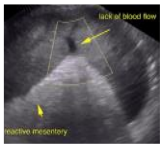

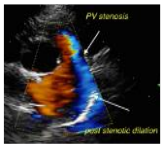

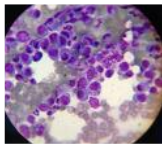
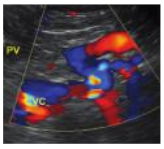

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PATIENT
Oscar Prange-Morgan

SPECIES
Feline

BREED
DSH

SEX
MN

AGE
11 years

WEIGHT
6.77 lbs.

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

IMAGING PERFORMED BY
A. Murphy CVT

HOSPITAL NAME
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REFERRING VET
Kate Self, DVM

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14147

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6/28/22

PRESENTING CLINICAL SIGNS

Presented to rDVM on 6/21/22 for decreased appetite and diarrhea of 2 weeks duration. Environmental stressors occurred in home as well as change of canned food diet - consistent dry kibble fed but uninterested. Client suspects pet has not been vomiting but cannot confirm due to presence of second cat in the home. Other cat unaffected with diet or diarrhea. No concerns with urination. Rx metronidazole 15mg/kg BID and a/d diet. Pet continued to decline and presented to emergency clinic for hospitalization. UA performed at hospital showed adequate concentration and negative for crystals/bacteria. Bloodwork panel drawn for submission. Rx mirtazepine after IV fluids, IV unasyn, cerenia, and famotidine. Discharged 6/23/22.
Abnormal PE/Chem/CBC/UA Results: Enlarged mesenteric lymph nodes on abdominal palpation. Dehydrated and slightly underweight. Tortuous retinal vessels appreciated with delayed PLR-OU. Ravenous appetite when offered a/d at exam. Elevated SDMA, chronic inflammatory leukogram, mildly decreased albumin, total T4 within normal limits.

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. Dependent to non-dependent, mildly hyperechoic sediment was present which may Indicate suspected crystalline debris, cellular debris / protein or mucus. 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 renal size with asymmetrical margination were present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomedullary distinction was also present. Left kidney pinpoint medullary mineral was noted. No evidence of pyelectasia was noted in either kidney. The renal medullary volume was subjectively reduced. The left kidney measured 3.5 cm in length. The right kidney measured 3.6 cm in length.

Adrenal Glands

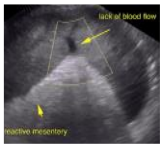
No overt pathology was noted in the area of the left or right adrenal glands.

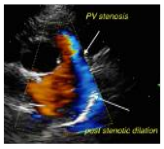
Spleen

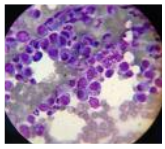
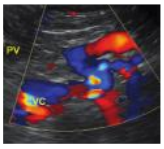
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute 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/ Gallbladder

The liver exhibited subjective mild enlargement with normal structure and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and





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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. The lumen of the stomach was empty with no signs of ileus, obstruction, or foreign material. The pylorus wall width measured 0.25 cm.

The visualized segments of definitive small intestine exhibited intact wall layering and maintained a 1:3 muscularis/mucosa ratio to the level of the ileocolic junction. No evidence of ileocolic masses was noted. The duodenum wall width measured 0.22 cm. The jejunum wall width measured 0.2 cm. The ileocolic wall width measured 0.26 cm.

The proximal colon exhibited intact yet mildly prominent wall layering containing semi-formed feces. The proximal colon wall width measured 0.25 cm.

Pancreas

The left pancreatic limb was normal In size and contour with subtle hypoechoic parenchyma compared to adjacent omentum.

Free Abdomen

Mid to cranial abdominal intestinal mural mass noted immediately caudal to the stomach and appearing to extend caudally within the left abdomen exhibiting moderate hypoechoic mural hypertrophy and loss of discernable wall layering potentially measuring 5.0-6.0 cm in length with wall width measuring 0.63 cm was present. Associated metabolic to paralytic ileus was noted. Minor peri intestinal reactive mesentery along with multiple mildly prominent uniform hypoechoic mesenteric lymph nodes were present. An example of a mesenteric lymph node measured 0.75 cm width. No evidence of concurrent peritoneal free fluid was noted.

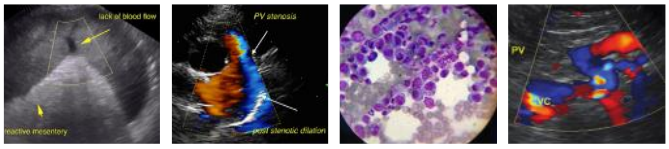
ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Intestinal mural mass - most likely transverse to descending colon mural mass given location and presence of diarrhea
- Associated peri intestinal reactive mesentery and multifocal mesenteric lymphadenopathy
- Possible concurrent low-grade pancreatitis
- Subjective mild nonspecific hepatomegaly

Secondary Findings

- Moderate chronic renal changes
- Mild urinary bladder sediment



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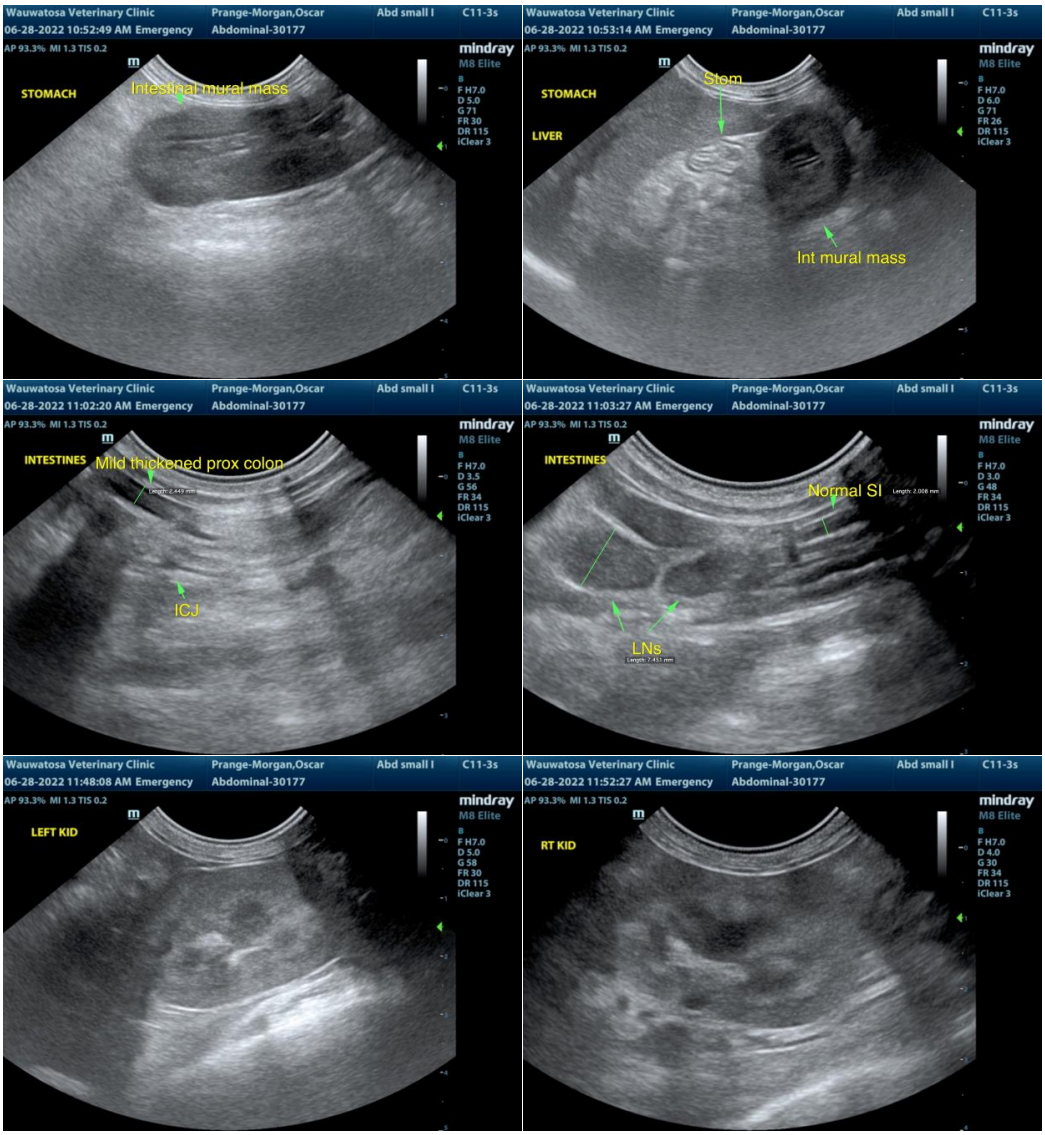
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming normal clotting status, ultrasound-guided FNA of the intestinal mural mass wall for screening cytology and potential further clarification could be considered. General etiologies may include severe inflammatory disease, and granulomatous disease (dry form FIP), with favored neoplastic criteria i.e., lymphoma or other. Biopsies are likely required for a definitive diagnosis, yet given suspected transverse and descending colon involvement, complete resection of the mass is suspected to be precluded. Potential for associated mesenteric hyperplasia, reactive lymphadenitis, or early neoplastic lymphadenopathy possible.

Three view chest radiographs are recommended. Assuming normal clotting status, screening hepatic FNA using a 25-gauge needle is warranted primarily to assess for or rule out potential for multicentric neoplasia.



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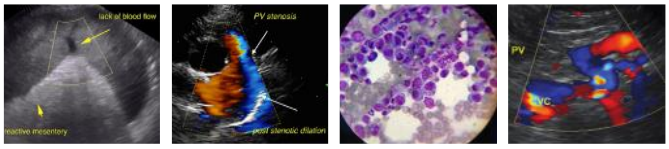

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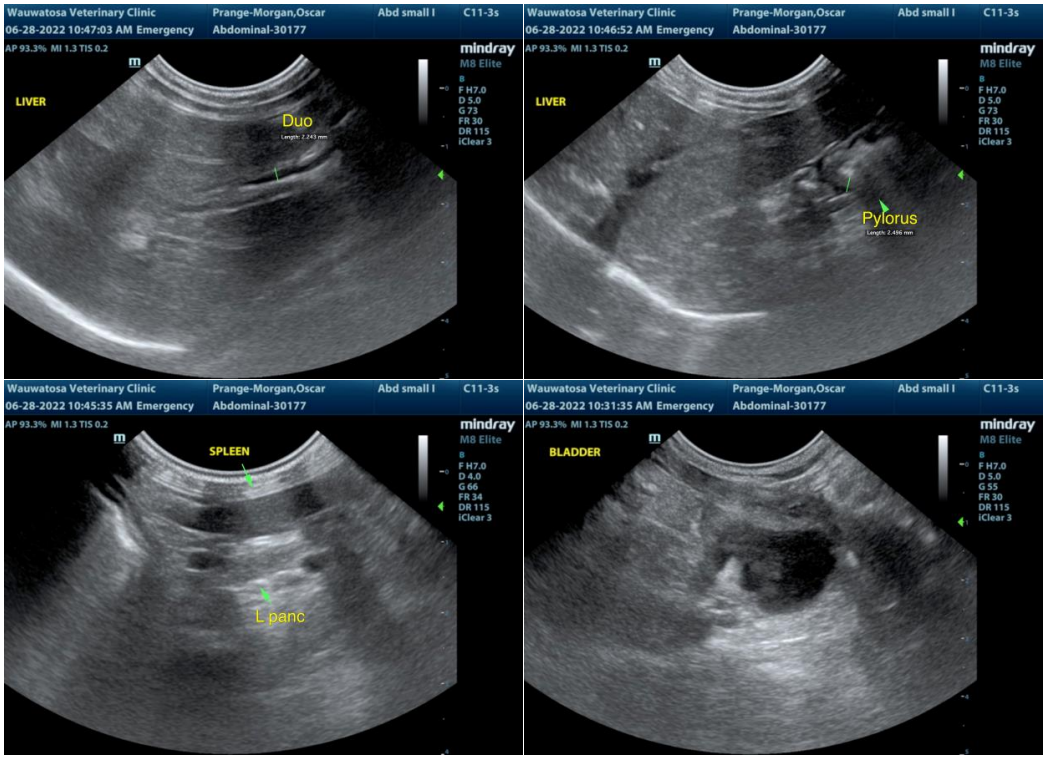

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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info@SonoPath.com