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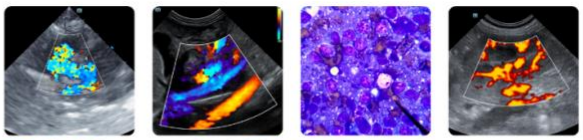

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Leo Stemmler

SPECIES

Feline

BREED

DSH

SEX

Male Neutered

AGE

4/11/2017

WEIGHT

3.88

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

BluePearl MP ER

REFERRING VET

Dr Alexis Starr

INVOICE

22383

DATE

1-15-2026

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: P was seen today for continued coughing, lethargy, inappetence, and loss of weight following consults at two previous veterinarians. O stated 12/30/25 P was seen at a veterinarian in James Island because P was losing weight, coughing, and PU/PD. At that time blood work showed hyperglycemia and P was started on amoxicillin (per O). 1/8/26 P was seen at Animal Medical West where BW showed a high fructosamine and radiographs showed bronchitis (per O). P was started on insulin, Miratax transdermal, and changed antibiotics. P has been getting 2U prozinc q12. P is no longer eating or drinking and seeking attention less often. Diabetic.

Abnormal lab-work values:
GLU: 240
CRE:0.6
BUN: 13
Sodium: 147
Chloride: 106
ALT: 183
ALP: 131
Total bili: 1.3
Cholesterol: 234
AMY: 1503
Reticulocyte Hemoglobin: 11.9
Eos: 0.13
PLT: 16

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. A large amount of aggregated, echogenic, suspended debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (3.39 cm in length) with a slightly irregular shape. The cortex is variably thickened. There is moderate to severe loss of corticomedullary distinction. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.12 cm in length) with a slightly irregular shape. The cortex is variably thickened. There is moderate to severe loss of corticomedullary distinction. Trace pyelectasia is present. There is a suspected cortical infarct at the craniolateral aspect. There is no evidence of nephroliths or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.29 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.39 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.78 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic

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vasculature is normal.

Liver
The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is hyperechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No cholеliths are observed. The cystic and common bile ducts are normal. The duodenal papilla is normal-in-size (0.19 cm in width).

Gastrointestinal
The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal. There is disruption in the normal 1:3 muscularis: mucosal ratio in several segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas
The pancreas is normal in size with normal peripheral contours. The pancreatic duct is normal. The base and limbs of the pancreas are isoechoic to surrounding omental fat. No focal lesions are observed. There is no evidence of peripancreatic inflammation or effusion.

Lymph Nodes
The abdominal lymph nodes are normal/not visible.

Free Abdomen
There is no obvious evidence of free fluid.

Other
A brief echocardiogram reveals no obvious evidence of pericardial or pleural effusion in the visible window.

ULTRASONOGRAPHIC FINDINGS

- The hepatic changes could be consistent with a diabetic hepatopathy, hepatic lipidosis, inflammatory disease (i.e., cholangiohepatitis, lymphoplasmacytic hepatitis, feline infectious peritonitis), emerging neoplasia (i.e., lymphoma) or some combination thereof.
- The small intestinal wall changes could be consistent with inflammatory bowel disease or may be a normal variant for this older feline patient. Correlation with the patient's clinical history is recommended.
- Bilateral chronic nephropathy. The trace pyelectasia may be secondary to parenchymal remodeling, pyelonephritis, PU/PD, fluid therapy (if applicable), or some combination thereof. There is also a suspected right cortical infarct.
- The urinary bladder debris could be consistent with cells, crystals, exfoliated material, mucus, and/or lipid droplets.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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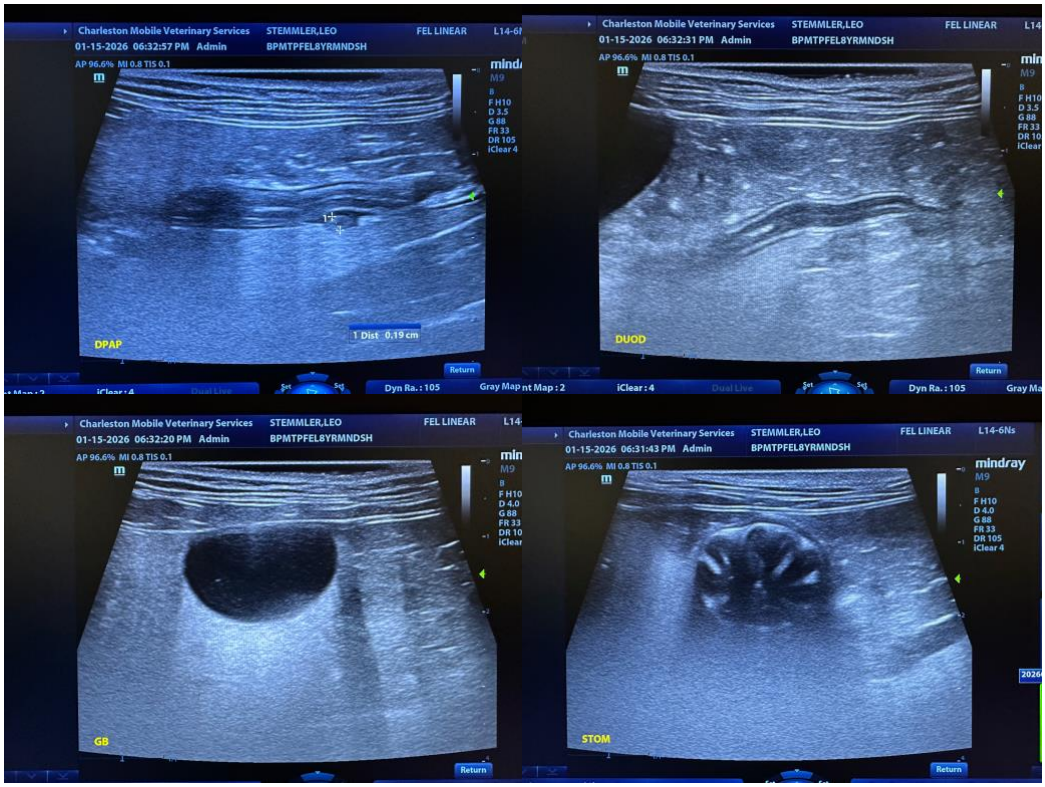
- A urinalysis with a culture and sensitivity are recommended.
- Regarding the hepatic changes and the elevated liver values, consider fine-needle aspiration (assuming normal clotting status). A 25-gauge needle should be used. Aerobic and anaerobic bile cultures would also be beneficial.
- Feline leukemia, FIV, and FIP testing can also be considered.
- If the patient has a history of chronic and/or intermittent GI signs, also consider a GI panel including serum cobalamin and folate, TLI and PLI.
- While awaiting test results, supportive care (including nutritional support as needed) is recommended.



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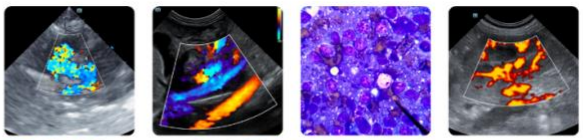

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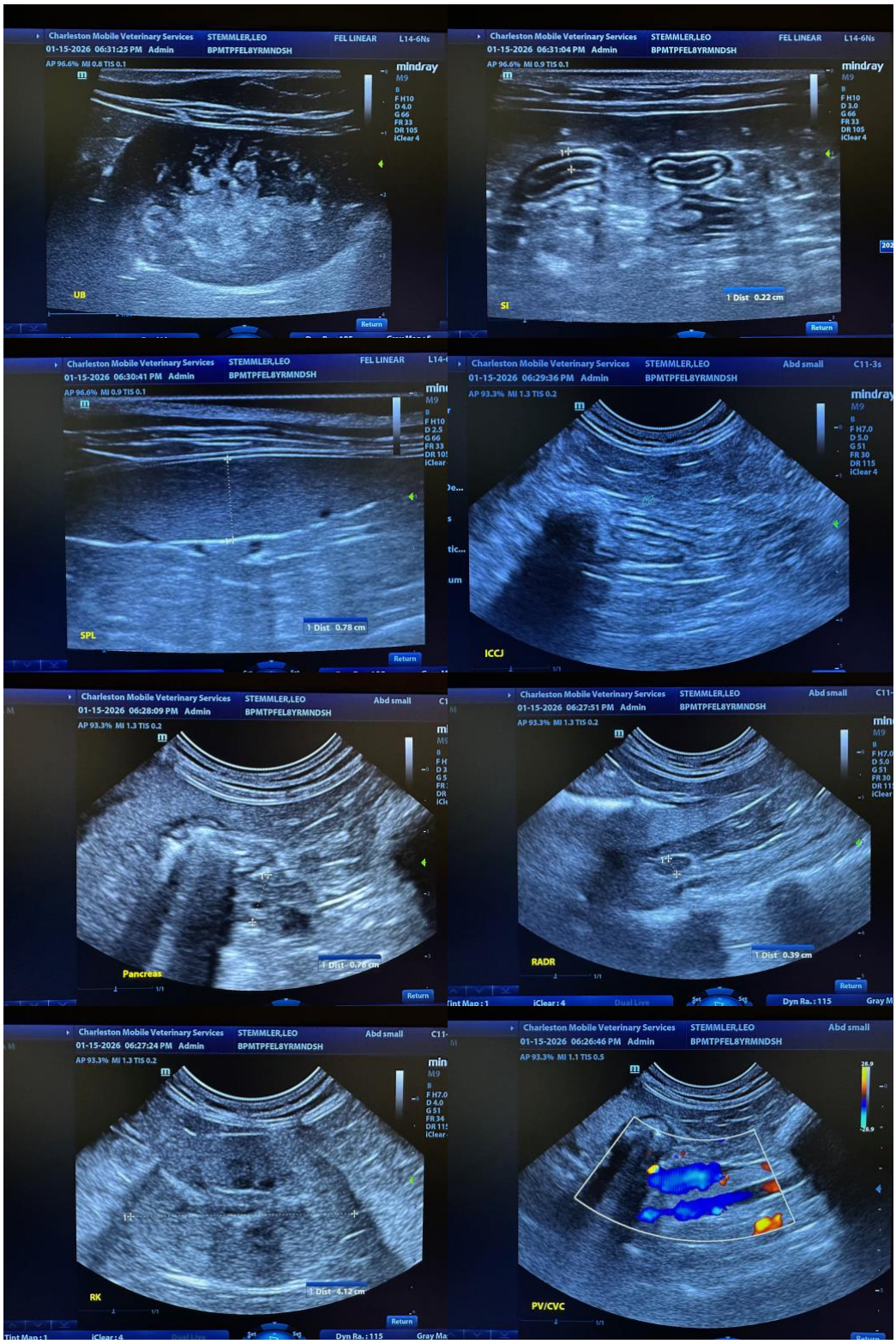

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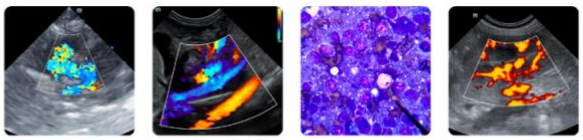

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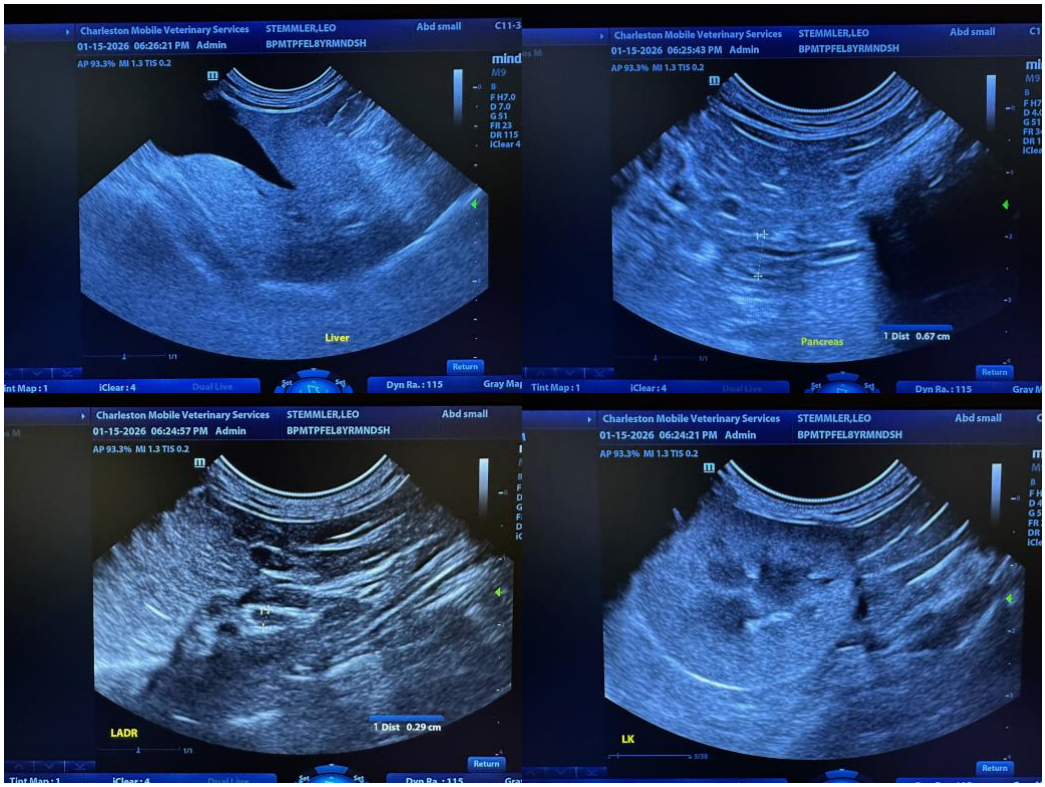

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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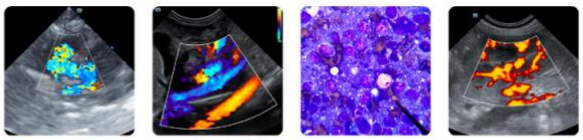

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