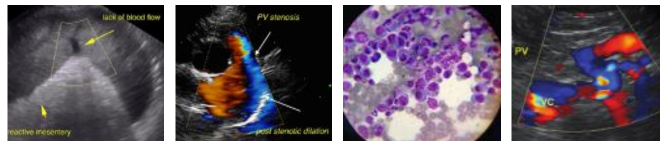


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Gizzy DeYoung

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

8 years

WEIGHT

7.25 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY
Jasmine Palacios

HOSPITAL NAME

Rivers Edge Pet Medical Center

REFERRING VET

Dr. David Gray

INVOICE

10858ag

DATE

06/18/2022

PRESENTING CLINICAL SIGNS

History: Vomiting for 2 weeks. P vomiting after eating, darker color with hairballs in it. Not interested in food since last night. No diarrhea.

Abnormal PE/Chem/CBC/UA Results: See attached bloodwork: Anemia, low Alb See attached rads: mass effect cranial abd

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 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. The left kidney measured 3.6 cm in length. The right kidney measured 4.1 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left and right adrenal gland were not definitively visualized owing to regional peri adrenal increased omental artifact.

Spleen

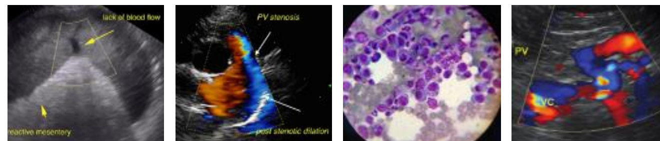
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted. The spleen measured 0.6 cm in width at the level of the hilus.

Liver

The liver was subjectively normal in size, structure, and contour. Subjective mild uniform decreased hepatic parenchyma echogenicity with a mild coarse echotexture was observed. 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

Regional moderate to severe gastric wall thickening and loss of gastric wall layer detail was present. The thickened gastric walls exhibited decreased echogenicity and an asymmetrical luminal surface. Moderate retained anechoic fluid was present in the gastric lumen without evidence of foreign material. Potential for small amounts of foreign material given the previous vomitus containing hairball is possible. Gastric wall width measured 1.7 cm. The pylorus wall measured 1.4 cm in width.



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The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. A focal area of small intestinal mural muscularis hypertrophy was present in a cranial abdominal intestinal segment caudal to the stomach with wall width measuring up to 0.75 cm.

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

Pancreas

The visualized pancreas exhibited normal size and contour with potential for subtle hypoechoic parenchyma yet no obvious evidence of significant pancreatic pathology was observed.

Free Abdomen

Regional nonuniform peri gastric omentum exhibiting ill-defined nodular hypoechoic changes along with concurrent intermittent hypoechoic to swollen cranial mesenteric lymphadenopathy was present. An example of a cranial mesenteric lymph node measured 1.3 cm x 1.1 cm.

Mild volume peritoneal free fluid was present.

ULTRASONOGRAPHIC FINDINGS

- Moderate to severe gastric wall thickening exhibiting decreased mural echogenicity, loss of discernable wall layering and concurrent gastric paralytic ileus
- Regional peri gastric nodular mesentery and concurrent swollen cranial mesenteric lymphadenopathy
- Concurrent emerging small intestinal mural mass
- Mild volume peritoneal free fluid

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although sampling is required for further assessment the gastric presentation with a similar appearing small intestinal mural mass is consistent with neoplastic criteria with primary concern for multicentric lymphoma. High concern for regional peri gastric omental seeding i.e. lymphomatosis. Non neoplastic etiologies such as severe inflammatory disease are possible yet thought less likely. Dry form FIP is considered a less likely differential diagnosis. Assuming normal clotting status an ultrasound guided FNA of the thickened gastric wall +/- accessible enlarged cranial mesenteric lymph node is warranted for screening cytology and potential for oncology consult with possible immediate chemotherapeutic intervention pending cytology. This case does not appear to be surgical.

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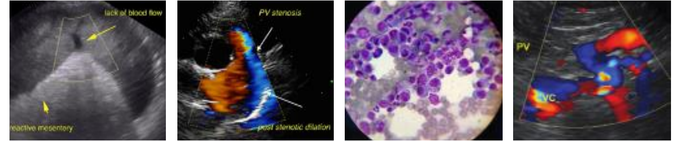

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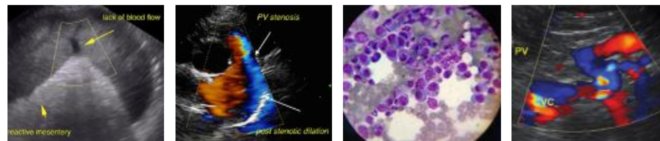

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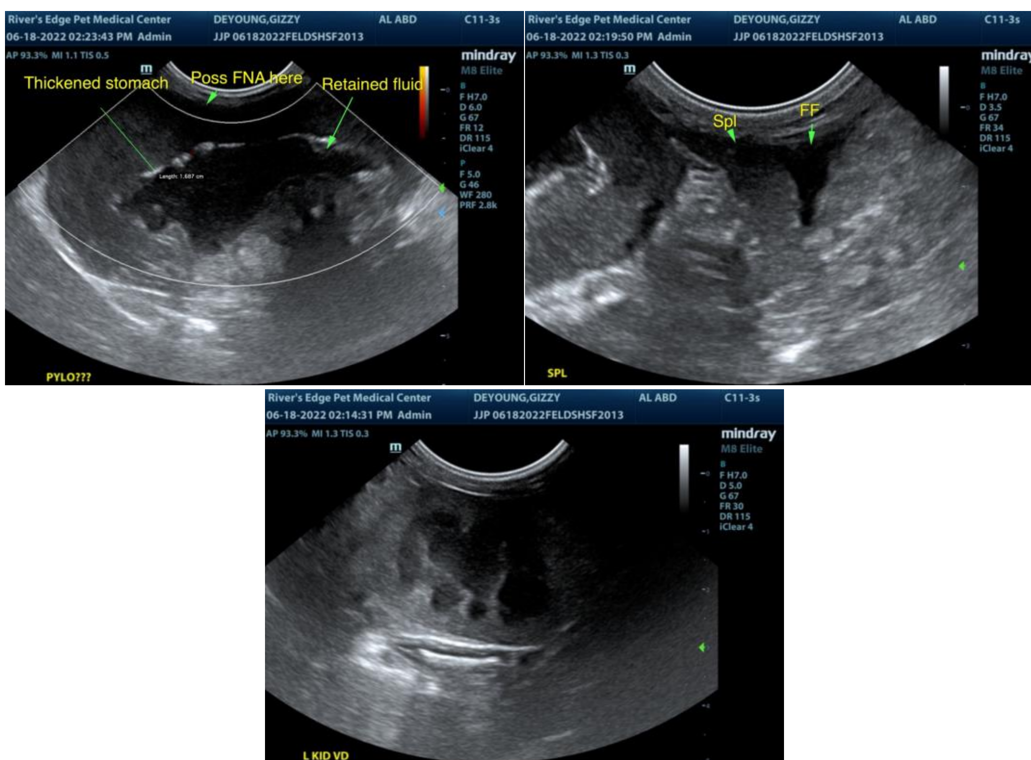

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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