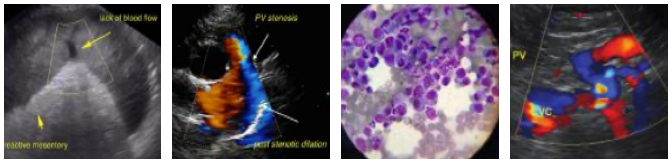

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1-800-838-4268 info@sonopath.com

PATIENT

Princess Vignoles

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

12 years

WEIGHT

7.4 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Tam Mengine

HOSPITAL NAME

Stoney Creek VH

REFERRING VET

Dr. Tam Mengine

INVOICE

12756

DATE

4.13.23

PRESENTING CLINICAL SIGNS

History: Patient was found sometime in the last year, had ultrasound elsewhere which identified splenomegaly. Patient was started on steroids and has been on them for months (uncertain exact duration) and clients now wish to pursue more definitive diagnosis as patient is lethargic with reduced appetite. CBC - unremarkable, Chem - Alb 2.3, Globs 7.7, ALT 114, marked hematuria, else unremarkable. T4 normal, FeLV / FIV neg.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. A small amount of echogenic luminal sediment is present, which is freely-movable. The ureteral papillae, trigone and pelvic urethra are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted. Urethra visualized to 3.0 cm.

Both kidneys are hyperechoic and exhibit moderately decreased cortico-medullary differentiation. There is no evidence of nephrolithiasis, mineralization, pyelectasia or hydronephrosis. The proximal ureters are not visible (normal). The left kidney is 4.3 cm in length. The right kidney is 4.8 cm in length.

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 height is 2.5 mm at the caudal pole. The right adrenal gland height 2.8 mm at the caudal pole.

Spleen

The spleen is diffusely thickened, measuring 1.1 cm at the hilus. The capsular margins are regular and the parenchyma is mottled. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears 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 moderate 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.

Gastrointestinal

The stomach is empty. The gastric wall is subjectively normal in thickness, and exhibits appropriate wall layering, but cannot be accurately measured due to normal deviations of the rugal folds. The pylorus is of normal appearance.

The small bowel has diffuse changes to the normal 1:3 muscularis to mucosa ratio. Wall measurements are increased up to 2.6 mm for duodenum and 3.2 mm for jejunum. Overall wall layering is preserved. Intestinal motility appears normal.

The visible portions of the colon are of normal thickness, up to 1.1 mm, with intact wall layering. The ileocecal junction is visualized and appears normal.

Pancreas

The left limb of the pancreas is hypoechoic, but of normal size and with no changes to the surrounding mesenteric fat. There is no evidence of peripancreatic inflammation. The pancreatic duct appears normal.

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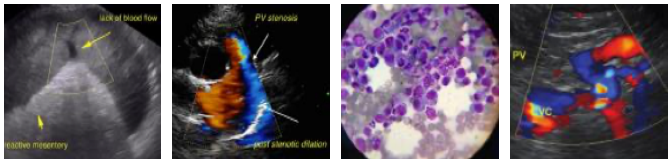

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Free Abdomen
There is no evidence of free fluid within the peritoneal cavity. The omentum and intra-abdominal fat are of hyperechoic. The mesenteric lymph nodes were moderately enlarged and hypoechoic with a rounded shape, measuring up to 2.7 cm. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Diffuse small bowel thickening and mesenteric lymphadenopathy, consistent with infiltrative bowel disease
- Borderline splenomegaly with mottled parenchyma

Secondary Findings

- Chronic renal changes
- Hypoechoic pancreas
- Bladder sediment

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes in the gastrointestinal tract are suggestive of infiltrative bowel disease, including both inflammatory bowel disease or low grade gastrointestinal lymphoma. Recommendations include:

- Fecal parasite testing and empiric fenbendazole treatment
- Trials with a novel protein or hydrolyzed diet
- A complete GI panel, or empiric cobalamin supplementation
- Empiric therapy with prednisolone at 2-4mg / kg daily could be considered if a diet trial is unsuccessful.
- Definitive diagnosis would require biopsy of the affected tissue, ideally with intra-operative ultrasonographic guidance. If there is concurrent lymphadenopathy, ultrasound-guided sampling of the lymph node using a 25 or 22G needle could be considered.

The splenic changes are concerning for infiltrative neoplasia such as lymphoma or splenic mastocytosis, though a reactive splenitis is also possible. Recommendations include:

- Ultrasound-guided fine needle aspiration with a 25G needle, after pre-medicating with diphenhydramine.

The changes in the kidneys are consistent with chronic renal disease. Findings should be correlated with laboratory values, IRIS staging and clinical signs.

The appearance of the pancreas can be a normal change in an older cat, or it can also indicate a prior history of pancreatitis. If symptoms such as frequent vomiting or anorexia occur, then checking a pancreatic blood marker would be recommended.

The sediment in the bladder may be incidental, but given the presence of hematuria on the recent urinalysis, the possibility of urinary tract infection also exists. If the patient is showing symptoms of lower urinary tract disease (such as frequent urination or straining to urinate) then either a urine culture or an antibiotic trial would be recommended.

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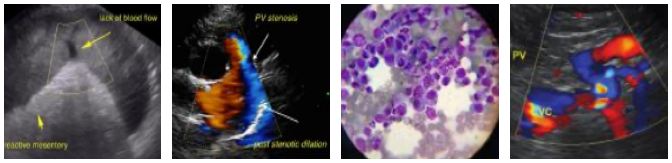

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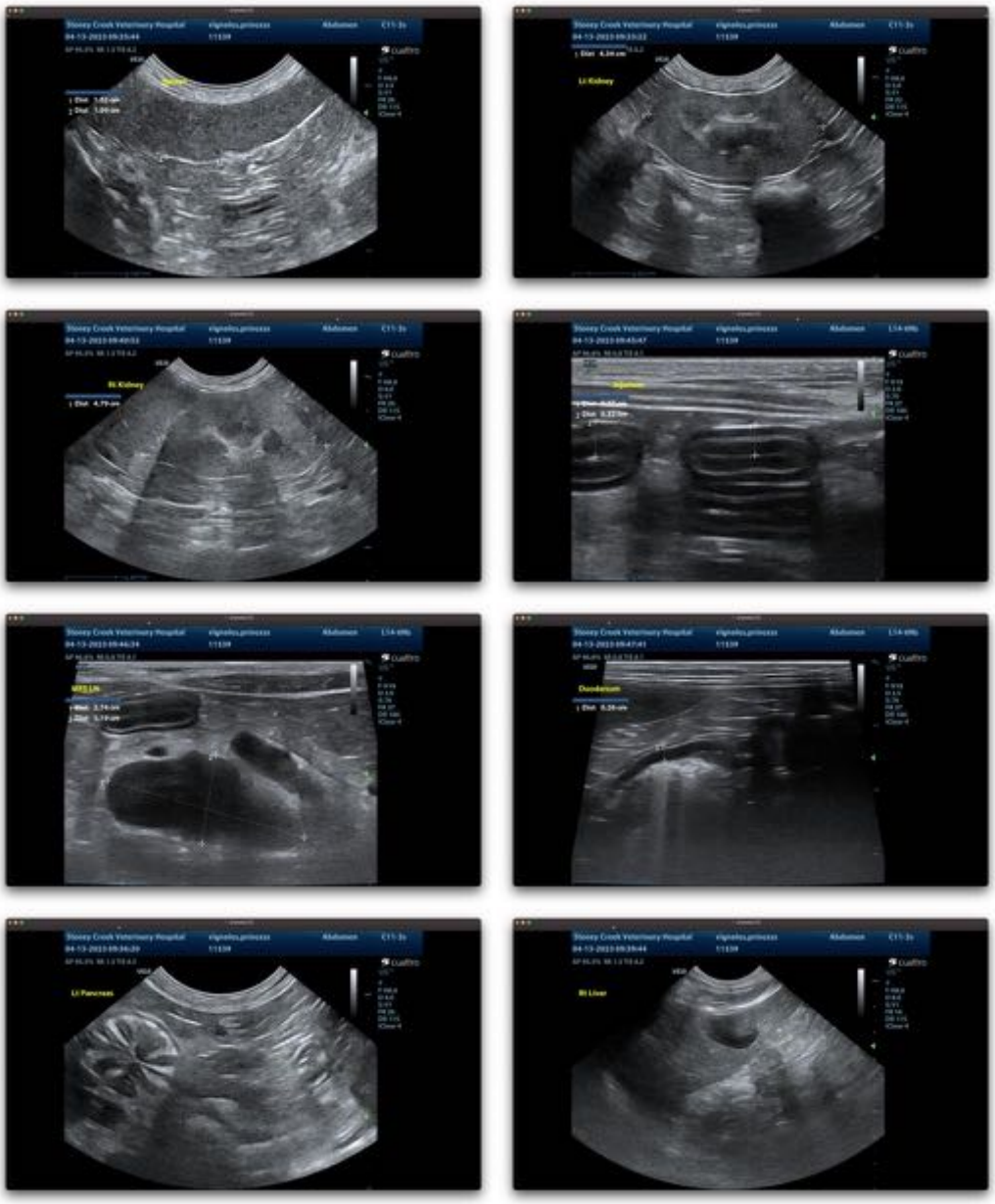

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Tam Mengine, DVM, DABVP (canine/feline practice) info@SonoPath.com