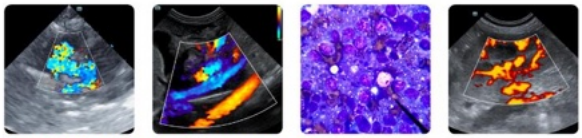

PATIENT

Sampson Paleo

SPECIES

Feline

BREED

Domestic longhair

SEX

Male, neutered

AGE

4/7/20

WEIGHT

8.8 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Pawleys VH

REFERRING VET

Dr. Kiningham

INVOICE

13677

DATE

4/22/26

PRESENTING CLINICAL SIGNS

Chronic diarrhea
Occasional vomiting
Significant weight loss within the year
Not eating and drinking well

Lab work performed in February including a CBC chemistry panel, T4, urinalysis and fecal all normal. This lab work was performed at a different hospital. Has only been to Pawleys Vet for one visit. Received a Depo injection on 3/6. Has been on a urinary diet.

Pt sedated with Ketamine and Diazepam for this study.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

*Recent Depo Medrol injection may be masking underlying pathology.

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. The wall is normal in thickness with a smooth mucosal surface. Mobile mineralized sand is observed within the lumen +/- tiny calculi. 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 (3.52 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (4.04 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.30 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 (0.73 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 to slightly 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.

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The gall bladder 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 at 0.31 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 segmentally dilated with gas and chyme. The small intestinal wall is normal to mildly thickened (up to 0.30 cm). There is disruption in the normal 1:3 muscularis: mucosal ratio with a 1:1 ratio in some segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The left limb is visible/prominent with normal peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat and homogeneous in appearance. The pancreatic duct is not overtly dilated.

Lymph nodes

A few prominent mesenteric lymph nodes are visualized, one of the nodes measuring 1.23 x 0.60 cm. A 0.44 x 0.41 cm gastric lymph node is also seen.

Free Abdomen

Trace ascites is present.

Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The small intestinal wall changes could be consistent with inflammatory bowel disease or emerging lymphoma.
- Trace ascites
- The slightly hyperechoic liver may be a normal variant for this patient or could indicate an emerging hepatopathy (i.e., hepatic lipidosis, inflammatory disease, infiltrative neoplasia (i.e., lymphoma), other).

Secondary Findings:

- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Mild bilateral nonspecific, age-related renal changes with dystrophic mineralization
- Urinary bladder sand +/- tiny cystic calculi

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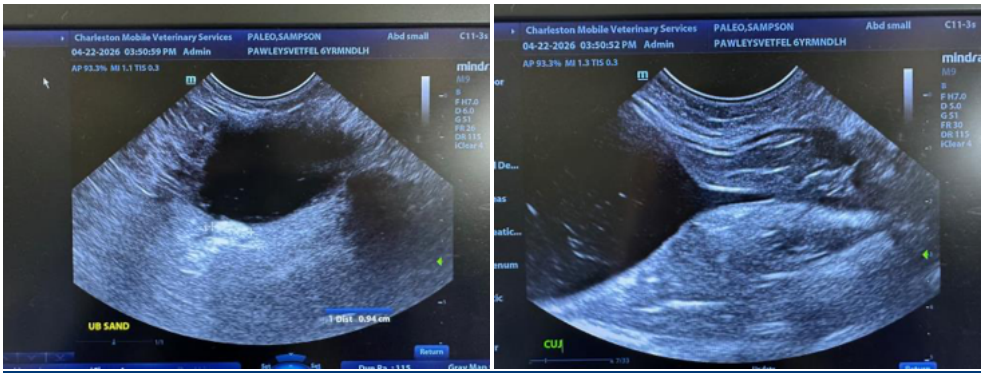
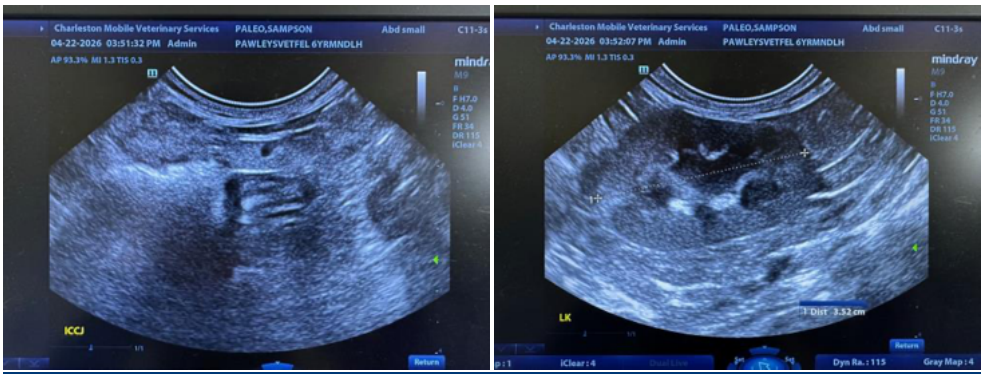
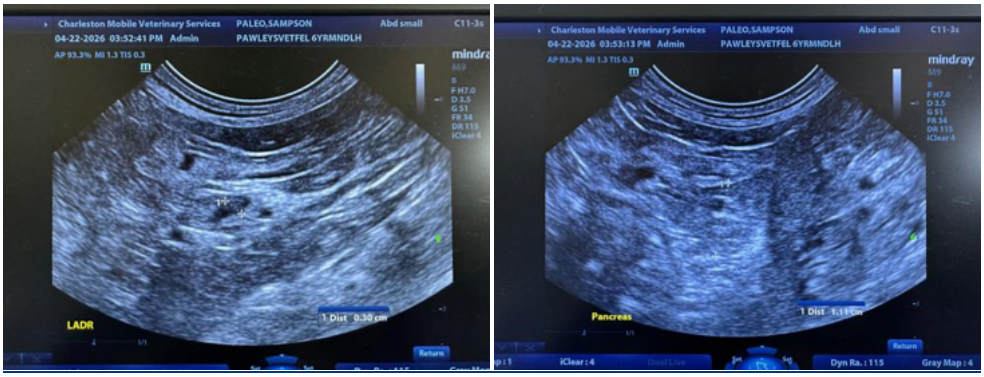
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. Repeat baseline lab work including a CBC chemistry panel and urinalysis is recommended to assess overall metabolic function.
2. Consider a GI panel including serum cobalamin, folate, TLI and PLI.
3. Initiation of a limited antigen or hydrolyzed protein diet is also recommended to assess for food allergies.
4. Ultimately, endoscopic or surgical GI biopsies may be necessary to get a definitive diagnosis. If biopsies are not pursued, empirical treatment for inflammatory bowel disease (i.e., corticosteroids, limited antigen diet, cobalamin supplementation) can be considered as long as the client understands the risks of treatment without a definitive diagnosis.







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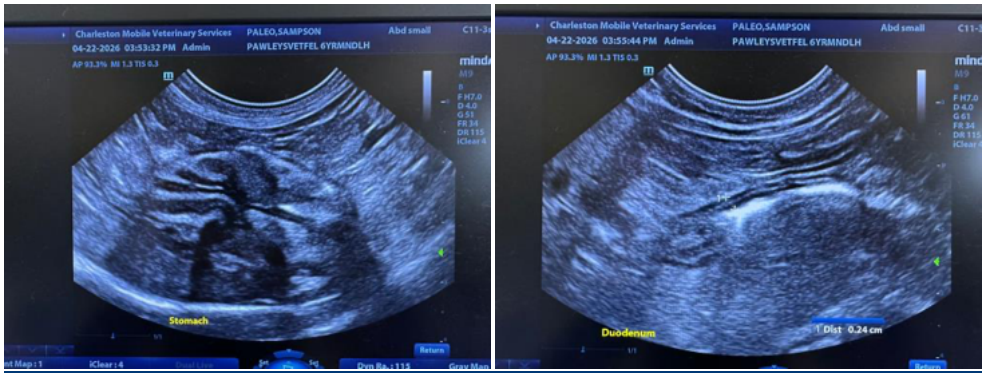

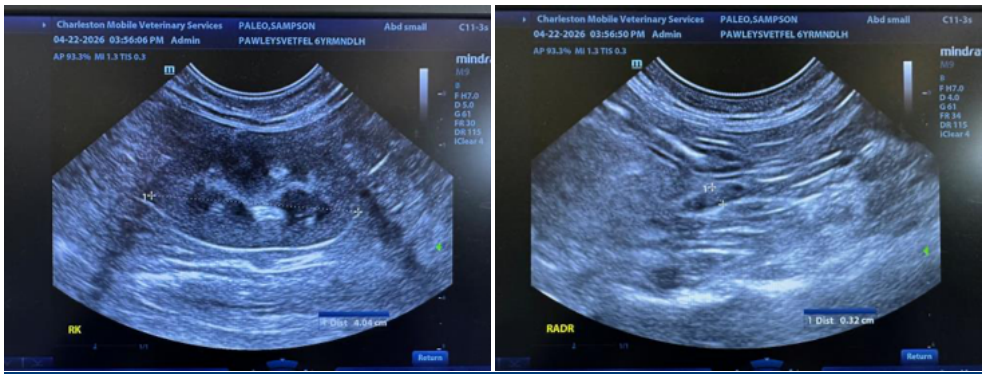

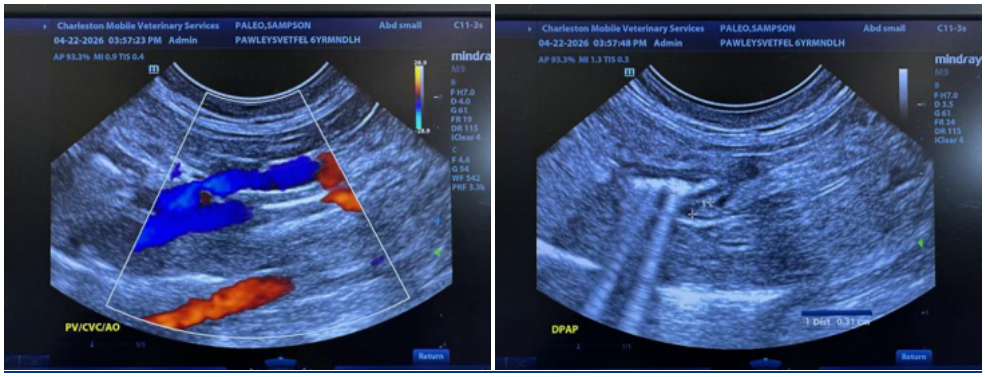

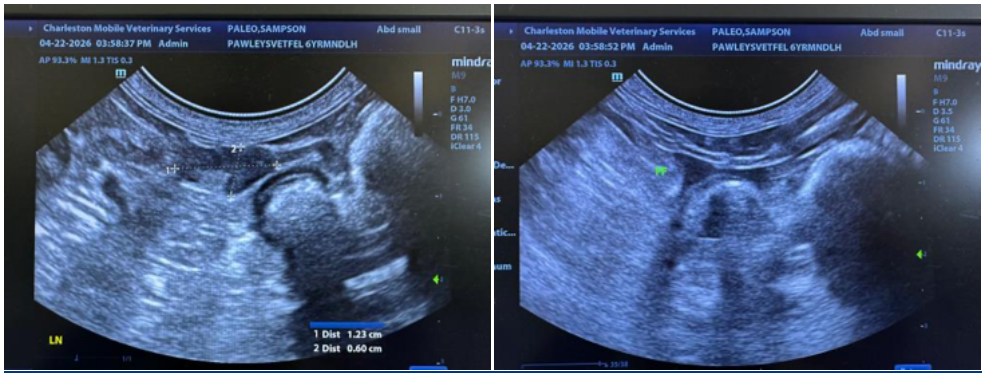

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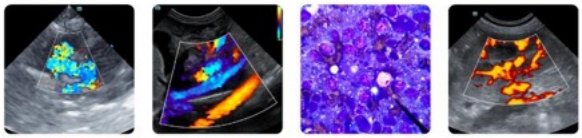

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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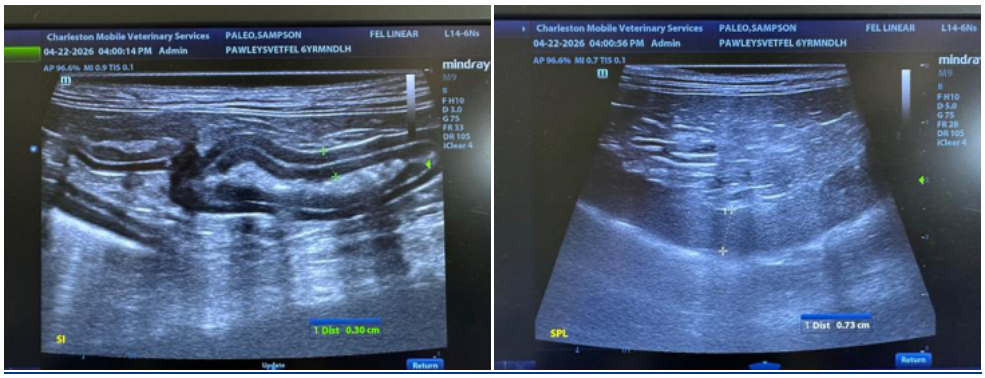

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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