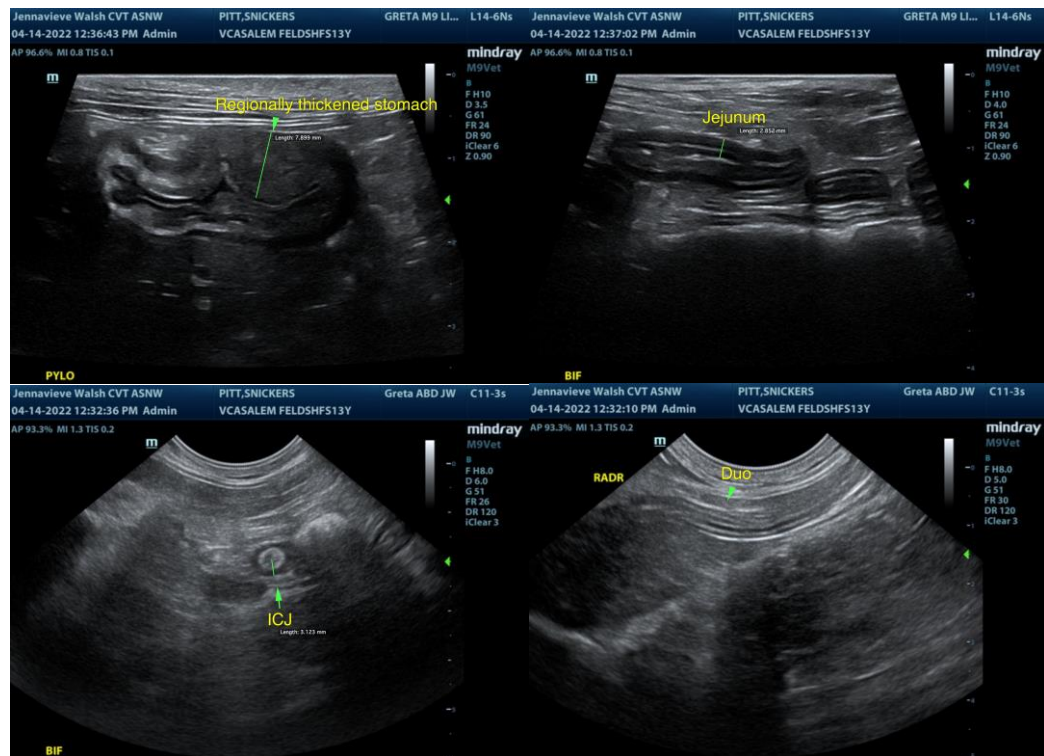
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the lack of diarrhea in this patient, the primary cause of the clinical signs including anorexia and vomiting may primarily be related to the stomach. Suspicion for concurrent Inflammatory enteropathy and potential low-grade to chronic pancreatitis is warranted. This presentation may indicate inflammatory gastroenteropathy, i.e., IBD or eosinophilic gastroenteritis, given the eosinophilia in this patient, although emerging infiltrative neoplasia such as lymphoma or other in light of regional indistinct gastric wall layer detail may be possible. Definitive diagnosis would require gastric and full-thickness intestinal biopsies for histopathology.

A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Empirical therapy for IBD / eosinophilic enteritis would be reasonable if biopsies are not elected or possible with sonographic monitoring of the GI tract for signs of progressive mural changes. A guarded prognosis is warranted.





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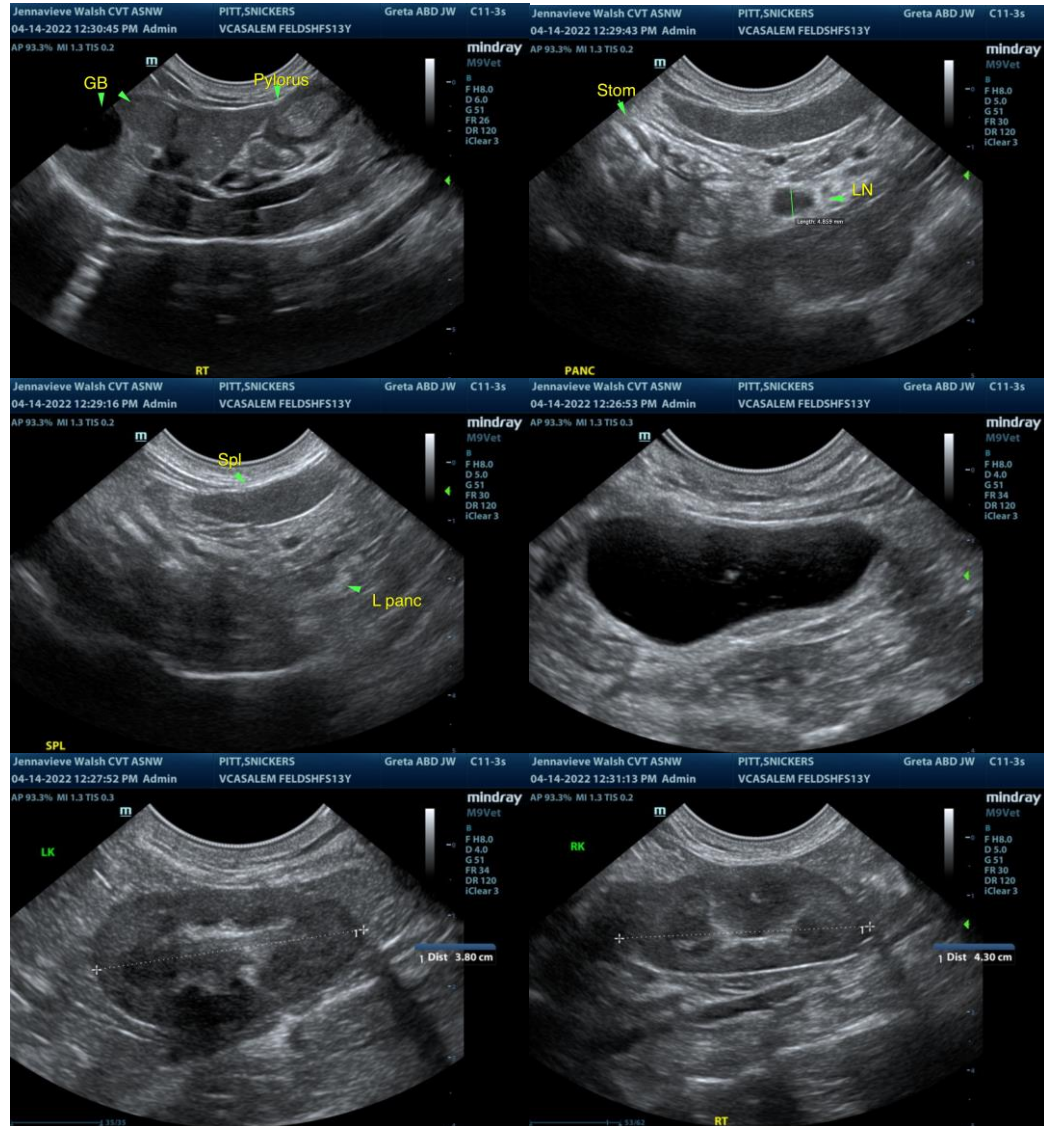
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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