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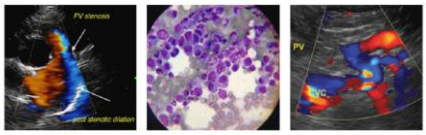

SonoPath
Clinical Sonography & Telecytology
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PATIENT

Ninja Arvanitis

SPECIES

Feline

BREED

Bombay

SEX

MN

AGE

10yr

WEIGHT

2.76kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Madison Veterinary Specialists-Dr. Patton

INVOICE

11185ag

DATE

07/26/2022

PRESENTING CLINICAL SIGNS

History: Patient presented to MVS for prolonged lethargy. History of: GI lymphoma weight loss hyporexia diarrhea hypoglycemia hypothermia hypotension anemia hypoalbuminemia neutropenia, normal on diff but left shift hypokalemia Ninja has significantly improved overnight. His Bg has increased on 20% dextrose supplementation but still remains dependent on supplementation. He is mentally appropriate and responsive. bradycardia has improved with his HR being about 150bpm and BP normal. He is eating well. No diarrhea or vomiting noted. AFAST revealed a scant amount of free fluid.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Anechoic urine was present in the lumen with sediment indicative of cellular vs crystalline debris, mucus or lipid. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

Borderline enlarged renal size with asymmetrical margination was 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. The renal medullary volume was subjectively reduced. Mild bilateral pyelectasia was noted. The left kidney measured 4.7 cm in length. The right kidney measured 5.0 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

Both adrenal glands were mildly prominent in size with symmetrical capsule contour and subtle nonhomogeneous parenchyma. The left adrenal gland measured 0.68 cm width. The right adrenal gland measured 0.51 cm width. Overt evidence of neoplastic criteria was not observed. Chronic stress hyperplasia or age-related patient variant is possible.

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.

Liver

The liver presented increased in size. 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. Pockets of echogenic free fluid noted between liver lobes as well as the peritoneal cavity.

The gallbladder was non-distended to mildly contracted in size with prominent walls exhibiting potential for minor gallbladder wall edema. The gallbladder wall measured 0.27 cm in width. Primarily anechoic luminal content with very minor nonmineralized sediment was present. The cystic and common bile ducts were normal.

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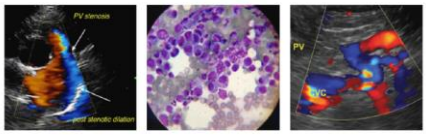

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Gastrointestinal

The stomach presented intact yet mildly prominent 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 measured 0.27 cm in width.

The small intestine presented intact to mildly prominent wall layering with a prominent muscularis layer. Focal areas of cystic appearing small mural lesions were present which may indicate areas of previous biopsy. The duodenum wall measured 0.27 cm in width. The jejunum wall measured 0.22 cm in width.

The colon exhibited intact yet prominent wall layering primarily in the descending colon with mild indistinct colonic wall layer detail. The descending colon wall measured 0.35 cm in width.

Pancreas

The pancreas appeared subtly prominent in size with symmetrical capsule contour and non-homogeneous to subtly hypoechoic parenchyma compared to adjacent omentum.

Free Abdomen

Pockets of echogenic free fluid noted between liver lobes as well as the peritoneal cavity.

Intermittent variably sized isoechoic to homogeneous mesenteric lymph nodes were present, an example measuring 2.1 cm x 0.85 cm. This is not overtly consistent with neoplastic criteria.

ULTRASONOGRAPHIC FINDINGS

- Likely chronic cholangitis / cholangiohepatitis hepatobiliary pattern, lipidosis vs hepatic neoplasia i.e. lymphoma possible
- Chronic enteropathy pattern with small cystic mural lesions - chronic inflammatory enteropathy vs infiltrative neoplasia (lymphoma)
- Possible low grade chronic to chronic active pancreatitis
- Bilateral nonspecific chronic nephropathy exhibiting hyperechoic corticomedullary echogenicity and minor pyelectasia - chronic nephritis, CRD, less likely neoplasia
- Mild UB sediment
- Intermittent isoechoic to prominent mesenteric lymphadenopathy – chronic hyperplasia, chronic lymphadenitis, neoplastic lymphadenopathy thought less likely
- Scant peritoneal free fluid

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

FNA of the liver +/- mesenteric lymph node, assuming normal clotting status and using 25 ga needle, is warranted to assess for inflammatory cells and rule out potential for neoplasia. Continued supportive care, given patient improvement, with potential continued GI lymphoma protocol if currently instituted vs cholangiohepatitis / empirical triad disease protocol pending liver cytology could be considered. Recheck GI panel and, if not done, 3 view chest radiographs to rule out thoracic pathology as a contributing factor could be considered.

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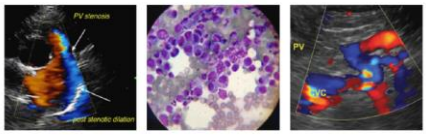

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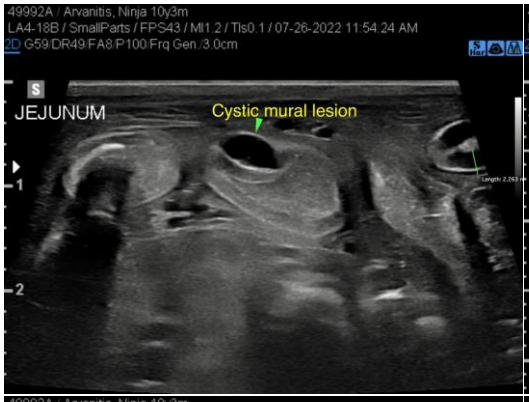

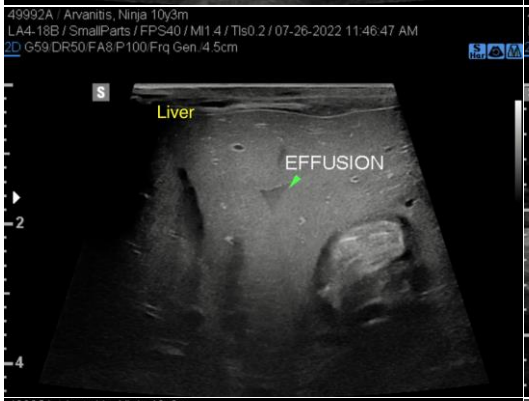

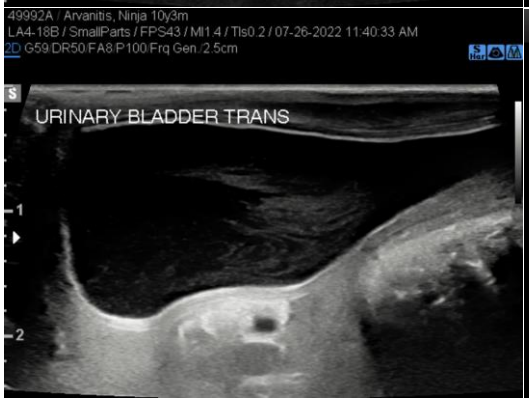

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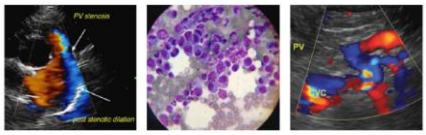

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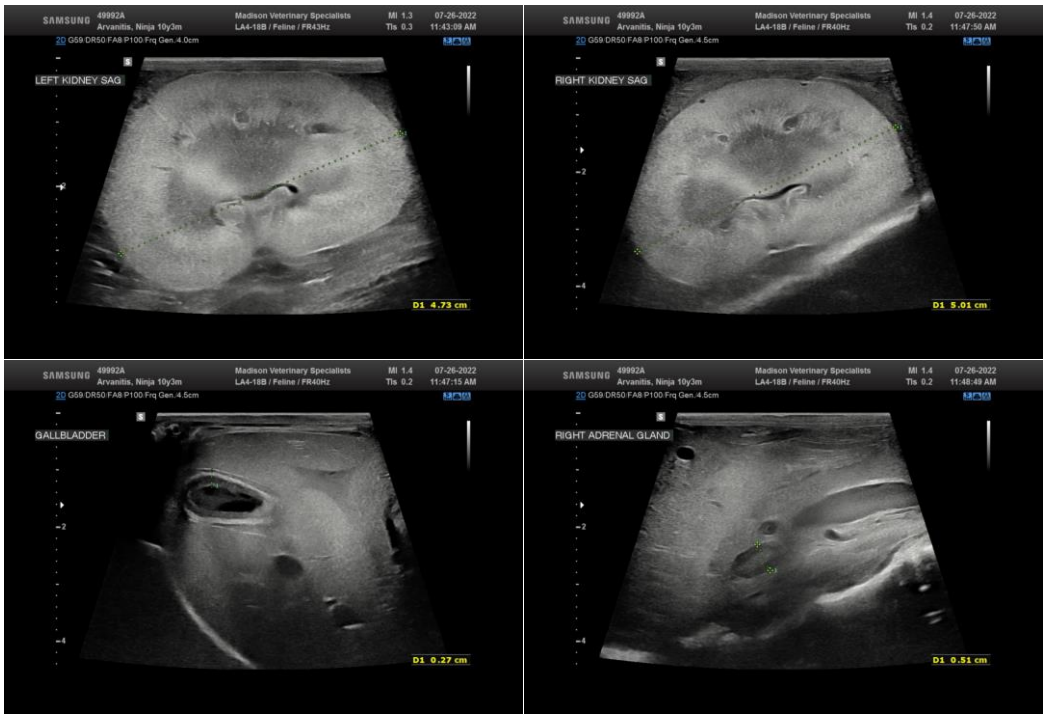

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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