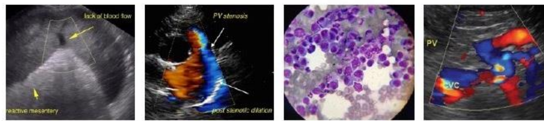


PATIENT

Annie Dinh

SPECIES

Feline

BREED

Tonkinese

SEX

FS

AGE

6 yrs

WEIGHT

4.3 kg

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP

IMAGING PERFORMED BY

Crystal HIll

HOSPITAL NAME

Main Street AH

REFERRING VET

Dr. Brochu

INVOICE

14306

DATE

7/19/22

PRESENTING CLINICAL SIGNS

Chronic vomiting nearly 1 year duration with mild improvement on RC hypo HP food but still vomiting every 3 days. Further improvement during prednisolone trial last month when at dose nearly 1mg/kg PO SID. Now fully off steroids - vomiting multiple times a day - often just bile - weight loss - 23% of body weight since first seen at MSAH early April 2022. Omeprazole 5mg PO BID - last dose will be given day of exam. Cause of vomiting - neoplasia, poor gi motility, functional obstruction? Best medical tx to stop chronic vomiting for this patient O previously had cat with GI lymphoma so very concerned

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. Mild, nondependent, particulate sediment was present without evidence of calculus formation. The sediment may indicate mild cellular or crystalline debris or potential 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 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 pyelectasia. The left kidney measured 4.0 cm in length. The right kidney measured 4.0 cm in length.

Adrenal Glands

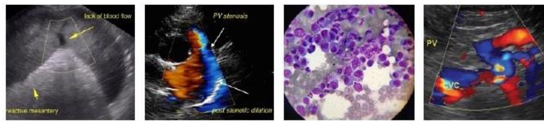
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.44 cm width. No overt pathology was noted In the area of the right adrenal gland.

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 0.70 cm width at the level of the hilus. No evidence of splenic neoplastic criteria was noted.

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. No evidence of hepatic neoplastic criteria was



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noted. 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 exhibited regional mild yet variable wall thickening exhibiting decreased wall echogenicity and indistinct to loss of discernable wall layer detail in the areas of thickening, primarily in the area of the gastric body extending into the area of the antrum and pylorus. The gastric body wall width measured 0.66 cm. The pylorus wall width measured 0.65 cm width. The stomach contained a mild amount of retained, nonshadowing Ingesta / chyme and mild luminal gas.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction, or foreign material. The duodenum wall measured 0.23 cm width. The jejunum wall measured 0.22 cm width. The ileocolic wall measured 0.30 cm width.

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

Pancreas

The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia.

Free Abdomen

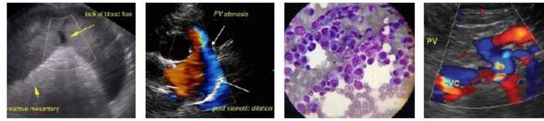
Subtle evidence of regional perigastric reactive mesentery was noted along with probable mild yet variably enlarged nonhomogeneous to mildly hypoechoic gastric lymph nodes. An example of a probable gastric lymph node measured 0.88 cm in diameter. No free fluid was present.

ULTRASONOGRAPHIC FINDINGS

- Reginal mild to variably thickened stomach with mild retained ingesta / chyme
- Probable associated regional gastric lymphadenopathy
- Suspect mild concurrent pancreatitis
- Sonographically unremarkable small bowel

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The cause of the patient's chronic vomiting appears to be primarily associated with gastric mural thickening / pathology with potential contribution owing to low-grade to mild pancreatitis. Primary considerations for the gastric presentation may Include chronic gastritis or emerging infiltrative neoplastic gastric disease, both of which may present in a similar sonographic manner. Concern for infiltrative neoplastic process potentially suppressed by recent Prednisolone therapy may be of primary concern, although the chronicity of vomiting in this patient may point to a chronic Inflammatory or nonneoplastic process.



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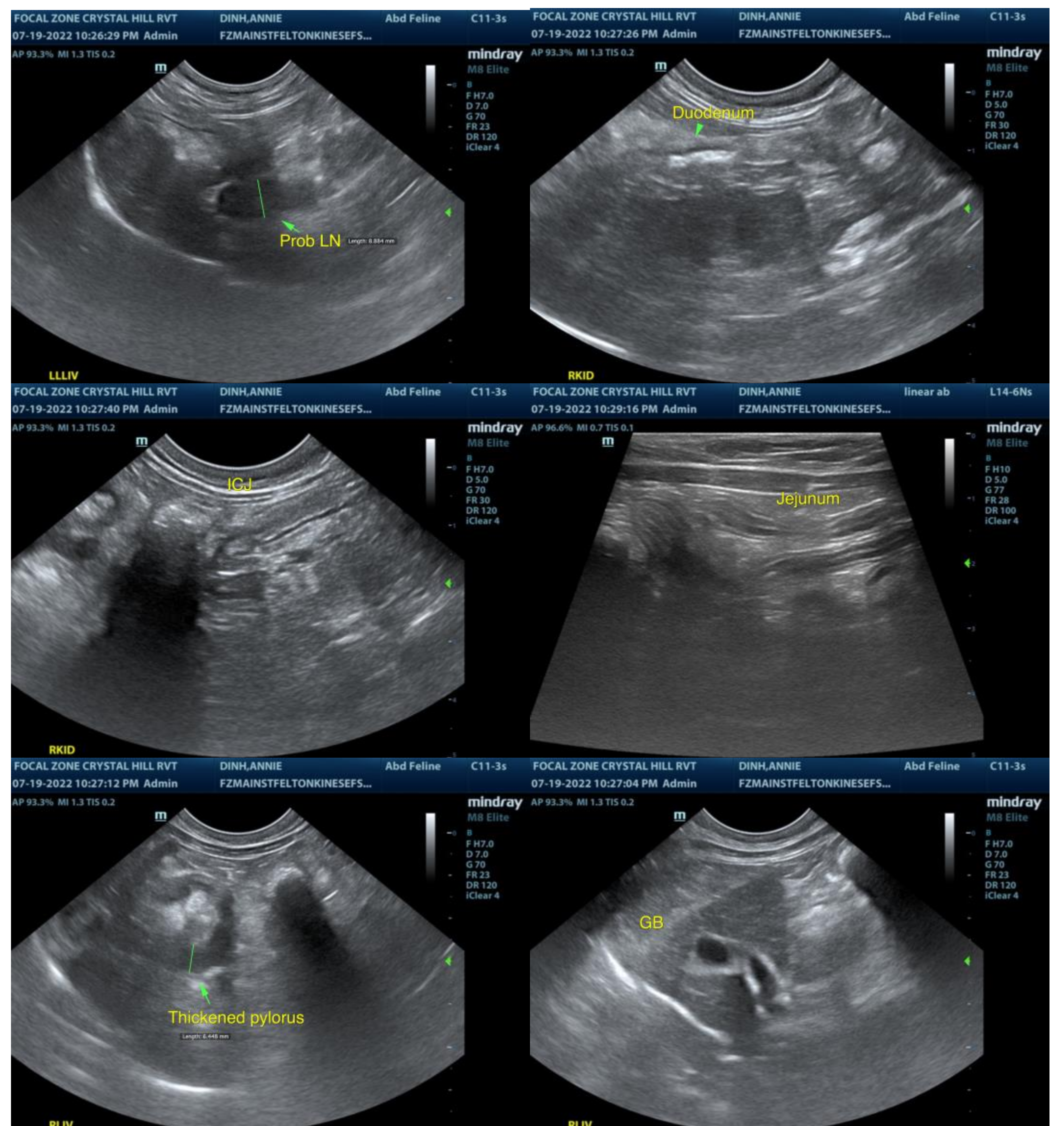
The associated probable gastric lymphadenopathy may indicate hyperplasia, reactive lymphadenitis secondary to chronic gastritis, or early neoplastic lymphadenopathy.
Spec fPL could be considered. Gastric sampling i.e., endoscopy or ideally laparotomy with gastric and lymphatic biopsies required for definitive diagnosis and recommended given the young age of the patient for definitive diagnosis, which may guide medical therapy.

Empirically, continued therapy for gastritis which may include gastroprotectants, empirical coverage for helicobacter, and as-needed antiemetics with sonographic monitoring of the stomach for evidence of progressive wall thickening and/or regional lymphadenopathy would be a more conservative approach. A guarded prognosis Is warranted. No overt sonographic evidence of concurrent small intestinal involvement / disease was present.



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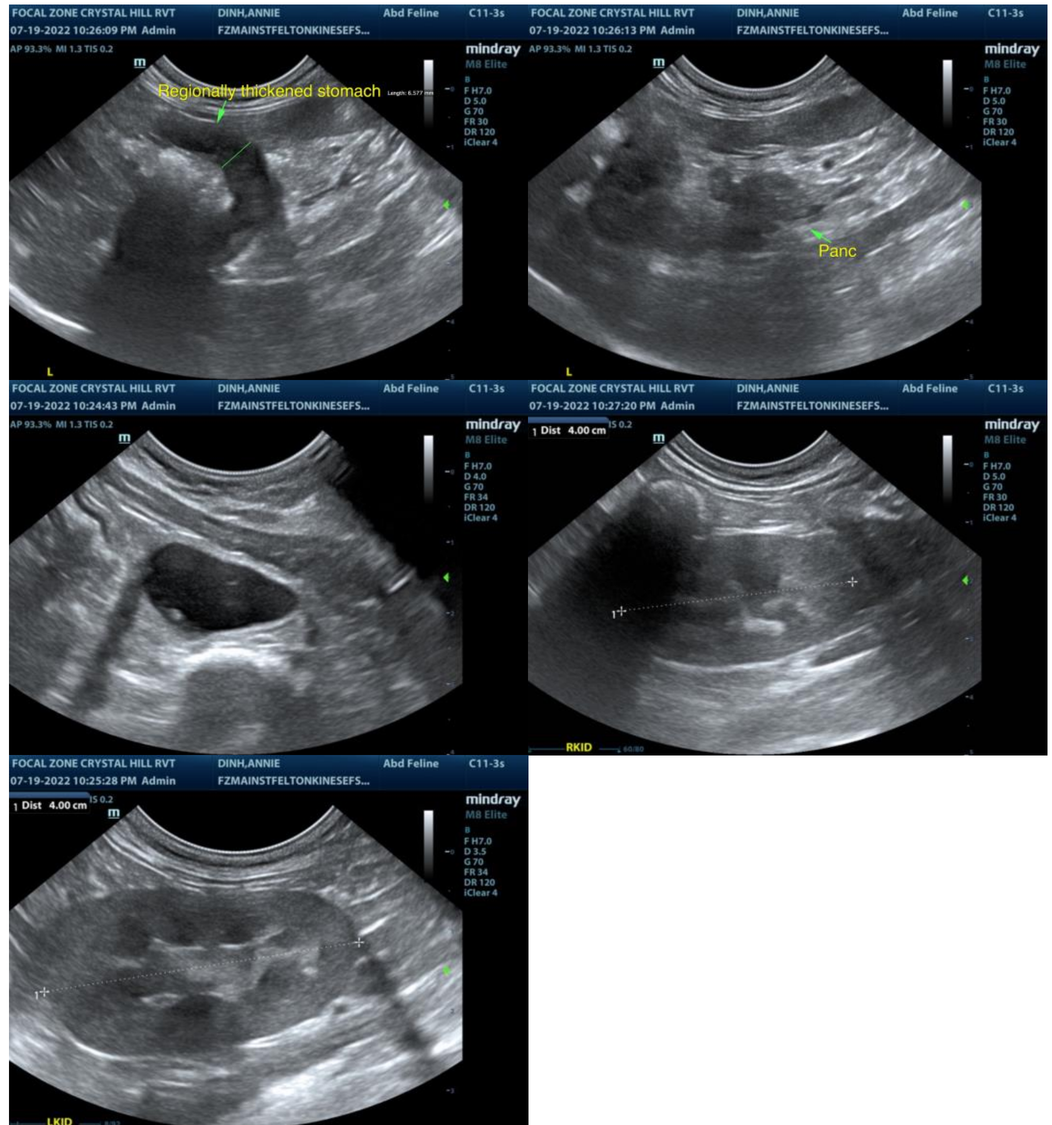

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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