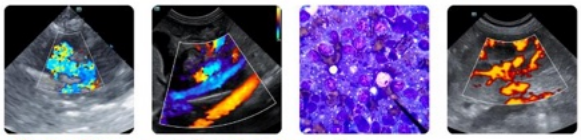


DATE

12/15/25

PATIENT

Rory Victor

SPECIES

Feline

BREED

Domestic shorthair

SEX

Male, neutered

AGE

6/8/2008

WEIGHT

7.19 lbs.

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

HOSPITAL NAME

Warm and Fuzzy Vet Center

REFERRING VET

Dr. Williams

INVOICE

13434

PRESENTING CLINICAL SIGNS

Patient History: Presented for weight loss despite increased appetite- daughter cat also had history of elevated liver values, is hyperT4

Current Medications: None.
Labwork Results: Labwork attached, reported as: Senior Profile: CBC NSF. BUN 33, Cr 2.2, SDMA 18, ALT 450, ALKP 225, AST 117, Tbil 0.7, Chol 363. T4 2.4 (gray zone) - FREET4 by ED -PENDING. UA SG 1.019, Protein TRACE
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and 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 the visible portion of the proximal urethra are normal.

The left kidney is normal in size (3.68 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate 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 (3.62 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with 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 (0.29 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.32 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 vasculature is normal.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous in appearance. There is a subtle increase in portal markings. Vascular is of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1:1.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated, echogenic, partially dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are visible/tortuous with mild dilation (up to 0.26 cm). The common bile duct can be followed to the level of

the duodenal papilla which is normal in size (0.24 cm in width). There is no obvious evidence of an intraluminal obstruction.

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 is normal to mildly thickened (up to 0.26 cm). There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The base and limbs of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is slightly 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 of the nodes measuring 0.65 x 0.47 cm. Surrounding mesentery is mildly hyperechoic.

Free Abdomen

There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The increase in hepatic portal markings is most consistent with an inflammatory hepatopathy (i.e., bacterial cholangiohepatitis, lymphoplasmacytic hepatitis). Other considerations include emerging hepatic lipidosis, emerging neoplasia and/or other hepatopathy.
- The small intestinal wall changes could be consistent with inflammatory bowel disease or less likely, emerging small cell lymphoma.
- 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.

Secondary Findings:

- Bilateral nonspecific, age-related renal changes

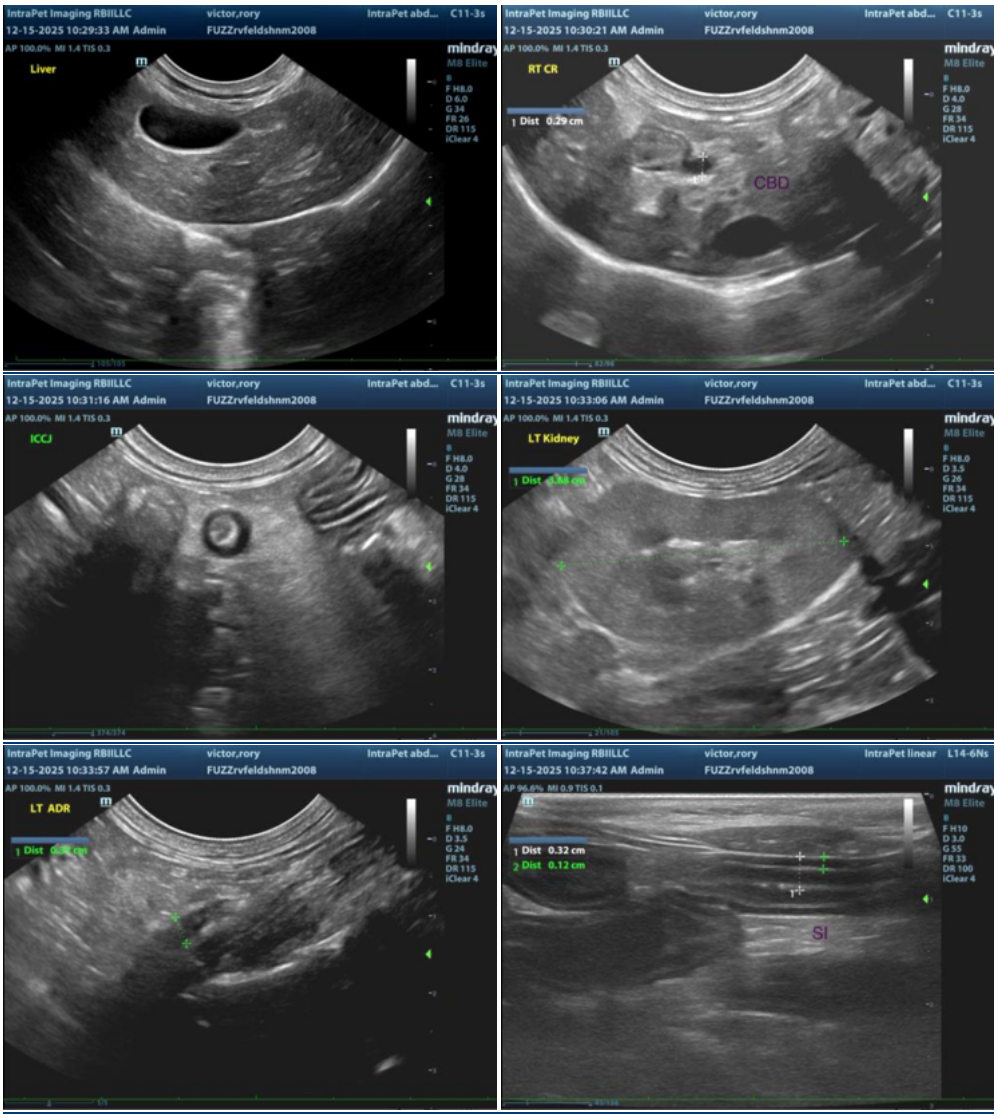
*Given the sonographic changes, “triaditis” is a consideration in this patient.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the patient’s clinical history and sonographic changes, consider the following:

1. Hepatic tissue sampling (i.e., aspirates or biopsies) with aerobic and anaerobic bile cultures (assuming normal clotting status)
2. GI panel including serum cobalamin, folate, TLI and PLI
3. Fecal evaluation for ova and Giardia

4. 3-4 week limited antigen or hydrolyzed protein diet trial
5. +/- endoscopic or surgical GI biopsies
6. Three-view thoracic radiographs to assess cardiopulmonary status, particularly in light of the patient's age.

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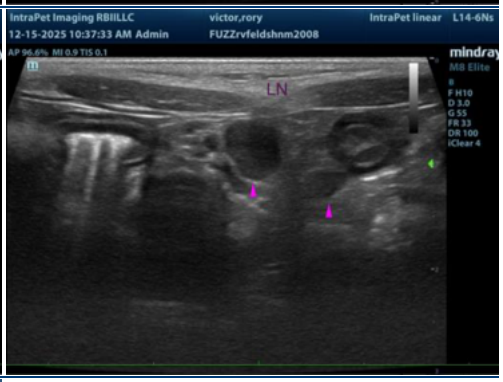
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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) info@SonoPath.com