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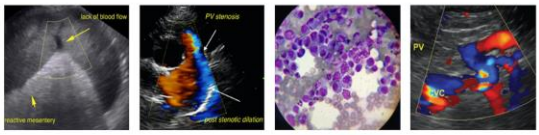

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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PATIENT

Audrey Button

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

2011

WEIGHT

10.2

INTERPRETED BY

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

IMAGING PERFORMED BY

Rebekah Jakum, CVT ARDMS/RVT

HOSPITAL NAME

Pocono Peak VC

REFERRING VET

Dr. Coyle

INVOICE

14356

DATE

7/21/22

PRESENTING CLINICAL SIGNS

Weight loss, diarrhea, lethargy Mirtazapine

ALP 275, Albumin 2.0, Globulin 3.4, BUN 9, Creatinine 0.6, Phos 2.5, Na/K 36, HCT 24.5, WBC 24, with neutrophilia, suspected band neutrophils, and mild monocytosis

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 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. A mild hyperechoic corticomedullary band, consistent with a mild medullary rim sign, was present. This is a nonspecific finding seen in both normal and abnormal kidneys. It may be associated interstitial renal disease, hypercalcemia, tubular necrosis, lymphoma, and FIP. However, it is a nonspecific finding. The left kidney measured 4.0 cm in length. The right kidney measured 3.8 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 1.0 cm in width at the level of the hilus.

Liver/ Gallbladder

The liver exhibited subjective mild enlargement. The parenchyma of the liver was subjectively increased in echogenicity compared to the spleen and renal cortices. The echotexture of the liver parenchyma was uniform with a mild coarse echotexture. The capsule of the liver was symmetrical in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size containing primarily anechoic content with mild nondependent yet nonorganized luminal debris. No evidence of gallbladder or peripheral gallbladder inflammatory criteria was noted. The cystic and common bile ducts were normal.

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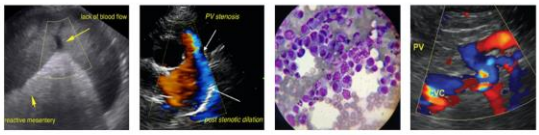

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Gastrointestinal

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 0.28 cm.

The small intestine presented intact yet generalized thickened wall layering owing to generalized propensity for mildly prominent to thickened muscularis layer. The small intestinal wall width measured 0.30 cm.

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

Pancreas

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.

Free Abdomen

Solitary probable colic lymph node was present in the mid-abdomen. The lymph node exhibited symmetrical to rounded margination with abnormal width: length ratio (>0.5). Regional perilymphatic to peri intestinal reactive mesentery was noted. The probable colic lymph nodes measured 3.4 cm x 1.9 cm. Additional smaller hypoechoic regional lymph nodes were also present around the solitary enlarged lymph node. No evidence of peritoneal free fluid was noted.

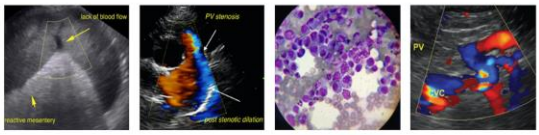
ULTRASONOGRAPHIC FINDINGS

- Bilateral nonspecific medullary rim sign
- Mild hepatomegaly exhibiting uniform mild parenchyma hyperechogenicity
- Minor gallbladder debris
- Intact yet generalized thickened small bowel walls
- Marked hypoechoic to swollen colic lymph node with additional smaller regional hypoechoic omental lymphadenopathy

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The overall appearance of the small intestine Is consistent with infiltrative enteropathy with considerations including Inflammatory vs. neoplastic infiltrative enteropathy. The concurrent probable colic lymphadenopathy may indicate significant hyperplasia, reactive lymphadenitis, or early neoplastic lymphadenopathy. Full-thickness intestinal biopsies, as well as lymphatic sampling, are required for further prognosis. Ultrasound-guided FNA of the enlarged colic lymph node could be considered initially for screening cytology.

Given the appearance of the enlarged colic lymph node, which meets neoplastic criteria, higher considerations for neoplastic lymphadenopathy and therefore neoplastic infiltrative enteropathy, warranted although not definitive. Potential for multicentric round cell neoplasia is possible.



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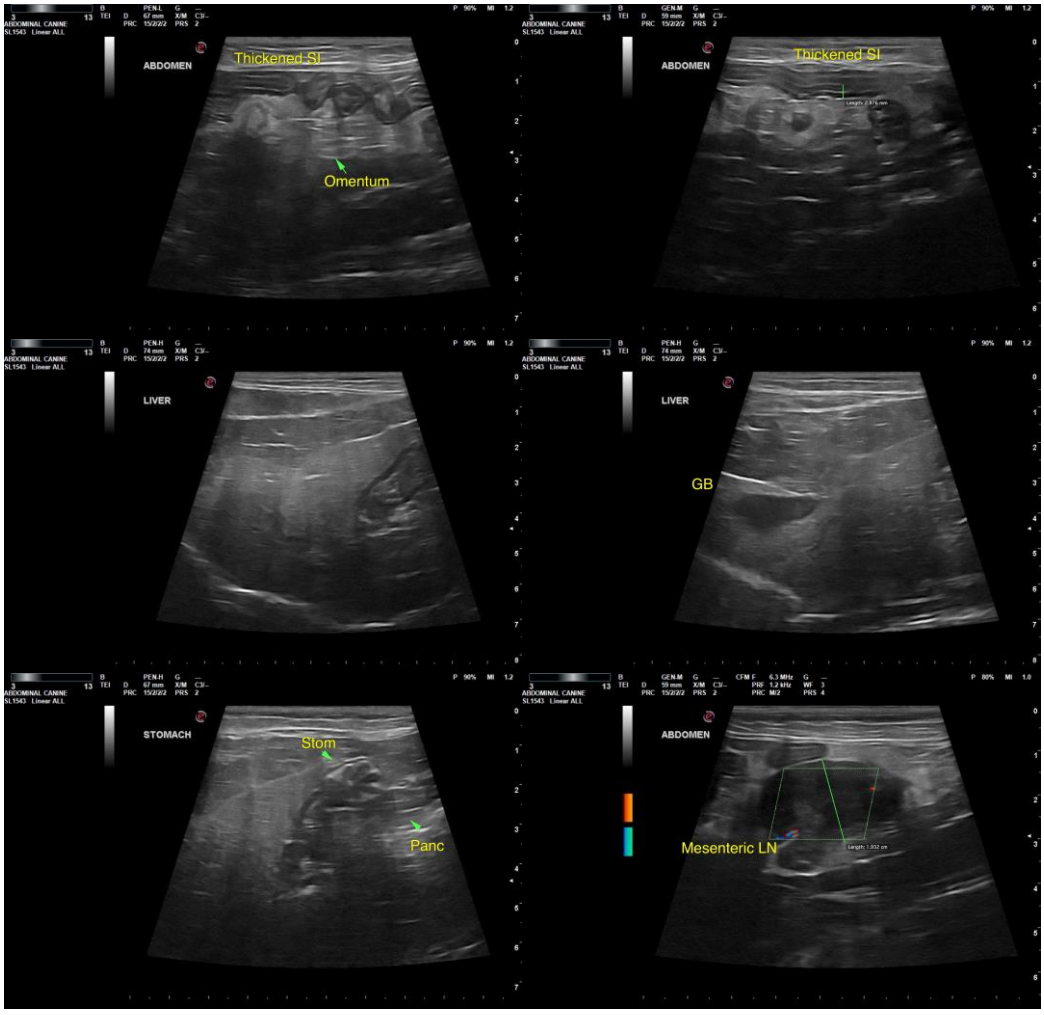
Concurrent hepatic FNA, assuming normal clotting status and using a 25-gauge needle, would also be recommended. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. IF not done, Three-view chest radiographs are suggested to rule out concurrent thoracic pathology as a contributing factor to the weight loss.

Empirically or if sampling is not elected, IBD protocol which may include hydrolyzed diet trial, cobalamin supplementation, high colony count probiotics such as Proviable, and Prednisolone 1.0-2.0 mg/kg PO SID at the lowest effective dose to control clinal signs and an assessment of clinical response would be reasonable.



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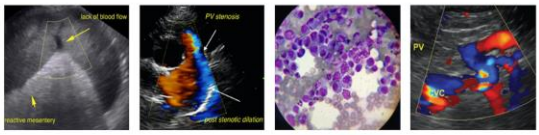

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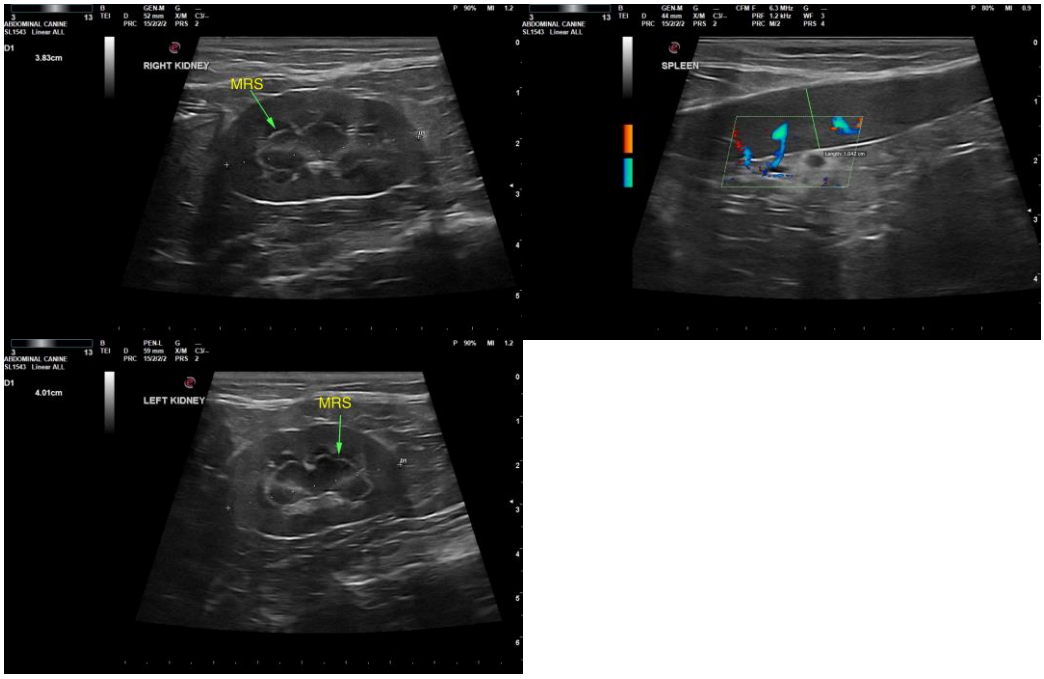

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
mac.daniel@sonopath.com