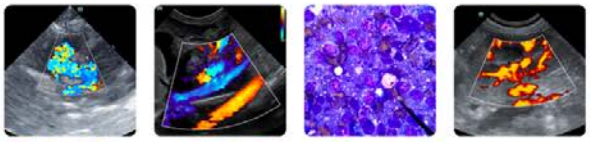


PATIENT

Boris Bippes

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Male

AGE

10 Years

WEIGHT

12.68 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Danielle Shemanski, DVM, MA

HOSPITAL NAME

Western New York Veterinary Services

REFERRING VET

Morgan Busby, DVM

INVOICE

72424

DATE

1/23/26

PRESENTING CLINICAL SIGNS

RDVM REASON FOR REFERRAL: Weight loss with no improvement on a steroid trial. No vomiting or diarrhea reported. Normal appetite. Indoor only. No parasites on fecal exam. Currently on a urinary diet, which he has been on for years. Previous blood work showed no definitive cause for weight loss. Calcium oxalate crystals were noted on urine sediment. He was previously on Prednisolone 5 mg once a day but has been off of it since the new year.

MEDICATIONS: Prednisolone 5mg SID - no response (tapered off last week)

Abnormal PE/Chem/CBC/UA Results: Globulin 5.2 g/dL Bilirubin - total = 1.4 mg/dL but liver values WNL TT4 = 1.9ug/dL Urine: wbc 2/hpf Urine Rbc 6/hpf

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended. The bladder wall appears thin and smooth. The urine is predominantly anechoic, with a small amount of suspended mineral sediment (“gravel-like”), without formation of a discrete urolith. The bladder neck and proximal urethra have a normal ultrasonographic appearance.

The left kidney is normal in shape and size, measuring 3.69×2.28 cm. Cortical thickness measures 0.26 cm in the sagittal plane. The renal cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

The right kidney is normal in shape and size, measuring 3.70×2.18 cm. Cortical thickness measures 0.33 cm in the sagittal plane. The renal cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

The left adrenal gland is partially visualized and measures 0.27 cm. The right adrenal gland measures 0.25 cm at the cranial pole and 0.23 cm at the caudal pole.

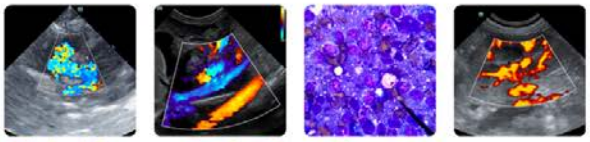
Spleen

Splenic thickness measures 0.77 cm. The splenic parenchyma demonstrates normal echogenicity with a fine, homogeneous echotexture. A small focal hyperechoic area measuring 2.63×2.73 mm is identified. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with sharp margins and a smooth, regular contour. The hepatic parenchyma is uniform and isoechoic relative to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is identified.

The gallbladder lumen is normally distended. The gallbladder wall is thin, and the contents are anechoic. The common bile duct measures 3.64 mm proximally, 2.18 mm mid-portion, and 0.72 mm distally.



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Gastrointestinal

The stomach is empty and folded, with intraluminal gas, a small amount of fluid, and minimal residual digested ingesta. Wall layering is preserved, and mural thickness measures 1.68 mm. The pylorus measures 2.45 mm.

Duodenum: mural thickness 1.83 mm.

Jejunum: mural thickness 2.90 mm; mucosa 1.34 mm; submucosa 0.78 mm; muscularis propria 0.72 mm. Ratio muscularis/mucosa: 0.54.

Ileum: mural thickness ranges from 2.16–2.54 mm; mucosa 0.86 mm; submucosa 0.73 mm; muscularis propria 0.58 mm. Ratio muscularis/mucosa: 0.67 mm.

The ileocecal junction measures 2.85 mm, with muscularis thickness of 0.93 mm.

Preserved wall layering throughout. No ultrasonographic evidence of gastrointestinal obstruction, ileus, or foreign material is identified.

Colon: the transverse colon wall measures 1.14 mm and contains formed fecal material with mild distal acoustic shadowing; the descending colon wall measures 1.04 mm and contains a small amount of formed feces.

Pancreas

The evaluated portions of the pancreas do not show ultrasonographic evidence of overt inflammation.

Free Abdomen

No abdominal effusion or sonographic evidence of peritonitis is identified. Cranial mesenteric and ileocecal lymph nodes are not visualized, and the surrounding regions appear unremarkable. The iliac trifurcation has a normal appearance.

PRIMARY FINDINGS

- Small amount of mineral sediment within the urinary bladder.
- Small focal hyperechoic splenic lesion (incidental myelolipoma).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This abdominal ultrasound examination is largely unremarkable, with preservation of normal organ size, architecture, and echogenicity throughout the abdomen. No ultrasonographic evidence of abdominal masses, significant lymphadenopathy, or infiltrative gastrointestinal disease is identified. Objective intestinal wall measurements and muscularis-to-mucosa ratios remain within expected limits in all evaluated segments, with preserved wall layering and no ultrasonographic evidence of diffuse intestinal inflammation or infiltrative disease at this time.

However, the absence of overt ultrasonographic gastrointestinal abnormalities must be interpreted cautiously in this case, as the patient recently underwent a therapeutic trial with prednisolone. Corticosteroid therapy may reduce intestinal mural thickening, lymphoid hyperplasia, and lymph node reactivity, potentially masking ultrasonographic changes associated with chronic inflammatory or

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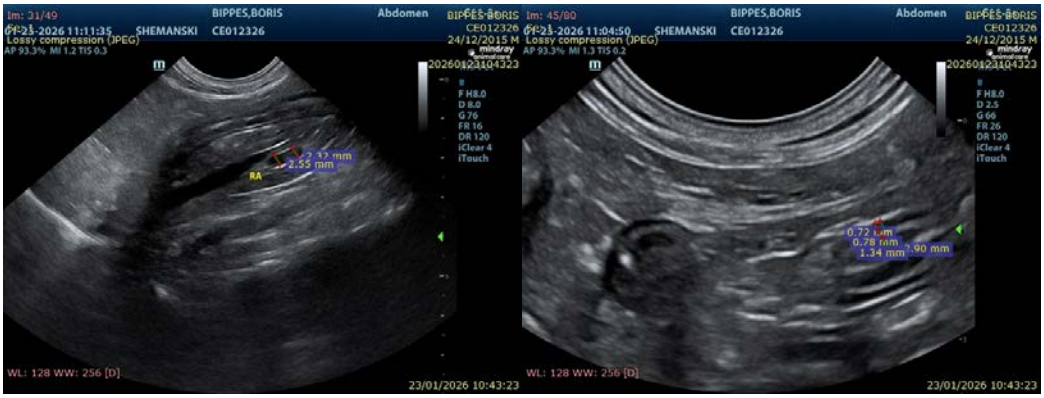
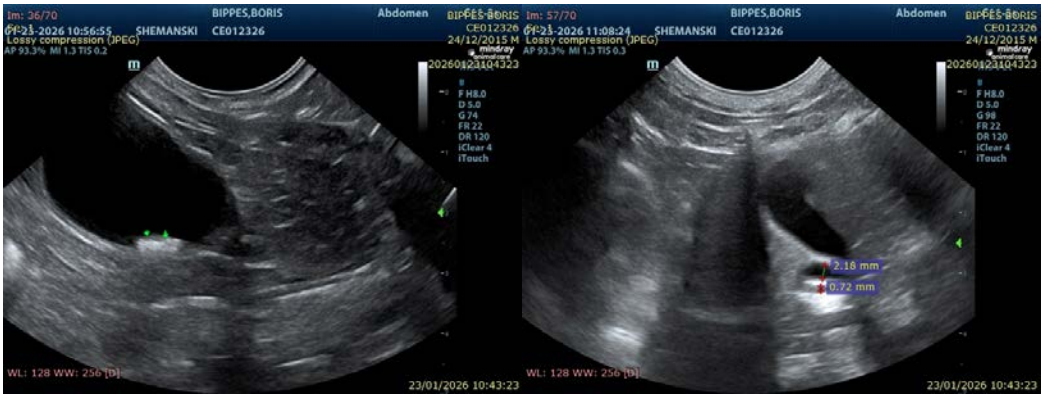
infiltrative gastrointestinal disease. Therefore, early or low-grade gastrointestinal pathology cannot be excluded based on this examination alone.

The small amount of mineral sediment within the urinary bladder is consistent with crystalluria or sediment and correlates with the history of calcium oxalate crystals, without evidence of urolithiasis.

Recommendations:

- Pursue a complete gastrointestinal panel, including serum cobalamin and folate concentrations, to further evaluate for malabsorptive or chronic inflammatory gastrointestinal disease; initiate cobalamin supplementation if deficiency is identified.
- Given the patient's history of urinary disease, the decision to modify the current urinary diet should be made in the context of prioritizing investigation of the ongoing weight loss, ideally after completion of a comprehensive gastrointestinal panel. Implement a highly digestible, novel-protein or hydrolyzed diet, with strict dietary control, may provide both therapeutic and diagnostic information, with urinary parameters monitored during any dietary transition.
- If clinical signs fail to improve, further diagnostic escalation may be warranted, recognizing that early inflammatory bowel disease or small-cell lymphoma may not be detectable on ultrasonography, particularly following corticosteroid exposure.





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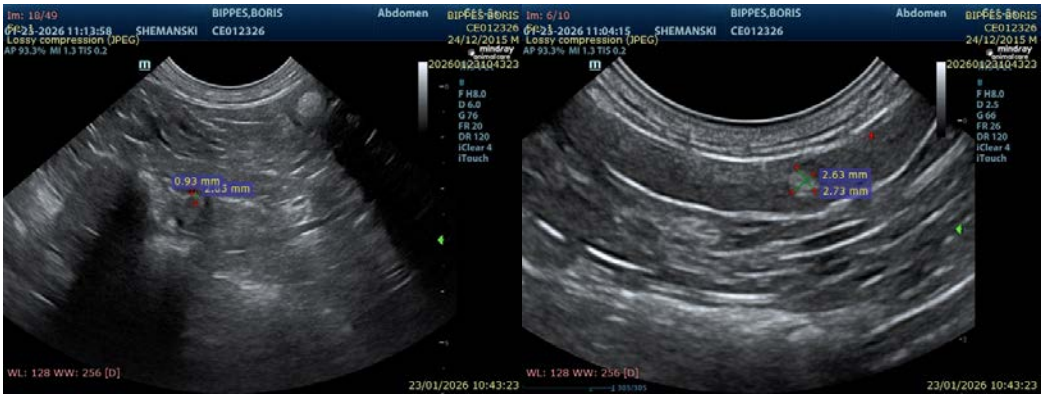

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

info@SonoPath.com