



**PATIENT**

Kodi Breitenstein

**SPECIES**

Feline

**BREED**

Domestic Shorthair

**SEX**

FS

**AGE**

14 years 1 month

**WEIGHT**

7.66

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Carly Pate

**HOSPITAL NAME**

VCA McKenzie AH

**REFERRING VET**

Dr. Fricke

**INVOICE**

14339

**DATE**

7/20/22

**PRESENTING CLINICAL SIGNS**

P has small cell lymphoma in stomach, small intestine diagnosed May 2019 via exploratory+biopsy. P gets monthly CBCs sent to Oregon State University who manages her chemotherapy. Chlorambucil 5mg given every 14 days, last given on July 10th PO. C notes P normally has ~2 days after Chlorambucil where P gets Cerenia PRN for nausea/reduced appetite. P was "normal" after July 10th Chlorambucil but this week started to have some interest in food, but not eating normal sized meals. No vomiting, lip licking and one episode of regurgitation after water was given to chase oral medication. Appetite has become more reduced. C tried Cerenia PO, Mirataz transdermal and Mirtazipine PO with no improvement in appetite or lip licking. C also notes P was hiding and laying oddly around the house- like she was restless. IV fluid therapy started today, IV Cerenia and Butorphanol 0.3mg/kg. Whole body radiographs taken P is on Cerenia and Mirataz PRN, B12injections, Vitamin D drops for previously diagnosed deficiency, Prednisolone 5mg SID, Royal Canin Hydrolyzed diet, Vet Immune Chews. Hx of ureterolith and right kidney hydronephrosis, chronic pancreatitis. Multiple previous abdominal US done via SonoPath- please compare. Abnormal PE/Chem/CBC/UA Results: CBC/Chemistry ran in clinic today.

**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 and without evidence of medial iliac or sublumbar lymphadenopathy/ masses.

Normal size and margination were present in the left kidney. 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. Pinpoint areas of medullary mineral were noted just inside the corticomedullary border suggestive of nonspecific minor medullary rim sign. Nonobstructive renoliths were present in the area of the left kidney pelvis. No evidence of pelvic dilation was present. The left kidney measured 4.2 cm in length.

Subnormal size and mild asymmetrical margination were present in the right kidney. 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. No evidence of pelvic dilation was present. The right kidney measured 2.2 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 0.38 cm width. The right adrenal gland was not definitively visualized.



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**Spleen**

The spleen subjectively was overall normal in size yet exhibited areas of asymmetrical lateral and medial contour, as well as ill-defined cranial and caudal folding. The spleen measured 0.66 cm in width at the level of the hilus.

**Liver/ Gallbladder**

The liver presented mildly enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. Focal to potential intermittent areas of likely biliary tree mineralization were noted. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with 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 gastric body wall width measured 0.27 cm.

The small intestine exhibited generalized intact yet segmentally thickened wall layering primarily involving the jejunum. The duodenum wall width measured 0.24 cm. The jejunum wall width was variable with normal-appearing jejunum wall measuring approximately 0.2 cm wall width compared to areas of thickened jejunum measuring 0.36-0.40 cm wall width.

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

**Pancreas**

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

**Free Abdomen**

Mild volume peritoneal free fluid exhibiting mild echogenic changes suggestive of fluid cellularity were present. Regional to generalized, primarily peri intestinal mild hyperechoic mesentery was noted. No overt evidence of significant lymphadenopathy was noted, although potential for minor mesenteric lymphadenopathy was possible.

**ULTRASONOGRAPHIC FINDINGS**

- Moderate nonspecific chronic renal changes with previously noted subnormal right kidney size and nonobstructive left kidney renoliths
- Folded to mild irregular spleen - nonspecific
- Possible mild hepatomegaly exhibiting focal to potential intermittent areas of likely biliary tree mineralization
- Intact yet segmentally thickened small bowel



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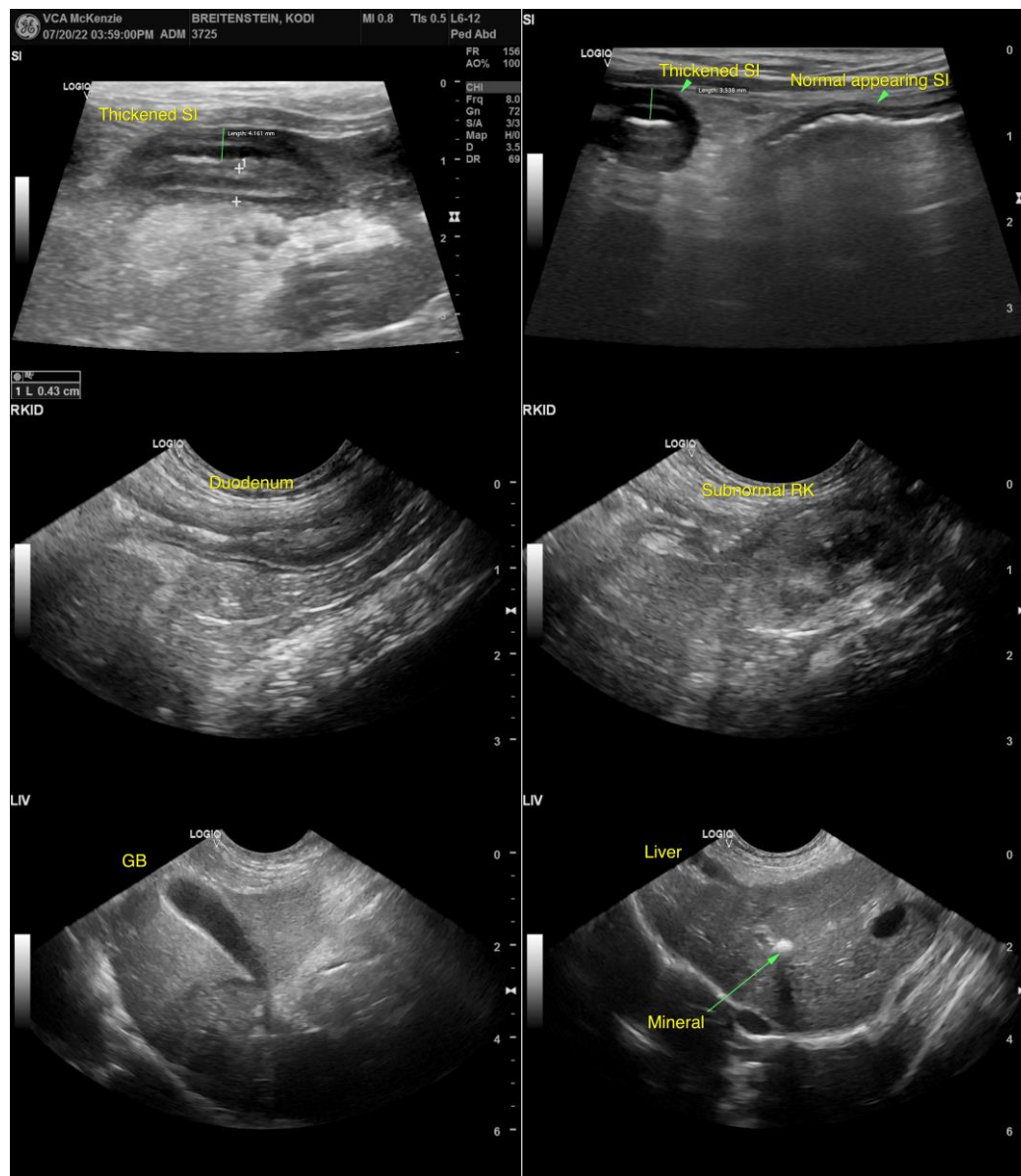
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- Mild volume peritoneal free fluid and primarily peri intestinal hyperechoic mesentery

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Given the intestinal presentation in light of patient history and current clinical signs, concern for recurrence of intestinal lymphoma is warranted vs. underlying inflammatory infiltrative enteropathy. Likewise, the potential for possible lymphomatosis, given the concurrent presence of peritoneal free fluid exhibiting potential for fluid cellularity, is possible. Further assessment may include abdominocentesis for fluid analysis, cytology, +/- C/S if evidence of inflammatory cells. Oncology consultation is recommended If possible. Bone marrow evaluation may be indicated.

Empirically, continued as-needed gastrointestinal support is recommended. A very guarded prognosis is warranted.





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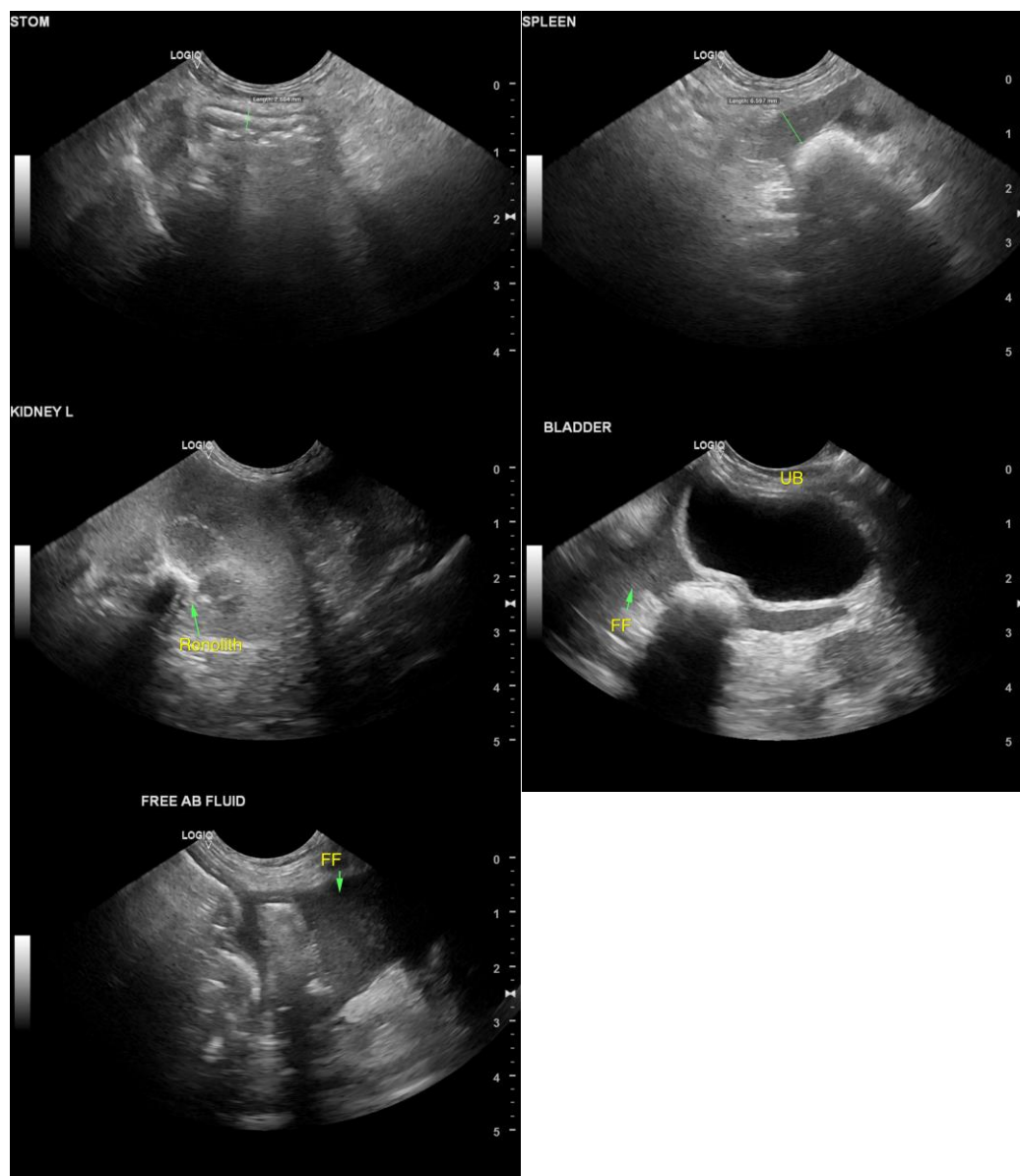
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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