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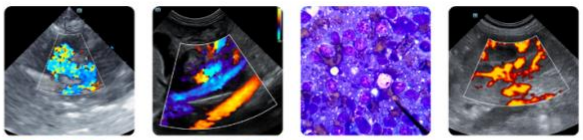

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

**PATIENT**

Darwen Gamble

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

8

**WEIGHT**

11 lbs

**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**

The Cats Meow Clinic

**REFERRING VET**

Dr Levy

**INVOICE**

22295

**DATE**

11-21-25

## PRESENTING CLINICAL SIGNS

Patient has a history of diabetes and is on insulin. Is losing weight over the past three weeks, but appears to be eating more. Currently on 4 units of Vetsulin q 12 hr. Mild leukocytosis with a neutrophilia and monocytosis. GGT 15. T4 normal.

## 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 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 size (4.42 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is mildly thickened and there is 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 (4.35 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio 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 (0.42 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.43 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

### *Spleen*

The spleen is normal in size (0.87 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 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 lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal. The duodenal papilla is normal-in-size (0.26 cm in width).

### *Gastrointestinal*

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is mildly distended with ingesta. 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 diffusely thickened (up to 0.39 cm). There is disruption in the normal 1:3 muscularis: mucosal ratio in segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

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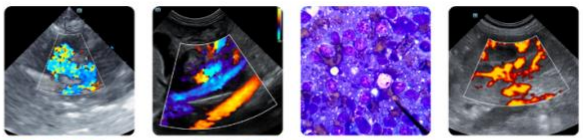

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***Pancreas***
The base and limbs are diffusely prominent-in-size with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and mottled in appearance. The pancreatic duct is borderline dilated (0.22 cm in diameter). The mesentery effacing the serosal surface of the right limb is slightly hyperechoic.

***Lymph Nodes***
A few prominent mesenteric lymph nodes are visualized (one measuring 0.7 x 0.47 cm).

***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

### Primary Findings

- The hepatic changes could be consistent with a diabetic hepatopathy, inflammatory disease (i.e., cholangiohepatitis, lymphoplasmacytic hepatitis), emerging hepatic lipidosis, infiltrative neoplasia (i.e., lymphoma), and/or other hepatopathy.
- The small intestinal wall changes are suggestive of inflammatory bowel disease, with a lower possibility of emerging small cell lymphoma.
- The pancreatic changes are suggestive of chronic, +/- active pancreatitis, with parenchymal remodeling.

### Secondary Findings

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Bilateral nonspecific age-related renal changes

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

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Orthopedic and neurologic examinations are recommended to assess for nonmetabolic causes of weight loss.
- Consider a fecal evaluation for ova and Giardia, along with a GI panel including serum cobalamin and folate, TLI and PLI.
- A 3-4-week limited antigen or hydrolyzed protein diet should also be considered.
- Fine-needle aspiration of the liver is also a consideration to rule out round cell neoplasia, particularly if clinical suspicion for disease is high. Clotting times should be performed prior to aspiration.

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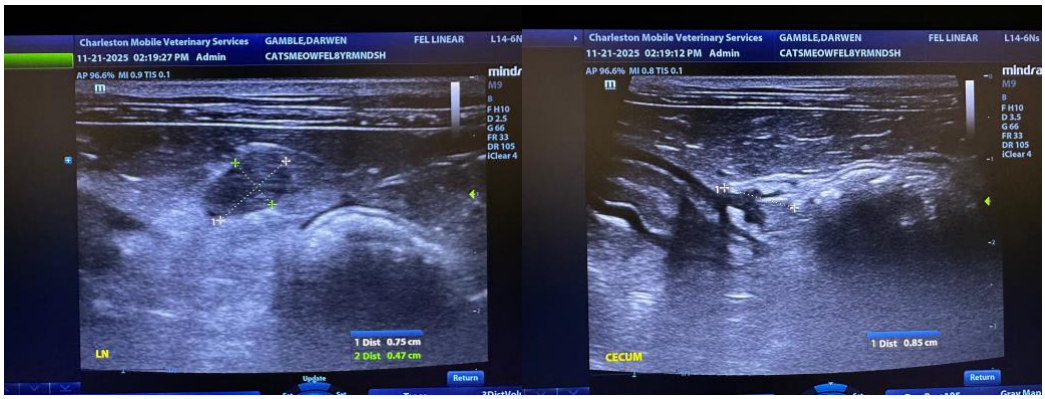
- Three-view thoracic radiographs should also be considered to assess for occult pathology in the chest.
- Given the patient is diabetic, also consider a urinalysis with culture and sensitivity to assess for occult infection.
- Depending on the results of the above diagnostics, further work-up may be indicated.



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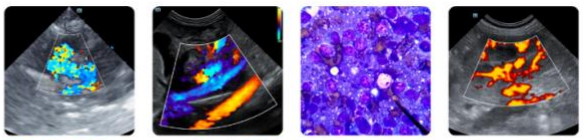

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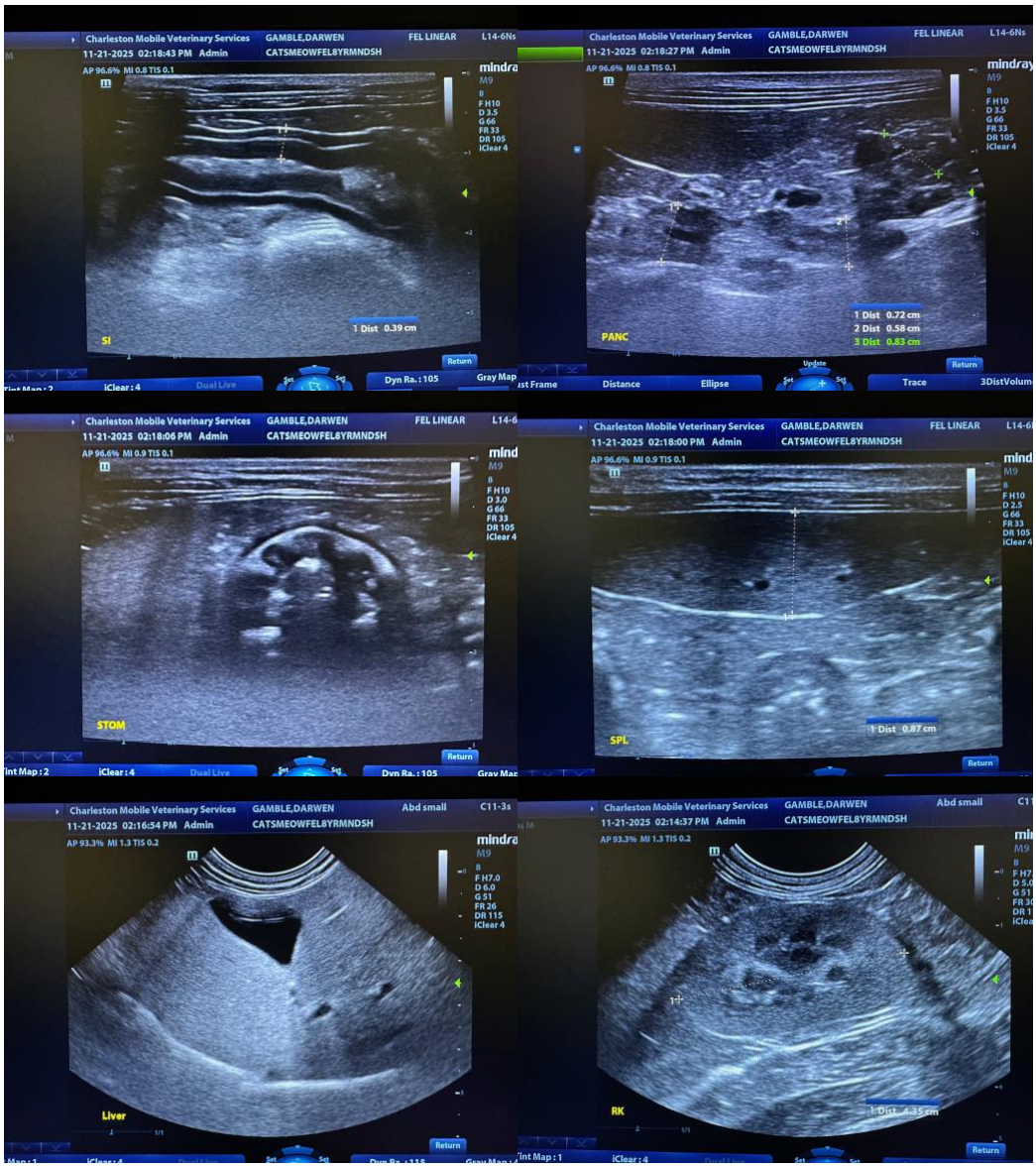

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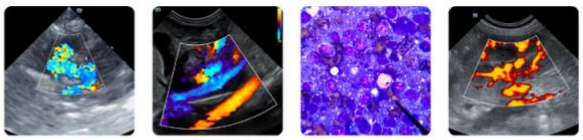

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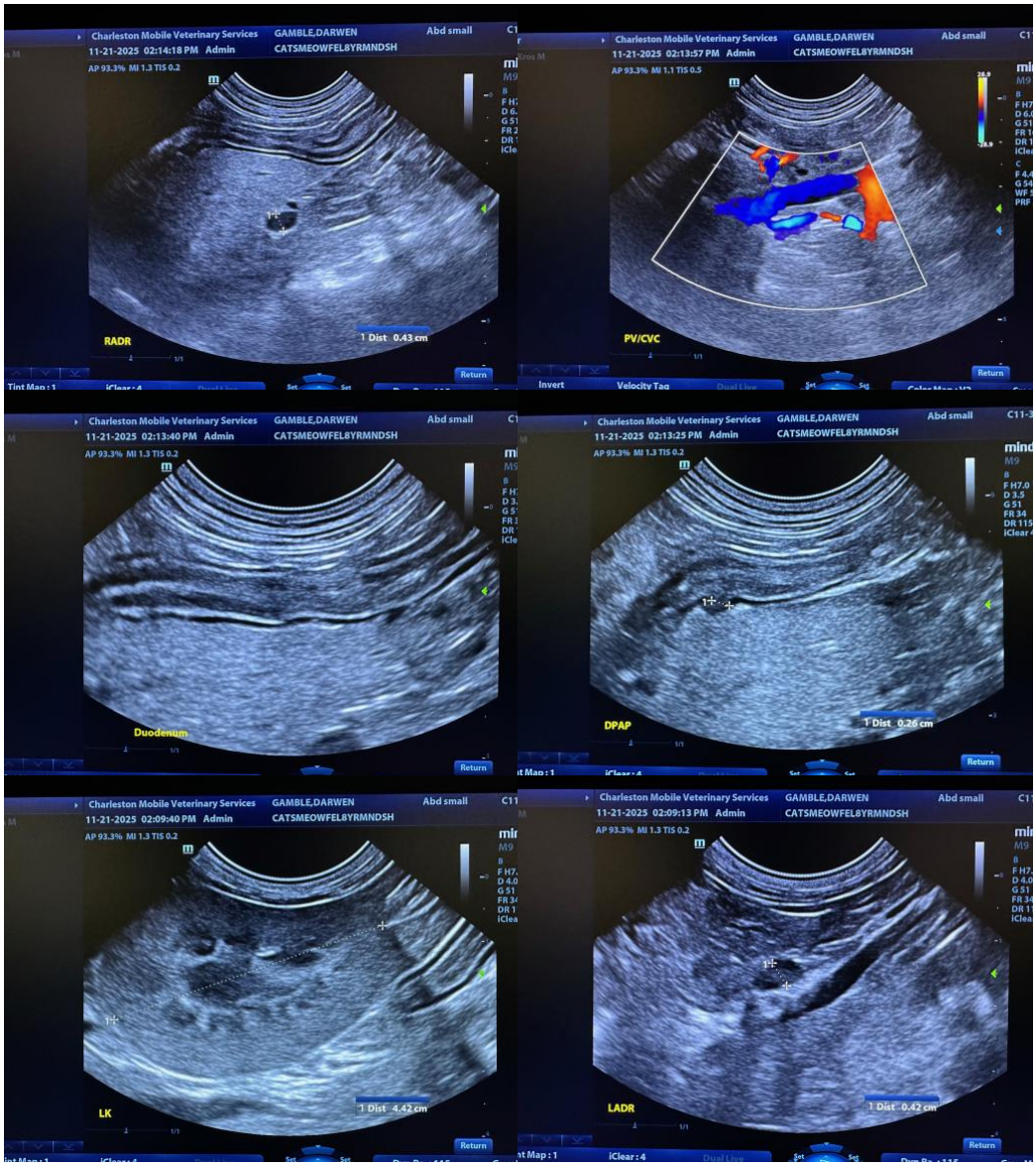

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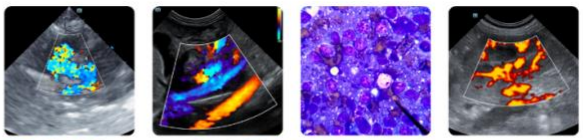

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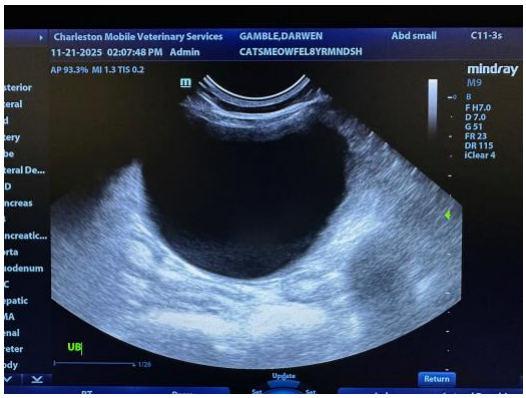


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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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