SonoPath
Clinical Sonography & Telecytology
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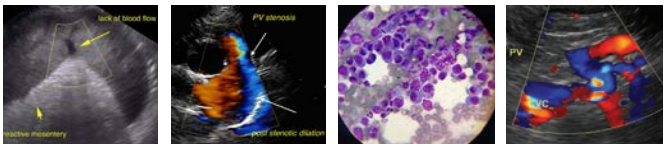

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Quee Leone

SPECIES

Feline

BREED

Oriental Shorthair

SEX

Neutered Male

AGE

17 Years

WEIGHT

10.8

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenn

HOSPITAL NAME

Rockaway AH

REFERRING VET

Dr. Maniar

INVOICE

25139

DATE

9/2/21

PRESENTING CLINICAL SIGNS

diabetes, hypoglycemia, pancreatitis

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 were noted.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. Uniform increased cortex echogenicity noted with mild loss of corticomedullary border demarcation. No evidence of pyelectasia or overt pyelonephritis. The left kidney measured 3.9 cm. The right kidney measured 4.3 cm.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

No overt pathology in the area of the left and 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 0.6 cm in width.

Liver

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.

Gastrointestinal

Regional moderate to severe gastric wall thickening and loss of gastric wall layer detail was present. The thickened gastric walls exhibited decreased echogenicity and an asymmetrical luminal surface. Mild retained anechoic fluid was present in the gastric lumen without evidence of foreign material. Gastric body wall measured 0.7-1.0 cm. The most prominent areas of gastric wall thickening were noted subjectively in the area of the gastric antrum and pylorus with intact yet moderate prominent wall layering noted in the area of the gastric body and fundus.

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. Duodenum wall measured 0.27 cm.

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

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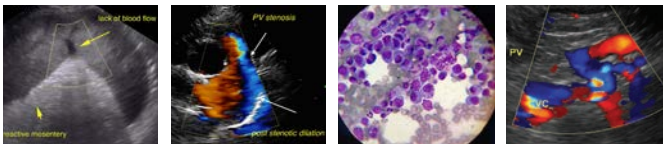

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Pancreas

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

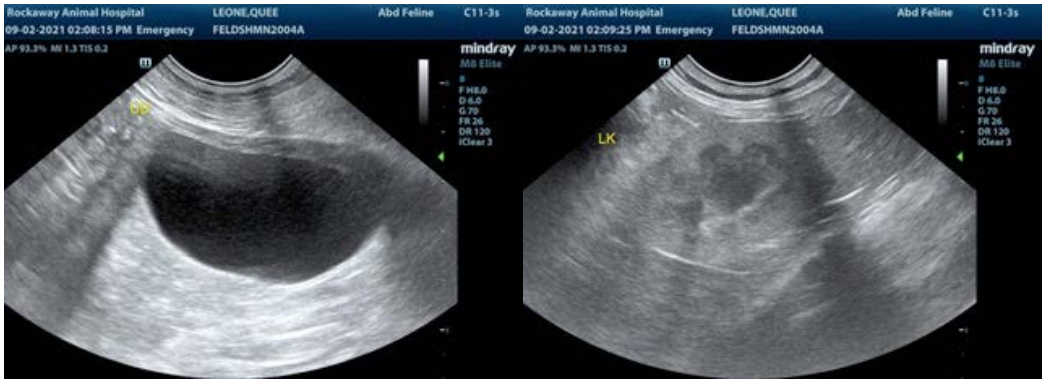
Intermittent, mildly prominent to hypoechoic gastric lymph nodes were noted adjacent to the pylorus were present. Example measured 0.9 cm in diameter. Regional perigastric reactive mesentery noted. No effusion.

ULTRASONOGRAPHIC FINDINGS

- Thickened stomach with associated metabolic to paralytic ileus – gastric neoplasia, specifically gastric lymphoma considered the primary differential diagnosis, severe gastritis possible.
- Associated gastric lymphadenopathy – hyperplasia, reactive lymphadenitis, or early metastatic lymphadenopathy possible.
- Mild chronic renal changes
- Mildly heterogeneous pancreas – patient or age related variant, minor parenchymal remodeling owing to previous pancreatitis or low-grade chronic to chronic active inflammation possible.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Gastric wall sampling is required for definitive diagnosis. Ultrasound guided FNA of the gastric wall (assuming normal clotting status and if accessible) could be considered. Otherwise, endoscopic biopsies may be considered. As-needed gastroprotectants and gastrointestinal support (if evidence of vomiting or anorexia) is recommended. 3-view chest radiographs are suggested.



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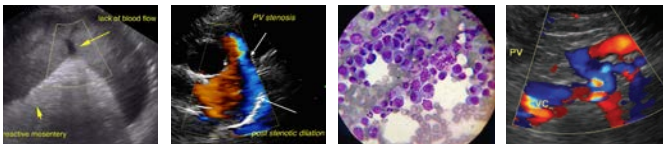

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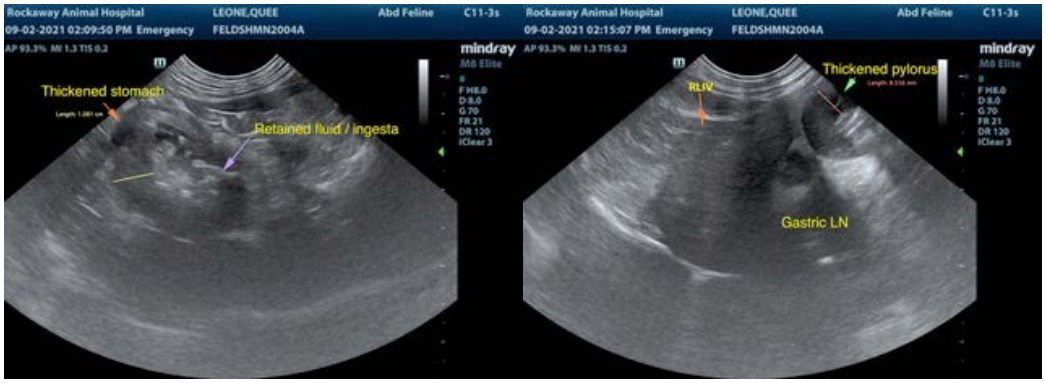

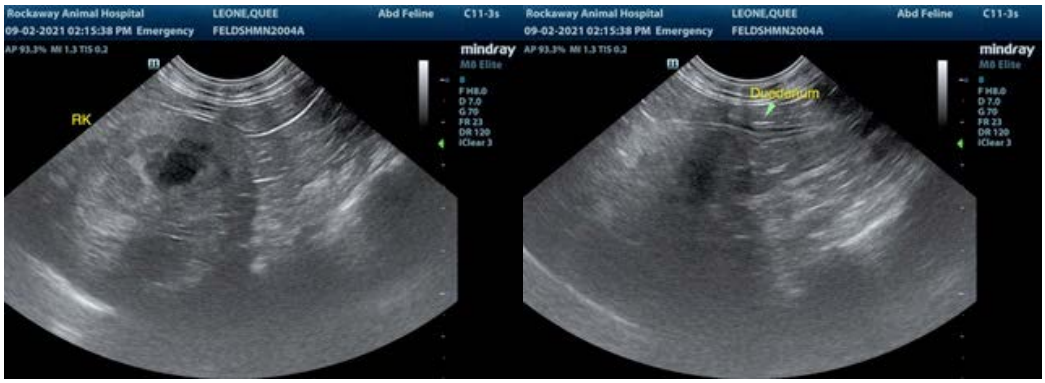

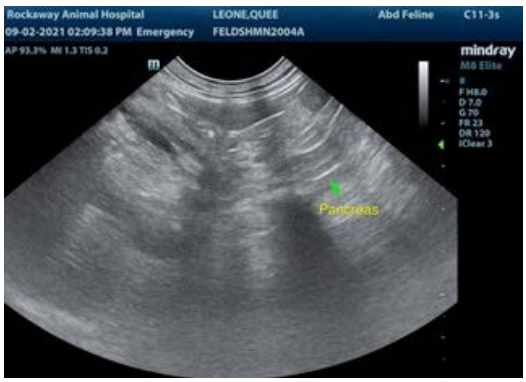

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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