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Clinical Sonography & Telecytology
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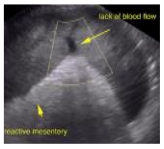

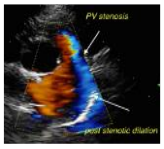

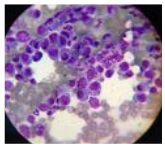
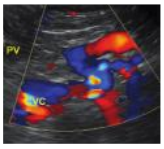

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1-800-838-4268 info@sonopath.com

PATIENT
Rainie Garrison

SPECIES
Feline

BREED
DSH

SEX
FS

AGE
13 years

WEIGHT
8.94

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

IMAGING PERFORMED BY
Dr. Hannah Fearing

HOSPITAL NAME
Lanier Animal Hospital

REFERRING VET
Dr. Hannah Fearing

INVOICE
14110

DATE
6/16/22

PRESENTING CLINICAL SIGNS

long hx (years) of intermittent vomiting, worsening in the last few months; also having soft stools consistently for the last few months; small, poorly-defined abdominal mass (also present for at least a year) - biopsy inconclusive but suspicious of reactive lymphoid tissue vs. FIP (unlikely given course of disease) vs low-grade lymphoma; weight holding steady since 12/2021 at ideal BCS and current PE unremarkable except abdominal mass current medications: prednisolone 5 mg PO EOD and chlorambucil 2 mg PO Monday, Wednesday, and Friday
Abnormal PE/Chem/CBC/UA Results: 6/15/2022: CBC: leukopenia (WBC = 3.1k) characterized by neutropenia (2.56k) and lymphopenia (0.32k) Chem/UA/T4: 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. Minor, 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 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 3.4 cm in length. The right kidney measured 3.7 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 0.44 cm width. 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 0.58 cm width at the level of the hilus.

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.

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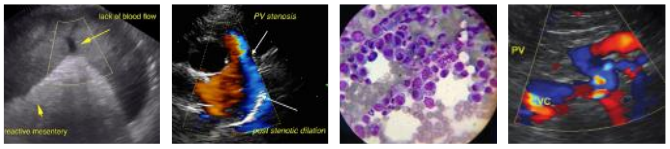

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Gastrointestinal

The gastric walls were sonographically normal exhibiting intact wall layering. The lumen of the stomach contained mild nonshadowing ingesta/chyme most consistent with post prandial presentation without signs of mechanical pyloric outflow obstruction. The pylorus wall width measured 0.22 cm.

The small intestine presented intact yet mild segmentally prominent wall layering with no overt evidence of loss of intestinal wall layering. The small intestinal wall width measured 0.26 cm.

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

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

Midabdominal mildly nonhomogeneous mesenteric lymphadenopathy was present with a lymph node measuring 2.8 cm x 1.4 cm exhibiting subjective borderline abnormal width: length ratio, (approximately 0.5). Subtle evidence of perilymphatic reactive mesentery was noted. No evidence of peritoneal free fluid was evident.

ULTRASONOGRAPHIC FINDINGS

- Intact segmentally prominent small intestinal walls
- Mid abdominal mesenteric lymphadenopathy with minor perilymphatic reactive mesentery
- Mild chronic renal changes
- Sonographically unremarkable stomach with mild nonshadowing gastric ingesta / chyme

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Sonographically, the small intestine exhibited subtle mural changes without evidence of significant mural pathology i.e., loss of intestinal wall layering, which may suggest chronic infiltrative enteropathy (inflammatory vs. neoplastic infiltrative enteropathy,) with concurrent midabdominal lymphoid hyperplasia, reactive lymphadenitis, or static neoplastic lymphadenopathy. The current chemotherapy may potentially be suppressing intestinal mural changes and lymphadenopathy. No other overt sonographic abnormalities as a contributing factor to the patient's vomiting were noted.

The presence of gastric ingesta/chyme may coincide with recent meal ingestion, although if documented NPO, given the vomiting, some degree of metabolic gastric stasis cannot be excluded. Intestinal and lymphatic biopsies, although previously Inconclusive, would be required for further assessment.

Continued medical therapy for presumed infiltrative enteropathy with potential hydrolyzed diet trial if not current done, with as-needed gastrointestinal support would be reasonable. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended.

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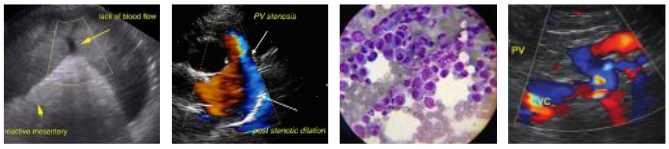

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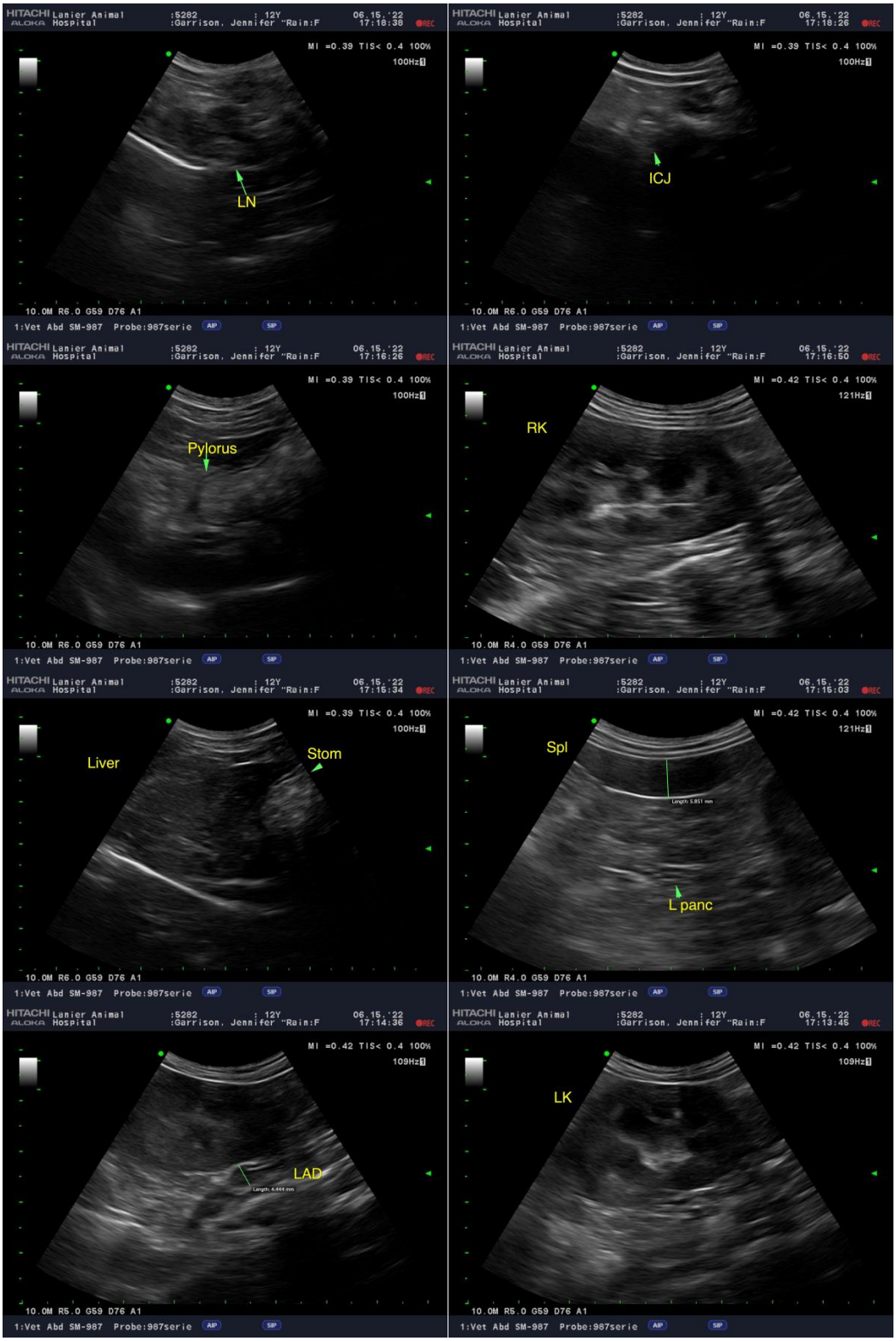

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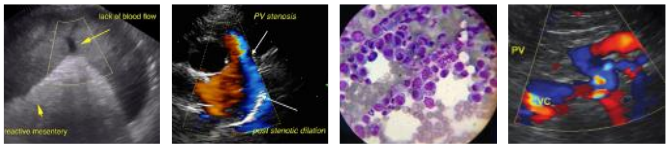

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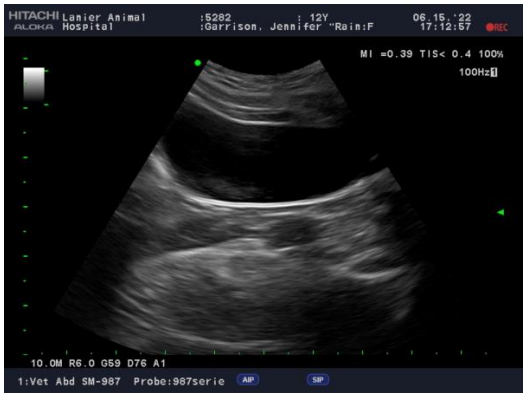

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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