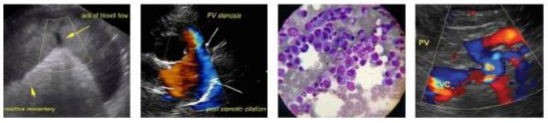


PATIENT

Cali Crowe

SPECIES

Feline

BREED

DLH

SEX

Spayed Female

AGE

N/A

WEIGHT

N/A

INTERPRETED BY

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

IMAGING PERFORMED BY

ɔetitia Saint-Jacques, RVT LVT

HOSPITAL NAME

Mountrose

REFERRING VET

Dr. Katie Weldon

INVOICE

13203

DATE

9/21/21

PRESENTING CLINICAL SIGNS

History: Breed:Calico DLH Female/Male:Female Spayed/Intact:Spayed Age:11 years, 5 months Weight:9.56 lbs. HISTORY: • Small intestinal mass found on abdominal ultrasound in July 2020, as well as an enlarged mediastinal lymph node (and mild pleural effusion), as well as an enlarged abdominal lymph node near the mass, along with possible pancreatitis and omental inflammation. Suspected GI lymphoma, but never biopsied surgically. A needle aspirate was inconclusive. • The enlarged mediastinal lymph node and mild pleural effusion went away with meds. • Patient is currently on ¼ cerenia 16 mg tab PO SID, Leukeran 2 mg PO q. 72 hours, and Prednisolone 2 mg PO SID. WE STARTED FAMOTIDINE 5 mg PO SID YESTERDAY. • O reports that she has been hypersalivating since Saturday (3 days). She has been having loose stools for about 1 month. She is currently having hard swallowing, and is less interested in food. • Workup yesterday included bloodwork (NSF aside from suspected nRBC) and full body rads (NSF aside from possible mild thickening of the small intesines). Physical Exam: Weight: 9.56 lbs. T- 99.5, P- 230, R- 60 CRT: < 2 sec mm: pink/moist/hypersalivating Dehydration: 0% BCS: 3/5 EENT: Grade 1-2/4 dental tartar. Thyroid slip on the L. No FB seen under the tongue. CV/Resp: Normal bv sounds all lung fields- grade 3/6 L sided murmur (stable murmur). GI: Abdomen palpates non-painful - possible mass vs stool in caudal abdomen, approx. 2 cm diameter (Similar in size to the first time I palpated it). Musk: No joint abnormalities. Muscles are symmetrical. No pain elicited on manipulation/exam. Integ: WNL LN: Palpate WNL Neuro: WNL Urogen: WNL, no obvious visible or palpable abnormalities REASON FOR ULTRASOUND: • Evaluate GI mass status. • Determine cause of hypersalivation Email (s) where report is to be sent:

Abnormal PE/Chem/CBC/UA Results:

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. Aortic trifurcation was normal.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some mild increased echogenicity and loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 3.4 cm in length. The right kidney measured 3.4 cm in length.

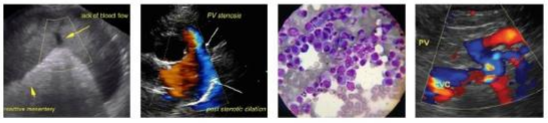
Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.33 cm width.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.40 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



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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 0.5 cm width at the level of the hilus.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. Suspect lobar minor biliary tree mineralization. The gallbladder itself was normal. The cystic duct presented mildly dilated in size. The common bile duct was dilated and tortuous without overt post hepatic obstruction. The common bile duct measured 0.2 cm diameter.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The pylorus wall measured 0.20 cm. Mild amount if echogenic chyme was present in the pylorus lumen. The gastric body wall measured 0.25 cm.

The small intestine presented primarily intact wall layering and maintained 1:3 muscularis/mucosa ratio. Previously focal to segmental jejunal mural hypertrophy and loss of discernable wall layering was present in the subjective mid abdomen. Jejunal wall width within the area of mural hypertrophy measured 0.34 cm – 0.37 cm by comparison. Normal appearing jejunal wall measured 0.2 cm width. No evidence of previously noted associated lymphadenopathy or peritonitis.

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

Pancreas

The pancreas was normal in size and contour with heterogeneous parenchyma

ULTRASONOGRAPHIC FINDINGS

Primary Finding

- Improved yet persistent focal to segmental jejunal mural hypertrophy to mild jejunal mural mass
- No evidence of previously noted lymphadenopathy or peritonitis
- Static chronic active pancreatitis pattern
- Bilateral chronic renal changes

Secondary Finding

- Probable mild lobar biliary tree mineral
- Non-obstructive proximal common bile duct dilation

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This finding may suggest age related changes or secondary to underlying cholangitis / cholangiohepatitis especially if previous or current liver enzymes elevations have been noted. No overt signs of post hepatic obstruction. Consider assessment of TLI/PLI/Cobalamin/Folate, if not recently done. 3 view chest radiographs recommended to rule out occult thoracic or esophageal pathology as the potential cause of the patients' clinical signs. If biopsies are not possible continued current therapeutic protocol would be appropriate with sonographic monitoring of the jejunum.

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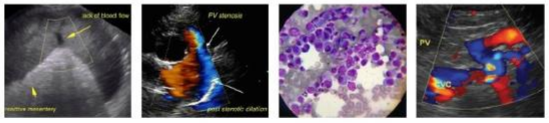

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pawsonography@gmail.com 530-786-8340

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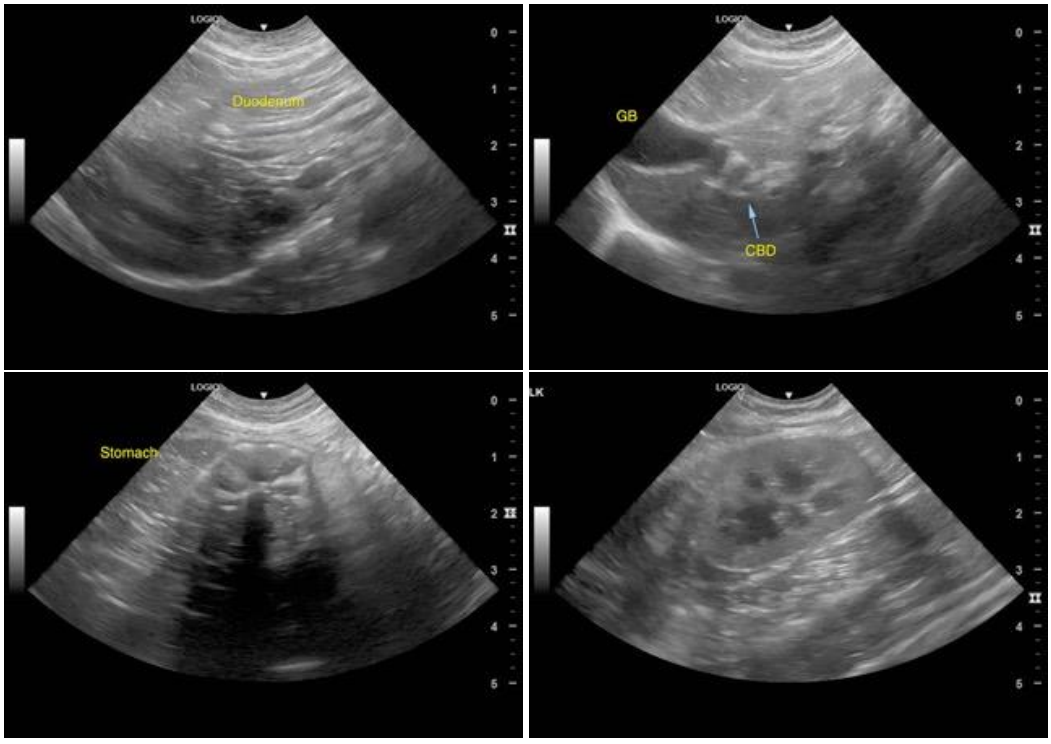

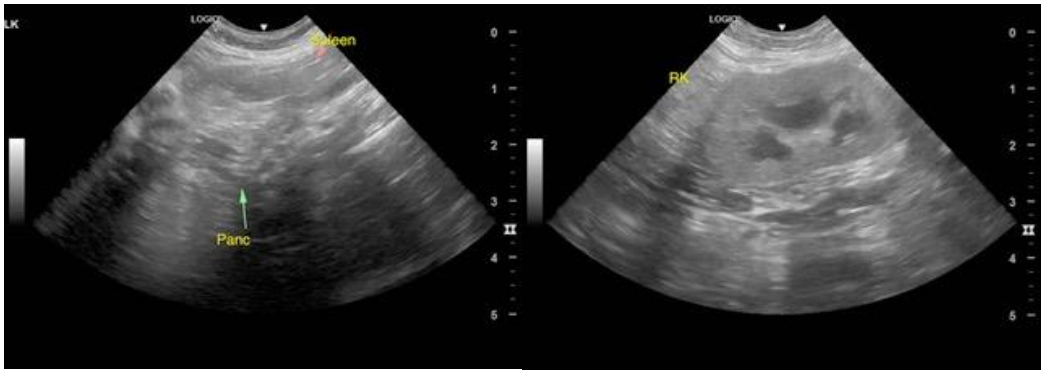

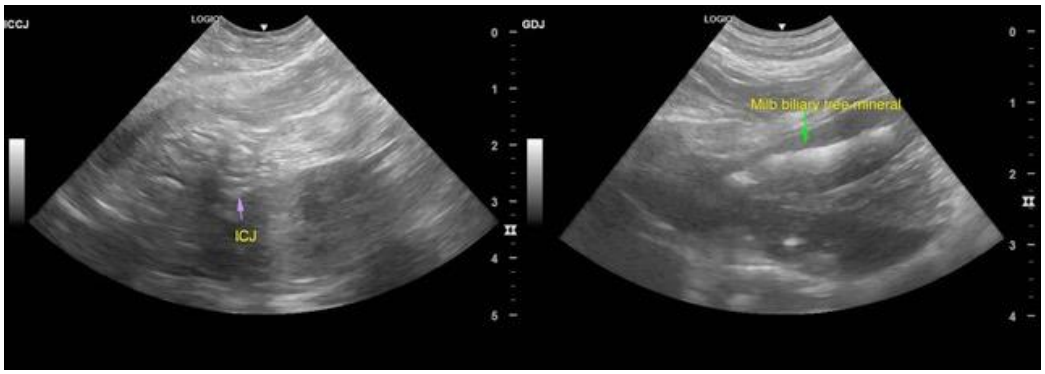

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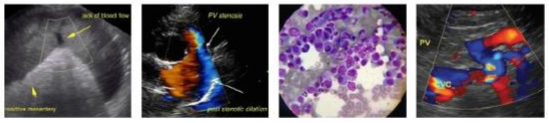

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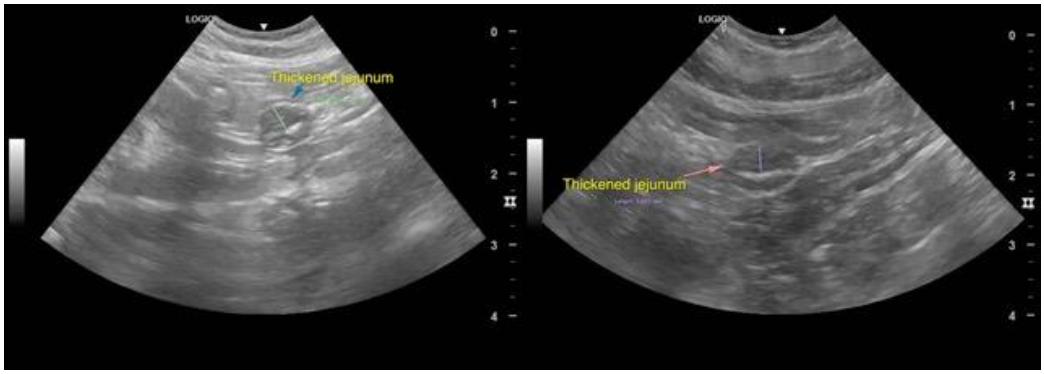

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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