PATIENT

Dusty Williams

SPECIES

Feline

BREED

DLH

SEX

Male Neutered

AGE

7Y 9M

WEIGHT

4.56

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

Blue Pearl MP ER

REFERRING VET

Graham

INVOICE

22746

DATE

3-26-26

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Dusty is a 7Y 9M MN DLH presenting as a DT for DKA. O states that pt was diagnosed with DM in November 2025. O notes that it has been difficult to manage and pt has not been regulated, as his insulin has been adjusted every 2-3 weeks. O says that pt has remained PU/PD since November. O says that she noticed pt did not eat dinner on Tuesday PM, and was lethargic by Wednesday. O brought pt into rDVM today, and had diagnostics performed (see below). Pt was referred here for further care DKA. No v/c/s/d. UTD on vaccines, not UTD on hw/flea prevention, indoor only, no known allergies per O

Medications: 1U of Lantis yesterday morning (pt normally has 2U BID)

Abnormal lab-work values:
- BG: 430 mg/dL
- CBC: MCH 17.0 **H** (11.6-16.8), WBC 15.1 **H** (4-14.5), NEU 13.9 **H** (1.4-9.7), MPV 10.3 **L** (11.2-19.7), RTC 157 **H** (0-60)
- Chemistry: BUN 42 **H** (10-30), remainder of values THTR (lipemic)
- Urinalysis (cystocentesis, pale yellow): USG >1.050, pH 6, Glucose 500+, Ketones 1000+, trace protein; Sediment: rare WBC, rare cocci
- Radiographs (3-view thorax, 1-view abdomen): Cardiac silhouette appears subjectively normal. Mild generalized bronchial pattern. Liver margins are rounded. Stomach is empty. Small intestinal loops contain gas and fluid. Urinary bladder is intact and moderately distended
- 3/26 3PM CHEM 17: GLU 420 mg/dL **H**, Chloride 111 mmol/L **L**, ALT 142 U/L **H**, TBIL 1.4 mg/dL **H**, Cholesterol 304 mg/dL **H**, AMYL 480 U/L **L**
- 3/26 3PM chem 8: Na 143 mmol/L **L**, TOC2 13 mmol/L **L**, BUN 41 mg/dL **H**, GLU 418 mg/dL **H** Blood Ketones: 6.1

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 the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (4.04 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.97 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal 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 (0.46 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.40 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.51 cm in width at the level of the hilus) with a normal capsular

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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 gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No cholelithsare observed. The cystic and common bile ducts are normal. The duodenal papilla is normal-in-size (0.17 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 is normal to mildly-thickened (up to 0.28 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 left limb and base are enlarged, with swollen peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and homogenous in appearance. The pancreatic duct is visible but not overtly dilated (0.15 cm in width). Surrounding mesentery is mildly hyperechoic.

Lymph Nodes

One- to two prominent left cranial abdominal lymph nodes are visualized (one measuring 0.80 x 0.57 cm).

Free Abdomen

Trace free fluid is observed.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The pancreatic changes are suggestive of mild- to moderate pancreatitis with adjacent peritonitis.
- The hepatic changes could be consistent with hepatic lipidosis, inflammatory disease (i.e., cholangiohepatitis, lymphoplasmacytic hepatitis, feline infectious peritonitis), emerging neoplasia (i.e., lymphoma) or some combination thereof.

Secondary Findings

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The small intestinal wall changes could be consistent with inflammatory bowel disease or may be a normal variant for this patient. Correlation with the patient's long-term clinical history is recommended.

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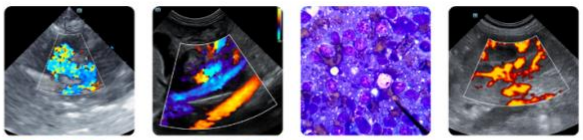

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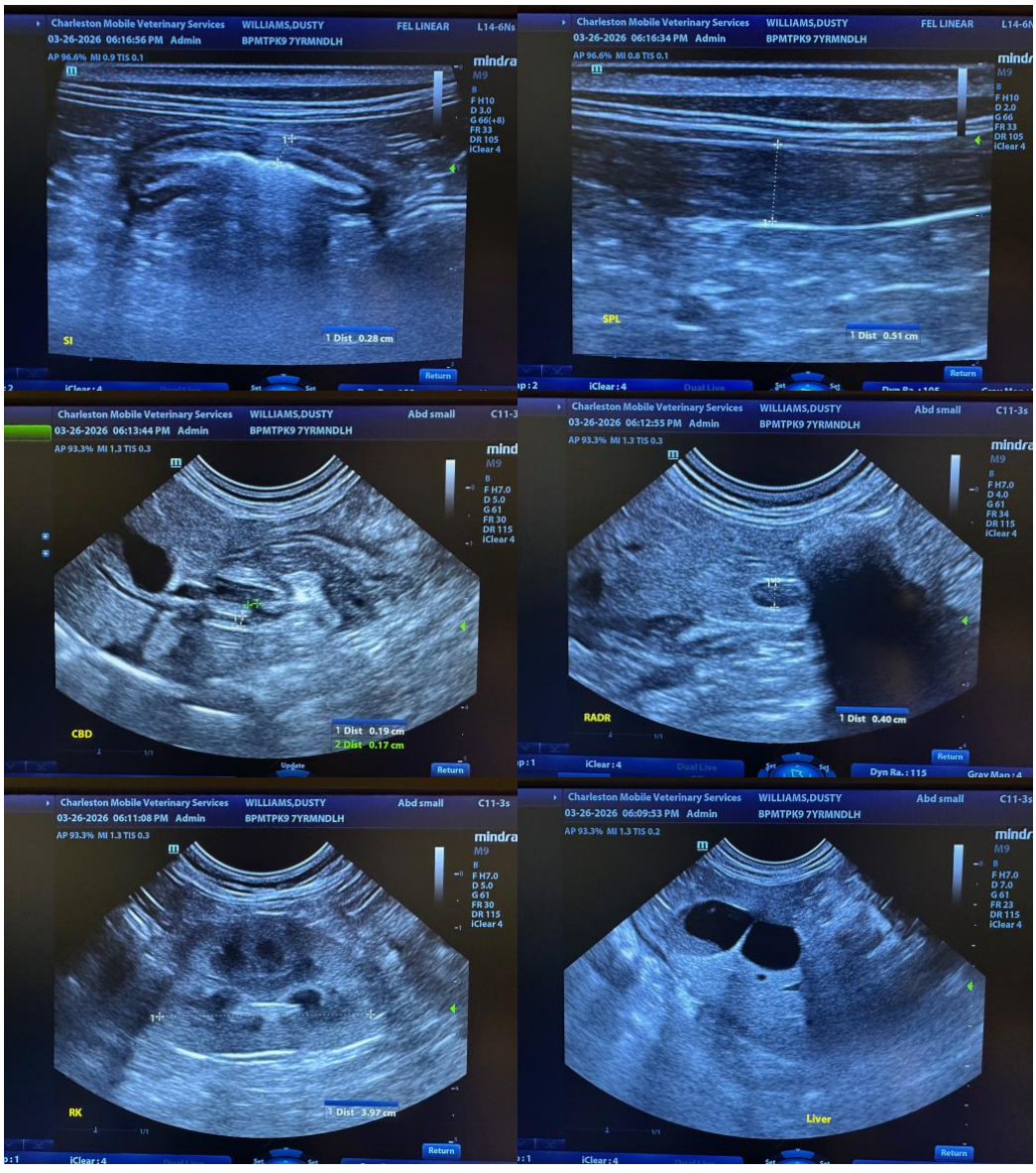
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider a GI panel including serum cobalamin and folate, TLI and PLI.
- Also consider fine-needle aspiration of the liver (assuming normal clotting status). Twenty-five gauge-needles should be used.
- While awaiting test results, supportive care is recommended.



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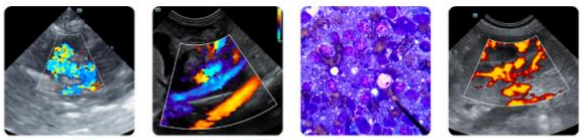

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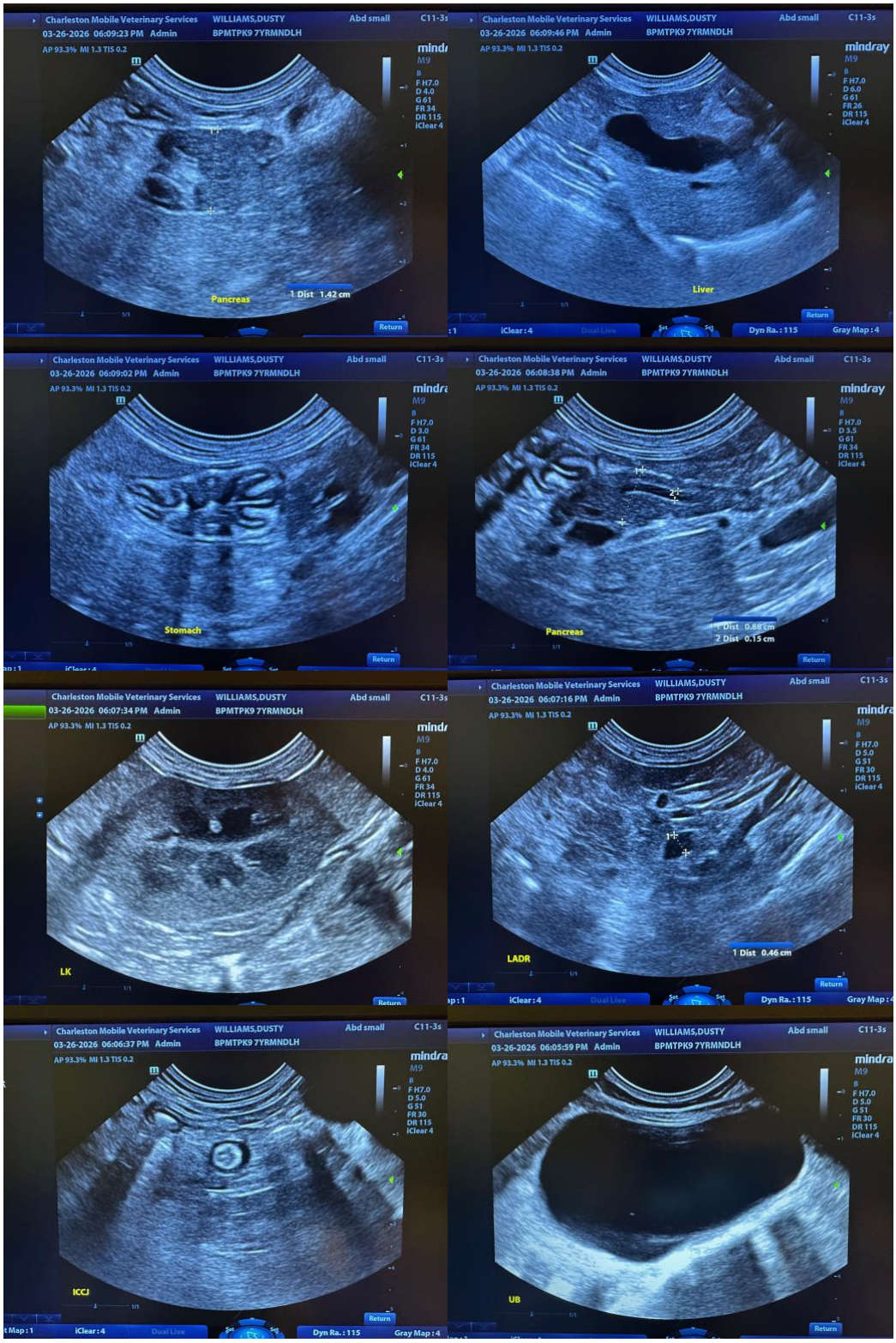

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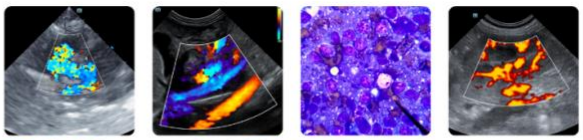

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com