



PATIENT

Goldie Correa

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

14 years

WEIGHT

8 lbs.

PRESENTING CLINICAL SIGNS

Hx of chronic diarrhea, 2/22/21 AUS generalized intraabdominal lymphadenopathy, with conglomerates of nodules of up to 5 cm, Rx prednisolone, unresponsive diarrhea to metronidazole and prednisolone 6mg SID. loss weight.

Abnormal PE/Chem/CBC/UA Results: Weight loss, muscle waste, mid abdomen mass, 5% dehydrated, DDZ gr 2-3 BCS 5/9, fleas infestation. BW: 02/20/22 CHEM: WNL CBC; RBC: 4.5 (L) 5.92-9.93 HEMOGLOBIN: 6.7 (L) 9.3-15.9 HCT: 24 (L) 29-48% PLATELET: 529 (H) 200-500 NEUTROPHILS: 12168 (H) 2500-8500

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. 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 was noted.

The area of the aortic trifurcation was free of pathology.

Normal size was noted 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 moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Several to multiple cortical infarcts resulting in areas of asymmetrical renal margination and hyperechoic cortical parenchyma were present in both kidneys. No evidence of pelvic dilation was present. The left kidney measured 4.4 cm in length. The right kidney measured 4.3 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 0.45 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.41 cm width.

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. Potential mild volume contraction was noted in the spleen. The spleen measured 0.56 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.

INTERPRETED BY

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

IMAGING PERFORMED BY

Jose

HOSPITAL NAME

Animal Clinic of
Queens

REFERRING VET

Dr. Mucera

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7/20/22



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Gastrointestinal

Goldie Correa

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 gastric body wall width measured 0.26 cm.

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The small intestine exhibited intact yet generalized thickened wall layering owing to propensity for thickened muscularis and mucosa. The jejunum wall measured 0.36 cm width. The ileocolic wall measured 0.41 cm width.

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The colon walls presented intact yet prominent wall layering with mild thickened to echogenic submucosa. Nonformed fecal matter, consistent with diarrhea, was present in the colon with lumen dilation.

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Pancreas

AGE

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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.

WEIGHT

8 lbs.

Free Abdomen

Ill-defined colic lymphadenopathy with potential for ill-defined mass in the area of the ileocolic junction potentially owing to marked to conglomerated lymphadenopathy, while the possibility of regional small intestine i.e., ileal or ileocolic wall proliferation is possible. The colic lymphadenopathy vs. ill-defined mass measured approximately 3.0-4.0 cm in diameter. Subtle generalized increased omental echogenicity was noted. No evidence of peritoneal free fluid was present.

INTERPRETED BY

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(Canine and Feline)

ULTRASONOGRAPHIC FINDINGS

IMAGING PERFORMED BY

Jose

- Infiltrative enteropathy, concurrent colitis pattern
- Moderate colic lymphadenopathy vs. possible ill-defined ileocolic mass
- Bilateral chronic renal changes with multiple cortical infarcts

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Dr. Mucera

The appearance of the generalized small intestine is consistent with infiltrative enteropathy with considerations including inflammatory vs. neoplastic infiltrative enteropathy i.e., IBD/eosinophilic enteritis vs. lymphoma, mast cell neoplasia, or other. A definitive diagnosis would require full-thickness intestinal biopsies.

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Ultrasound-guided FNA in the area of the colic lymphadenopathy vs. possible ill-defined mass could also be considered for screening cytology. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Three view chest radiographs are suggested if not done to rule out occult thoracic pathology as a contributing factor to the weight loss.

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Cobalamin supplementation empirically or pending GI panel, dietary therapy which may include hydrolyzed vs. higher fiber diet, continued Prednisolone at an appropriate dose, along with Metronidazole/ Sulfasalazine combination 62.5 mg each BID initially for 14 days with an assessment of



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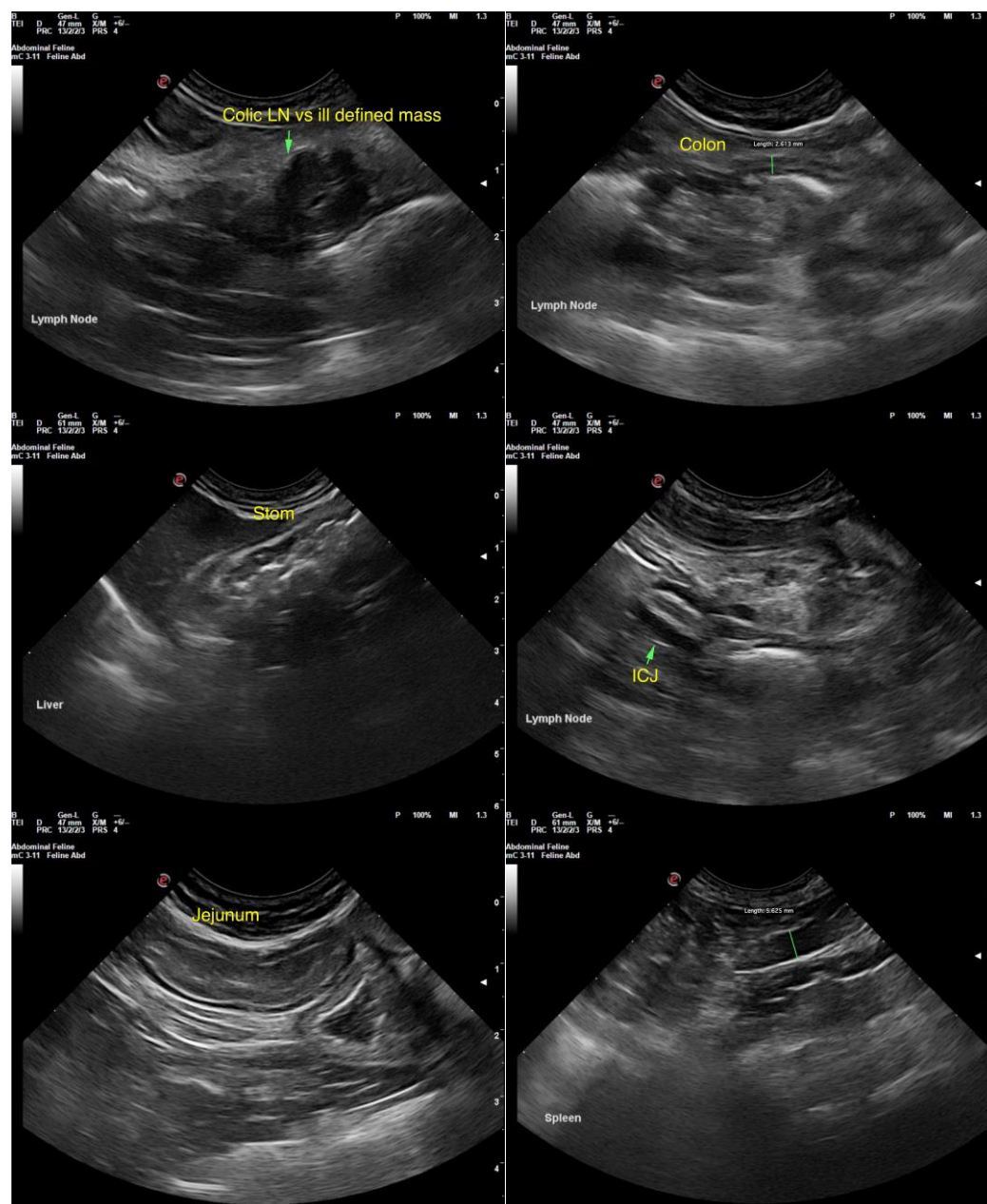
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clinical response could be considered. A guarded prognosis, given the potential for underlying intestinal and lymphatic neoplastic criteria.





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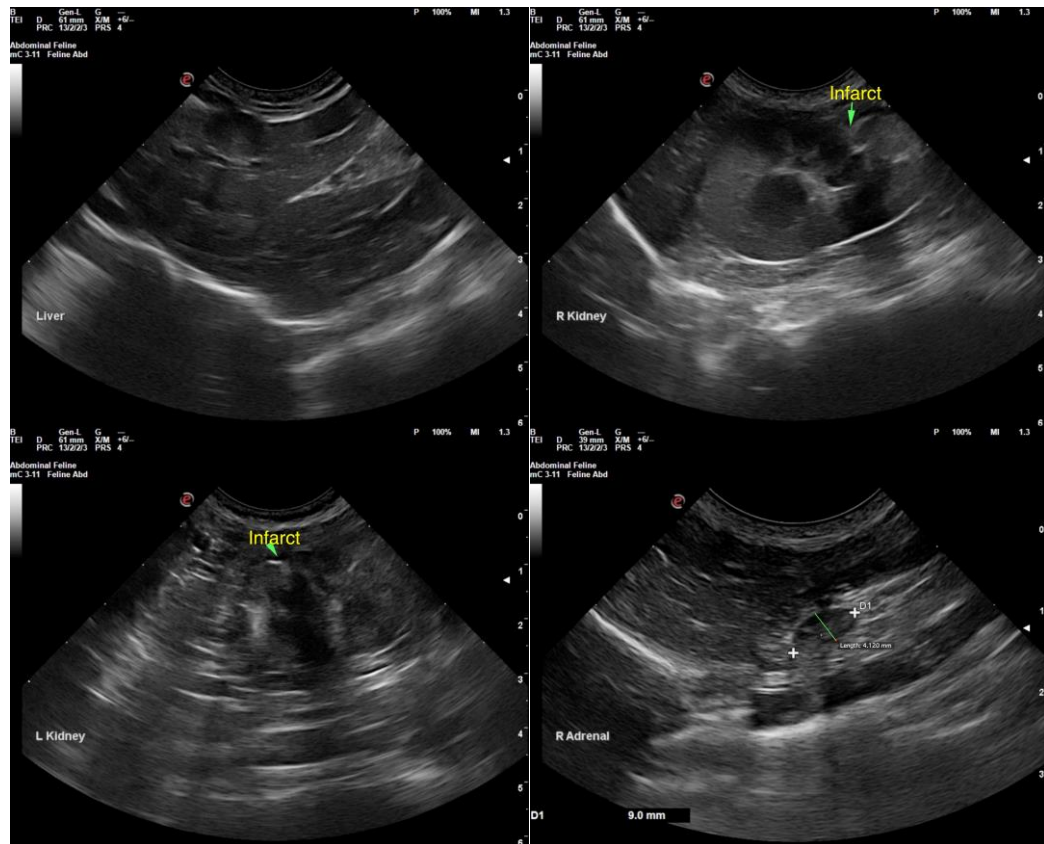
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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