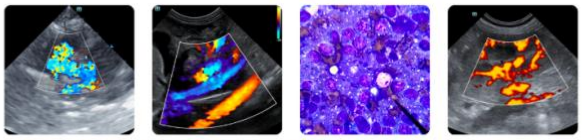


DATE

1-23-26

PATIENT

Mr. Black Weatherholtz

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

11/28/2012

WEIGHT

13.4lbs

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Animal EH

REFERRING VET

Dr. Heresniak

INVOICE

22441

PRESENTING CLINICAL SIGNS

Patient History: Recent acute onset lethargy, anorexia, adipsia since client's return from travel (was gone for two days). - No purring, not greeting client, not food-motivated (out of character). - Weight loss: 15 lb (approx. 6.8 kg) to 13 lb (approx. 5.9kg) over 1–2 months. - Diagnosed diabetes mellitus since 2020. - Current insulin: 1Unit BID (client-administered, Lantus). - Chronic vomiting x several months: variable volume, sometimes bile, sometimes clear, occasional kibble. - Previous history of urethral obstruction (approx. 2013); managed with Purina UR, transitioned to Purina DM after diabetes diagnosis.

Current Medications: None listed.
Labwork Results: Globulin 5.7. cPL elevated. PCV 32% (Labwork attached).
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: STAT requested.
Imaging Performed by: Rachel Brilhart, RDMS.

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. Luminal contents are mostly anechoic. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (4.76 cm in length) with a normal shape, architecture and smooth peripheral margins. The cortex is hyperechoic relative to the spleen, with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.93 cm in length) with a normal shape, architecture and smooth peripheral margins. The cortex is hyperechoic relative to the spleen, with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.48 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.38 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

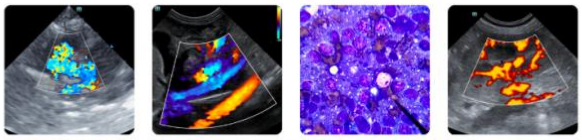
Spleen

The spleen is enlarged (1.22 cm in width at the level of the hilus) with scalloping of the medial contour. The parenchyma is subtly mottled in appearance. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is hypoechoic 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 gallbladder is moderately distended. The wall is mildly-thickened (up to 0.19 cm) and hyperechoic. A small amount of aggregated echogenic debris is observed within the lumen. The cystic and common bile ducts are normal. The duodenal papilla is normal-in-size (0.29 cm in width).



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Gastrointestinal

The gastric lumen is mildly fluid-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 is normal to mildly-thickened (up to 0.31 cm). There is disruption in the normal 1:3 muscularis: mucosal ratio in several segments. In some areas, there is a trend toward a loss of the normal layering pattern. At the ileocecocolic junction, there is a 1.0 cm focal area of wall thickening (measuring 0.59 cm in width). In this region, the wall is hypoechoic, with loss of layering. The colonic wall is normal. There is no obvious evidence of an obstructive pattern.

Pancreas

The base and left limb of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is largely hypoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph Nodes

A few prominent mesenteric lymph nodes are observed adjacent to the ileocecocolic junction (one measuring 1.86 x 0.52 cm).

Free Abdomen

Trace free fluid is observed. In addition, a 0.73 x 0.29 cm gastric lymph node is seen.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The small intestinal wall changes could be consistent with emerging neoplasia (i.e., lymphoma or inflammatory bowel disease).
- The focal cecal wall thickening could be consistent with emerging neoplasia, focal inflammatory process, other.
- The splenic parenchymal changes could be consistent with emerging neoplasia (i.e., lymphoma, lymphoid hyperplasia, extramedullary hematopoiesis, splenitis, antigenic stimulation, other.
- The hepatic parenchymal changes could be consistent with emerging neoplasia, inflammatory disease, congestion, other hepatopathy.
- The gallbladder wall changes could be consistent with cholecystitis, age-related hyperechoic, or may be a normal variant for this patient. Correlation with the patient's liver values is recommended.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Trace ascites

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Secondary Findings

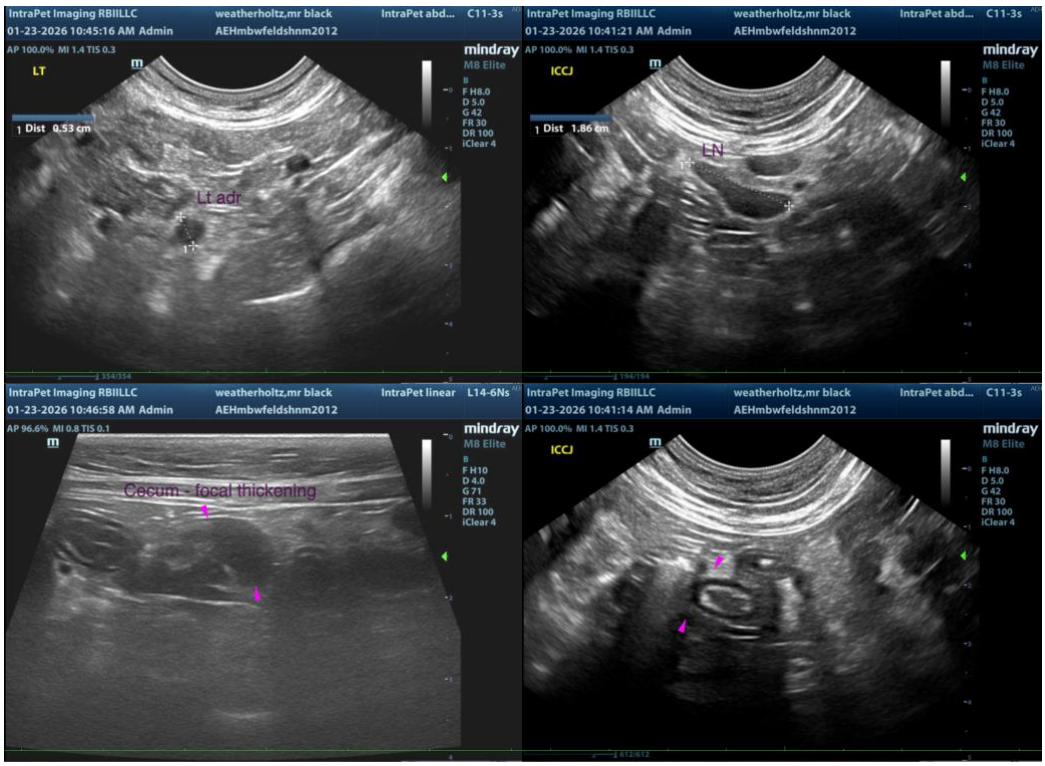
- Bilateral nonspecific age-related renal changes

*Given the sonographic changes, "triaditis" is a consideration in this patient.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

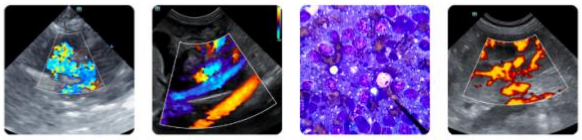
Given the sonographic changes, consider the following:

1. Fine-needle aspiration of the spleen and liver (assuming normal clotting status). Twenty-five gauge-needles should be used.
2. Three-view thoracic radiographs to assess cardiopulmonary status
3. GI panel including serum cobalamin and folate, TLI and PLI
4. A CBC, urinalysis, and T4 are also recommended (if not already performed).
5. If the above diagnostics are inconclusive, an abdominal exploratory with hepatic, GI, and abdominal lymph node biopsies may be necessary to get a definitive diagnosis. In the meantime, symptomatic care is recommended.



Imaging performed by IntraPet Imaging

IntraPet.com



Clinical Sonography & Telecytology
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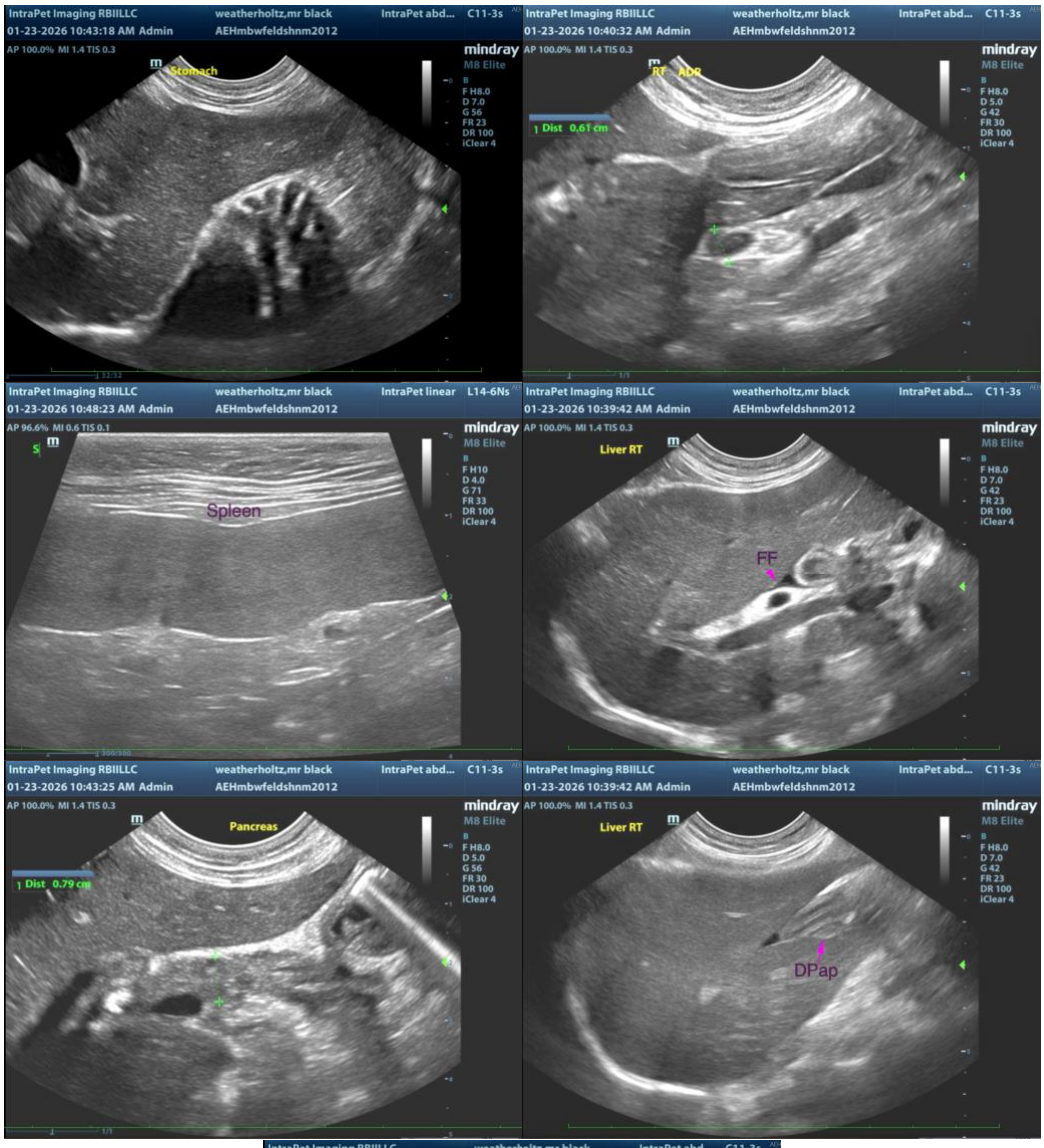
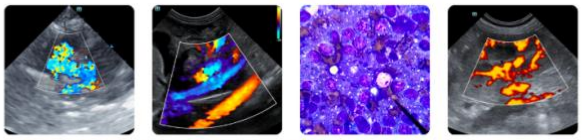


The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in



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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)
info@SonoPath.com