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Clinical Sonography & Telecytology
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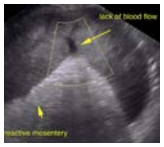
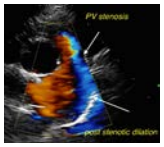
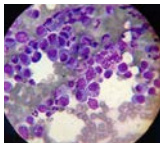
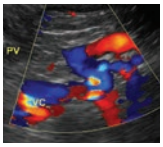

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1-800-838-4268 info@sonopath.com

PATIENT

Mojo Turner

SPECIES

Feline

BREED

DLH

SEX

Spayed Female

AGE

12 Years

WEIGHT

10.8 Pounds

INTERPRETED BY

Tam Mengine, DVM, DABVP (canine/feline practice)

IMAGING PERFORMED BY

Dr. Lucas Budden

HOSPITAL NAME

Frontier Vet Hospital

REFERRING VET

Dr. Lucas Budden

INVOICE

42580

DATE

11/6/22

PRESENTING CLINICAL SIGNS

Presented 10/18/2022 for chronic vomiting (weight 11.6#). Had been vomiting about once every other day and had developed diarrhea few days prior to presentation. Owners recently noticed some blood in the vomit so made an appointment. Appetite relatively normal at the time of presentation. Had lost about 0.7# since September 2022. Treated with Cerenia, Proviable probiotic, Panacur, omeprazole and Hill's z/d food. Would not eat z/d food. so owners started i/d. Presented on 11/1/2022 for continued vomiting. Frequency had increased to about once per day. Still had blood in the vomit. Diarrhea had resolved. Decreased appetite at that appointment. Painful abdomen and dehydrated. Treated with fluids, Cerenia, Sucralfate, gabapentin. Upon presentation today vomiting has resolved. Appetite still decreased. Has a history of grinding teeth when chewing. Had worsened recently and seems to not be able to keep food in her mouth. Ultrasound to assess for cause of vomiting and decreased appetite. Abnormal PE/Chem/CBC/UA Results: Senior panel 9/12/2022 BUN 23, Cre 1.9 (Hx 2.2) SDMA 13 Neuts 2.5K (low) T4 2.7 (grey zone) proBNP 239 (abnormal) USG 1.041 9/17/2022 fT4 and BNP Free t4 is normal BNP high 239 10/18/22 fecal negative 11/2/2022 CBC/Chem/T4/UA/FeLV/FIV/HW antibody Creatinine high 1.9 PSL high 31 T4 normal 3.1 USG 1.043 1+ protein Cloudy appearance Quite sediment FeKV/FIV/heartworm antibody all negative 11/4/2022 fecal negative

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine, and no luminal sediment is present. The ureteral papillae, trigone and pelvic urethra (visible to 2.0 cm) are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted.

The kidneys are of normal size and shape and exhibit appropriate corticomedullary differentiation with a normal 1:3 cortex to medulla ratio. There is no evidence of nephrolithiasis, mineralization, pyelectasia, cystic change or hydronephrosis. The proximal ureter is not visible (normal). The left kidney measures 3.7 cm. The right kidney measures 3.5 cm.

Adrenal Glands

The adrenal glands are both identified in their normal locations. They are normal in size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. The left adrenal gland measures 3.5 mm. The right adrenal gland measures 2.9 mm.

Spleen

The spleen is of appropriate size (7.1 mm) and has a normal, homogenous parenchyma with a smooth, continuous capsular surface. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal. Thickness at the splenic hilus is normal.

Liver

The liver is of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents and a small amount of freely-moveable echogenic sludge. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

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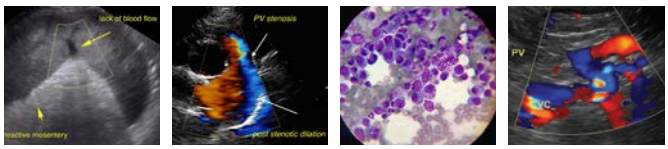

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Gastrointestinal

The stomach is moderately distended with echogenic fluid. The stomach wall is focally thickened in the region of the body to 1.9 cm with a loss of wall layering. The pylorus is of normal appearance with no evidence of outflow obstruction.

The visualized portions of the duodenum, jejunum, and ileum are of normal thickness with intact wall layering that exhibits the appropriate 1:3 muscularis to mucosa ratio. Duodenum wall measures 2.7 mm. Jejunum wall measures 2.4 mm. Intestinal motility appears normal.

The visible portions of the colon are of normal thickness (1.6 mm) with intact wall layering. The ileocecal junction is visualized and normal.

Pancreas

The right limb of the pancreas is swollen and hypoechoic, surrounded by hyperechoic mesenteric fat. The pancreatic duct appears normal.

Free Abdomen

There is no evidence of free fluid within the peritoneal cavity. The omentum and intra-abdominal fat are of appropriate echogenicity. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

PRIMARY FINDINGS

- Gastric mass

SECONDARY FINDINGS

- Pancreatic inflammation

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Differentials for the mass in the stomach include gastric lymphoma, with other malignancies, or benign etiologies such as eosinophilic sclerosing fibrosis, considered less likely. Recommendations include:

- ❖ Ultrasound-guided fine needle aspiration of the affected area with a 25 or 22 gauge needle. Surgical or endoscopic biopsy of the affected tissue could also be considered.
- ❖ Three-view chest radiographs to screen for metastasis
- ❖ Supportive care as indicated, including fluid therapy, bland diet, antiemetics, appetite stimulants and gastroprotectants.

The changes in the pancreas are consistent with acute pancreatitis. Concurrent pancreatic neoplasia, while less likely, cannot be ruled out. Recommendations include:

- ❖ an fPLI, or preferably a full GI panel, are indicated for confirmation and to screen for concurrent intestinal disease.
- ❖ supportive care including fluid therapy, anti-emetics, analgesics, appetite stimulants (if needed) and cobalamin supplementation are warranted.
- ❖ a highly digestible intestinal diet is recommended.
- ❖ if the patient is not responding to medical management, fine needle aspiration with a 25G needle for cytology could be considered after first checking a coagulation profile.

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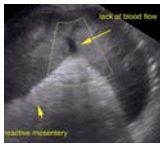
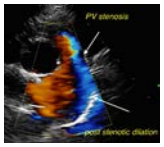
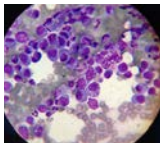
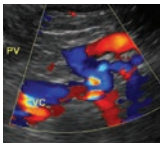

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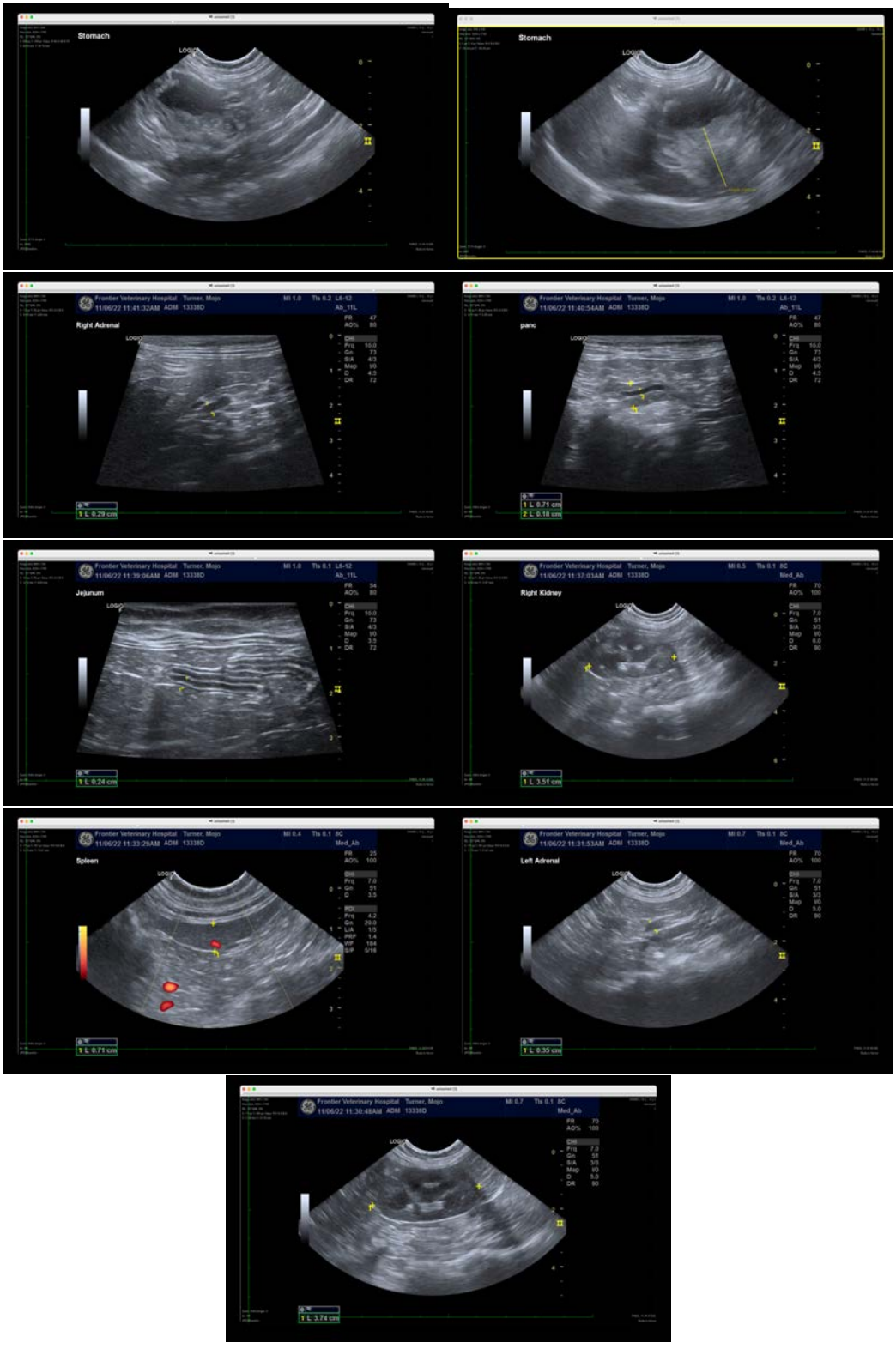

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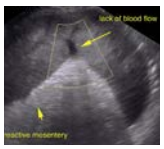
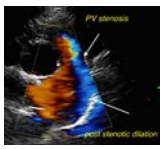
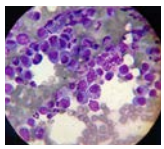
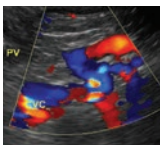

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Tam Mengine, DVM, DABVP (canine/feline practice)

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