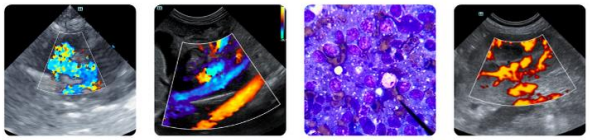


PATIENT

Saoirse Burkitt

SPECIES

Feline

BREED

DSH

SEX

SF

AGE

7 yrs

WEIGHT

2.5 kgs

INTERPRETED BY

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

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Main Line Animal Rescue

REFERRING VET

Alicia Royer, DVM

INVOICE

10759

DATE

4/2/26

PRESENTING CLINICAL SIGNS

History:

- AUS to further evaluate weight loss despite an increased appetite. BW noted anemia that is normocytic, normochromic, leukocytosis with a mild neutrophilia, monocytosis, lymphopenia. Hypoalbuminemia, hyperglobulinemia, hypercalcemia, hyponatremia. Concern for IBD vs lymphoma vs other neoplasia. Protein electrophoresis preformed as noted below.

Abnormal PE/Chem/CBC/UA Results: CBC: Hct 25, Hgb 7.8L, RBC 5.3L, plts 130 L, est adeq, WBC 21.2H, Neut 19,928H, mild toxic, lymph 424L, Mono848H Chem: TP 10.7H, Alb 1.8L, Glob 8.9H, A/G 0.2L, Ca 10.9H, Na 140L T4: 0.6L, FeLV/FIV: Negx2 UA: USG 1.061, Bili 1+, pro 3+, Bili 1+ Feline HaemotroPCR: Negx3 Protein electroph: polyclonal gammopathy -active immune response to antigenic stimuli-chronic inflam, infectious, immune-mediated, occult hw, FIP, ehrlichiosis. An incr in Beta & Gamma globs seen w/active hepatic/dz, neoplasia (LSA), supp. dermatopathies, nephrotic syndrome. Present-narrow monoclonal-like peak over a broad polyclonal base bridging B&G fractions. Also seen w/lymphoid malignancy w/concurrent antigenic stim. Magnitude of the monoclonal peak arising in the beta fraction -supportive of lymphoid/ plasma cell malig

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.

No evidence of pathology in the area of the aortic trifurcation.

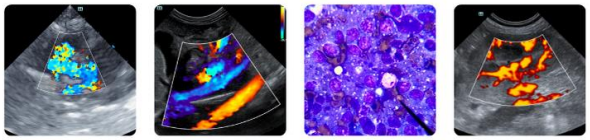
Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. 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 left kidney measured 3.3 cm in length. The right kidney measured 3.6 cm in length.

Adrenal Glands

The left and right adrenal glands were overtly normal in size, position, and shape. The left adrenal gland measured 0.25 cm width and the right adrenal gland measured 0.32 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 0.8 cm width at the level of the mid-spleen.



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Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mild / moderate nonuniform and hypoechoic to the spleen with a mild/ moderate coarse echotexture and subjective mild parenchymal remodeling. 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. Mild retained anechoic to echogenic fluid was present. There was no evidence of obstruction to pyloric outflow.

The intestinal walls demonstrated intact, borderline to mild thickened wall, exhibiting mild altered wall layer ratio owing to propensity for mildly thickened muscularis and submucosa layers. The small intestinal wall width measured 0.26 cm. The ileocolic wall was intact without overt pathology, measuring 0.31 cm wall width.

Normal visible colon wall layers were present with formed fecal matter in lumen.

Pancreas

The pancreas was mildly prominent in size with capsule asymmetry, exhibiting isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

Extensive hypoechoic to mixed echogenic mass was noted occupying the majority of the midabdomen. Surrounding hyperechoic omentum was noted. Scant effusion was present. The mass measured ~7.0 cm x 4.4 cm.

ULTRASONOGRAPHIC FINDINGS

- Extensive hypoechoic nonhomogeneous abdominal mass
- Enteropathy exhibiting intact mildly thickened wall
- Mild hypomotile stomach
- Chronic pancreatitis pattern with remodeling
- Bilateral nonspecific renal medullary rim sign

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Extensive lymphatic mass is favored at the mass was not definitively connected to the gastrointestinal tract. Nonobvious intestinal origin is thought less likely, yet evidence of diffuse concurrent intestinal disease is present with multicentric round cell neoplasia i.e., lymphoma or other, favored. Mild potential for FIP is possible yet thought less likely, given the patient's age.

Assuming normal clotting status, mass FNA cytology +/- C/S, a GI panel to include PLI/TLI/Cobalamin/Folate, and three-view chest radiographs are warranted.

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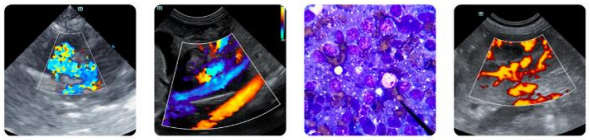

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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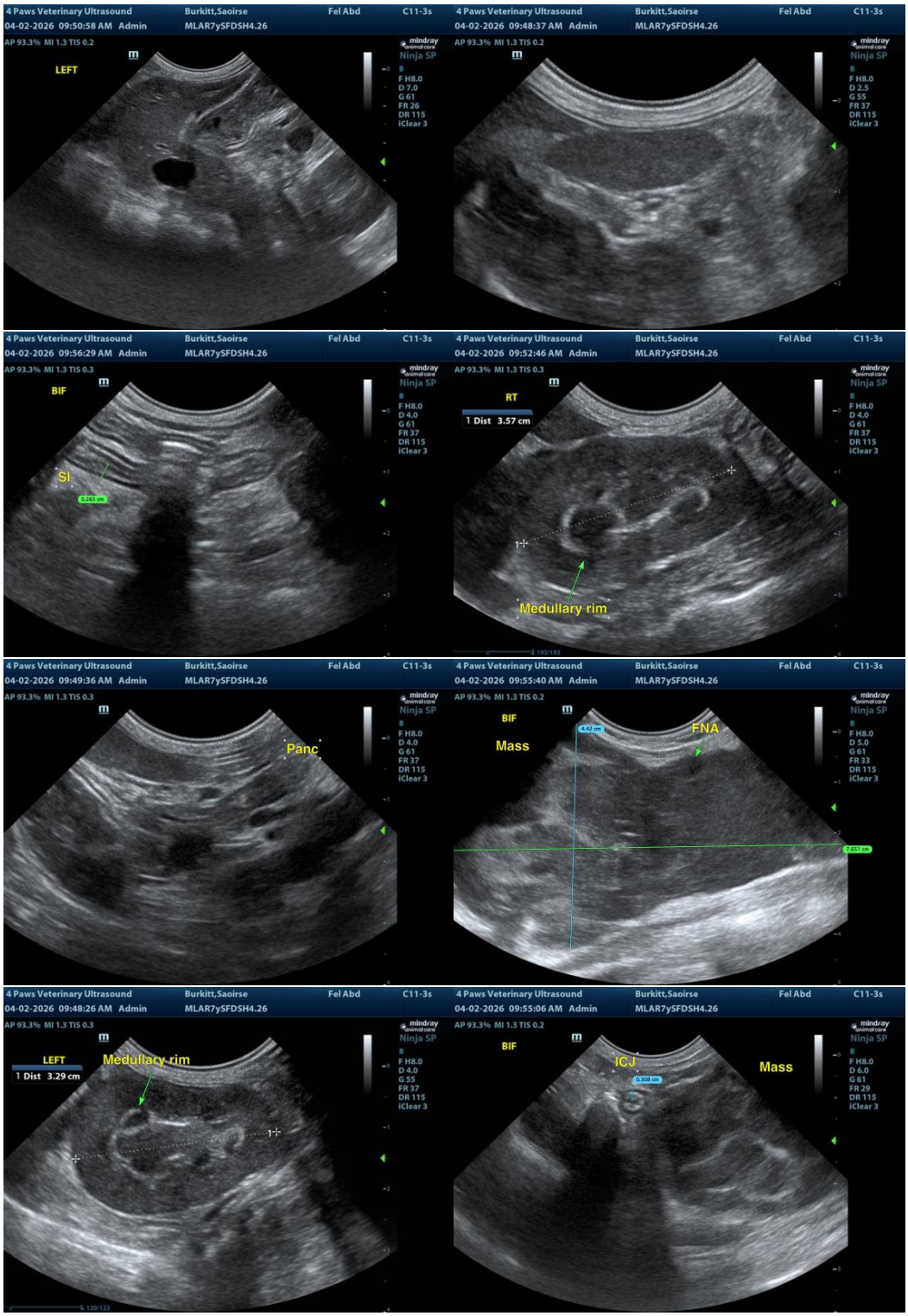

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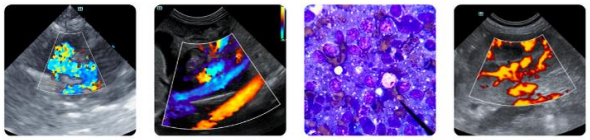

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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