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Clinical Sonography & Telecytology
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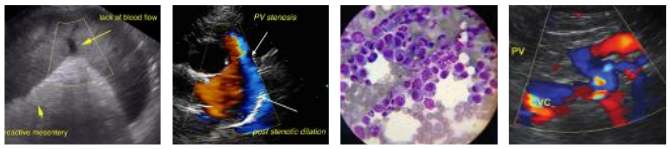

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1-800-838-4268 info@sonopath.com

PATIENT

Wampa Hershey

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

11 Years

WEIGHT

4.3 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Laura de Cordon

HOSPITAL NAME

Mason Dixon Animal Emergency Hospital

REFERRING VET

Dr. Laura de Cordon

INVOICE

37837

DATE

5/21/22

PRESENTING CLINICAL SIGNS

5/21/22 Bloodwork CBC: HCT:27.6 CHEM/LYTES: GLUC: 139 ALP:148 TBIL:2.3 PCV/TS:32/6.8 SNAP fPL: normal FIV/FeLK: negative for 3 Radiographs Thorax: no abnormalities seen. Normal hart silhouette . Abdomen: some food within the stomach. Fluid filled distended intestinal loops. Colon with large amount of stool. Enlarged spleen Ultrasound AUS: prominent spleen. Dilated fluid filled SI loops. Heterogeneous liver, some sludge within gall bladder. Other slide agglutination: suspect agglutination towards the edge of the sample on macro.
Abnormal PE/Chem/CBC/UA Results: 5/21/22 Bloodwork CBC: HCT:27.6 CHEM/LYTES: GLUC: 139 ALP:148 TBIL:2.3 PCV/TS:32/6.8 SNAP fPL: normal FIV/FeLK: negative for 3 Radiographs Thorax: no abnormalities seen. Normal hart silhouette . Abdomen: some food within the stomach. Fluid filled distended intestinal loops. Colon with large amount of stool. Enlarged spleen Ultrasound AUS: prominent spleen. Dilated fluid filled SI loops. Heterogeneous liver, some sludge within gall bladder. Other slide agglutination: suspect agglutination towards the edge of the sample on macro.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of – 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.

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 likely an idiopathic finding. The kidneys measured 4.2 cm each.

Adrenal Glands

The adrenal glands were not definitively visualized.

Spleen

The spleen exhibited mild generalized enlargement (1.0-1.1 cm in width at the level of the hilus) with areas of medial capsule asymmetry and finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Subtle splenic parenchyma heterogeneity noted with subjective minor decreased splenic echogenicity compared to the liver. No splenic masses noted. 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

The liver was mildly enlarged. 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. No evidence of hepatic masses. The gallbladder was non-distended in size with primarily anechoic luminal content. The cystic and common bile ducts were normal.

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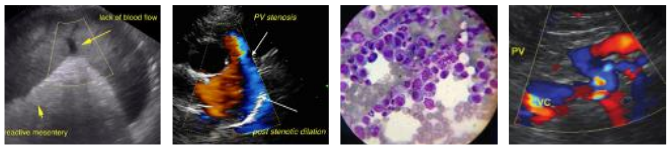

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Gastrointestinal

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 intestinal walls demonstrated intact wall layers with diffusely thickened walls and altered 1:3 muscularis / mucosa ratio primarily consisting of muscularis hypertrophy. Jejunum wall measured 0.36 cm. Ileocolic wall measured 0.40 cm.

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

Pancreas

The pancreas weas ill-visualized, yet the left pancreatic limb exhibited potential for mild hypoechoic parenchyma compared to adjacent omentum.

Free Abdomen

Focal enlarged mid abdominal mesenteric lymph nodes were present. Example measured 3.0 cm x 1.0 cm. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident.

Generalized mild reactive mesentery. Small pockets of scant peritoneal free fluid noted.

ULTRASONOGRAPHIC FINDINGS

- Bilateral non-specific renal medullary sign.
- Mild hepatosplenomegaly.
- Infiltrative enteropathy pattern – inflammatory (IBD/eosinophilic enteritis) versus neoplastic (lymphoma, mast cell neoplasia or other). Infiltrative enteropathy is possible.
- Associated intermittent mesenteric lymphadenopathy – hyperplasia, reactive lymphadenitis secondary to inflammatory bowel, early neoplastic lymphadenopathy possible.
- Possible concurrent low-grade pancreatitis.
- Scant peritoneal free fluid and mild generalized reactive mesentery.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming normal clotting status, hepatosplenic and, if accessible, lymphatic FNA for screening cytology warranted. Potential for multicentric round cell neoplasia, given the sonographic abnormalities, and if confirmed, hemolytic anemia, which at times may be associated with underlying neoplastic process, is warranted, yet not definitive. No reported gastrointestinal signs or weight loss in this patient, yet if these clinical signs are present, empirical therapy for IBD +/- low-grade pancreatitis would be reasonable. Guarded prognosis pending sampling, which is considered essential for further assessment.

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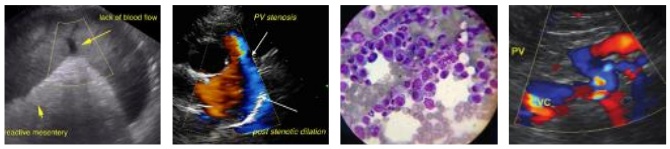

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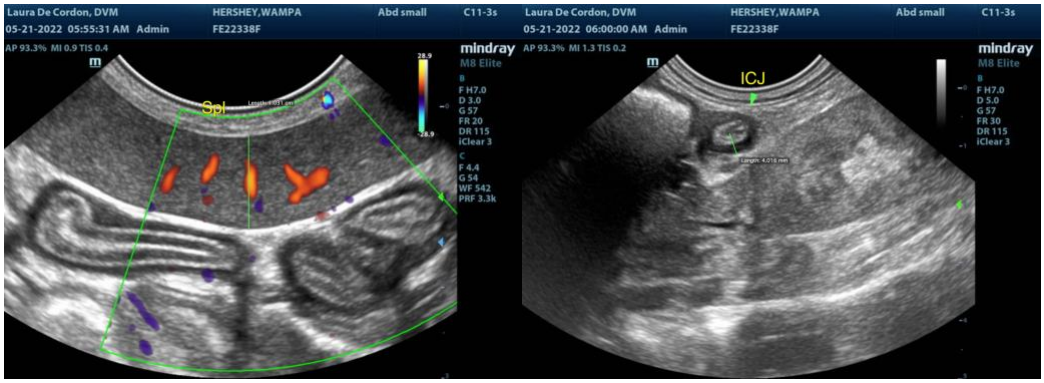

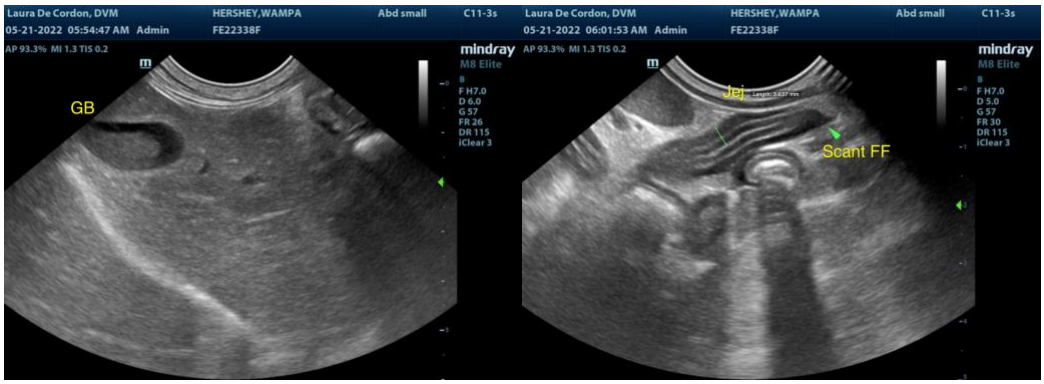

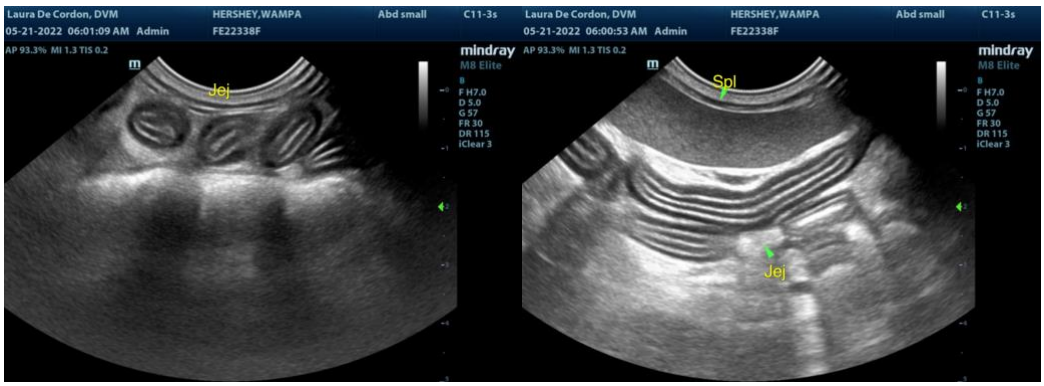

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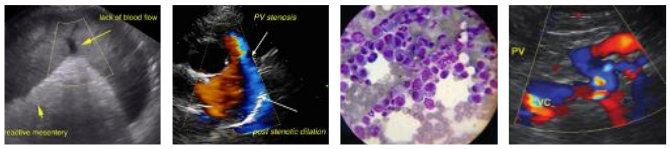

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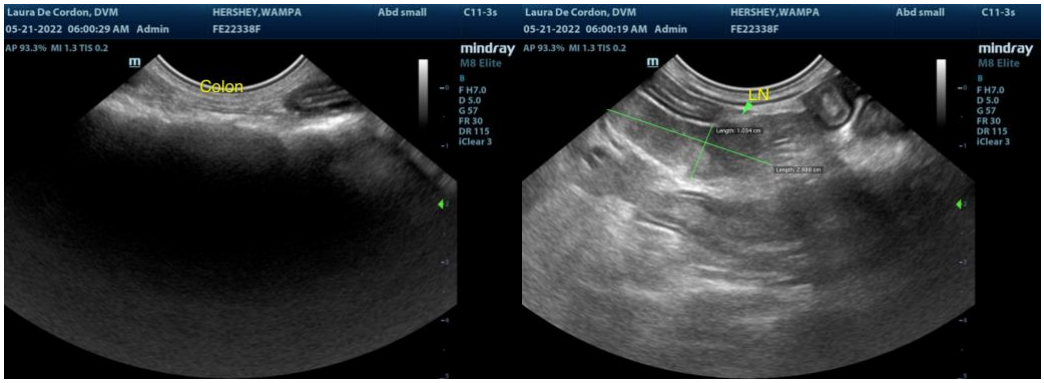

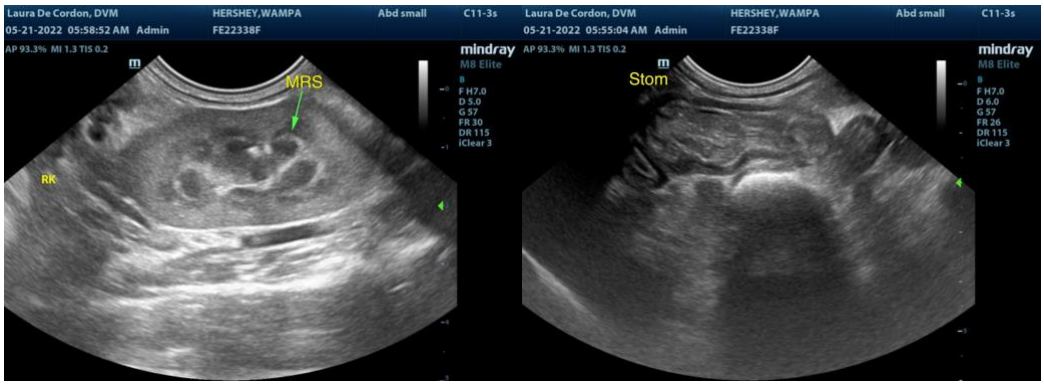

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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