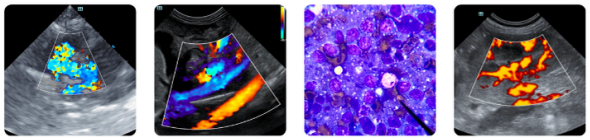


PATIENT

Emilio Crews

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

19 years

WEIGHT

7.8 lbs

INTERPRETED BY

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

IMAGING PERFORMED BY

Dr. Gudrun Gunther

HOSPITAL NAME

New Frontier Animal Medical Center

REFERRING VET

Dr. Gudrun Gunther

INVOICE

10885

DATE

12/5/2025

PRESENTING CLINICAL SIGNS

Seen 12/1 for hyporexia, lethargy, hiding and weight loss. BW run on 12/1 - elevated globulins and severely elevated neutrophils Treated with Convenia and Dexamethasone Recheck today to work-up neutrophilia (suspect inflammatory leukogram vs paraneoplastic vs myeloid leukemia). Yesterday patient demonstrated R sided weakness and paresis. This was not apparent during his exam today. His appetite has improved and he is doing better at home.

Abnormal PE/Chem/CBC/UA Results: 12/1/25: CBC - Mild Anemia - non-regenerative, normocytic, normochromic - HCT 28% Neutrophilia - 40,495 (2,620-15,170) Band neutrophils present 1365 (0-300) Lymphocytes normal Monotycosis moderate 1,365 (40-530) CHEM - elevated globulins 6.2 (2.8 - 5.1) Creatinine normal at 1.8 (0.8 - 2.4) but is sarcopenic w/ hx of CKD 12/5/25: Blood pressure normal Thoracic radiographs - unremarkable UA - pyuria/hematuria/bacteruria.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are unremarkable with normal wall thicknesses and normal tone. The ureters were not visualized, which is a normal finding. There are no uroliths or sediment noted, and anechoic urine is present. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size and structure. The cortex to medulla ratio is appropriate. The cortices are hyperechoic with a hyperechoic corticomedullary rim or band. There is mild to moderate pyelectasis and pelvic dilation with bilateral proximal ureteral dilation. The ureters are not visualized distally, and there is no evidence of nephrolithiasis or ureterolithiasis within the proximal ureters bilaterally. Left kidney measures 4.52 cm, and the right kidney measures 3.92 cm.

Adrenal Glands

Both adrenal glands are visualized and have normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. Left adrenal measures 0.36 cm, and the right adrenal measures 0.50 cm.

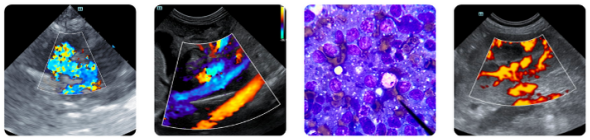
Spleen

There is a single hyperchoic nodule within the otherwise smooth and homogenous splenic parenchyma, with a smooth splenic capsule. The vasculature is normal with no evidence of spontaneous echo contrast, congestion, or thrombosis.

Liver

The liver has a hypoechoic well circumscribed mass effect with areas of focal mineralization within the cranial aspect of the liver. Theres no overt cavitation noted within the mass. This does not distort the otherwise smooth hepatic capsule. Hepatic vasculature is normal with no evidence of congestion.

The gallbladder has thin walls which contain anechoic bile. There is no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal. No hepatic lymphadenopathy is documented. There is no overt structural evidence of inflammatory, infiltrative or regenerative pathology evident.



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Gastrointestinal

The stomach contains echogenic ingesta with no evidence of pyloric outflow obstruction. The gastrointestinal walls are diffusely slightly thickened with a prominent muscularis layer that distorts the normal 1:3 muscularis to mucosal ratio. There's no shadowing gastrointestinal foreign material or evidence for small intestinal mechanical obstruction. The colon contains normal shadowing feces.

Pancreas

The pancreas is hypoechoic and irregular with nodular hypo- and hyperechoic changes throughout.

Free Abdomen

There is no overt regional steatitis or hyperechoic mesentery noted. There is no significant lymphadenopathy or free fluid.

ULTRASONOGRAPHIC FINDINGS

- There are degenerative changes to both kidneys, indicative of chronic renal disease. The proximal ureteral dilation is concerning for potential ureteral obstruction. These may be chronic or acute changes. There's no evidence of active obstruction secondary to urolithiasis at this time.
- There are hyperechoic splenic foci throughout the splenic parenchyma consistent with myelolipomas. These are likely incidental and not overtly pathologic.
- There is a hypoechoic mass effect within the mid cranial liver that is not distorting the normal hepatic capsule. This may represent infiltrative neoplastic disease, however, inflammatory or age-related conditions can't be definitively excluded.
- The intestinal submucosa is slightly irregular, thickened and hyperechoic suggestive of low grade, chronic disease. There is mild uniform prominence of the gastric mucosa as well as areas of "ropey" small intestinal wall with slight disruption of the normal 1:3 muscularis/mucosal ratio. This is most consistent with chronic enteropathy. No concerning lymphadenopathy or evidence of mechanical obstruction is present. Chronic inflammatory bowel disease is likely with a low possibility of an early neoplastic event such as lymphoma.
- The prominent, hypoechoic pancreas with an irregular contour and mixed ill-defined hyper and hypoechoic changes is most consistent with pancreatic remodeling and nodular hyperplasia. This may be secondary to active or acute-on chronic inflammatory disease or pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Fine needle aspirates of the liver with cytology are recommended. A coagulation profile and platelet estimate prior to sampling are indicated to ensure the absence of coagulopathy. Occasionally some tissues are poorly exfoliative, or cytology is non-specific, in which case biopsy with histopathology may be required for a definitive diagnosis.

A gastrointestinal panel (TLI, PLI, B12, folate) via Texas A&M gastrointestinal laboratory is indicated to further evaluate for potential chronic enteropathy. Ultimately, gastrointestinal biopsies may be required for a definitive diagnosis.

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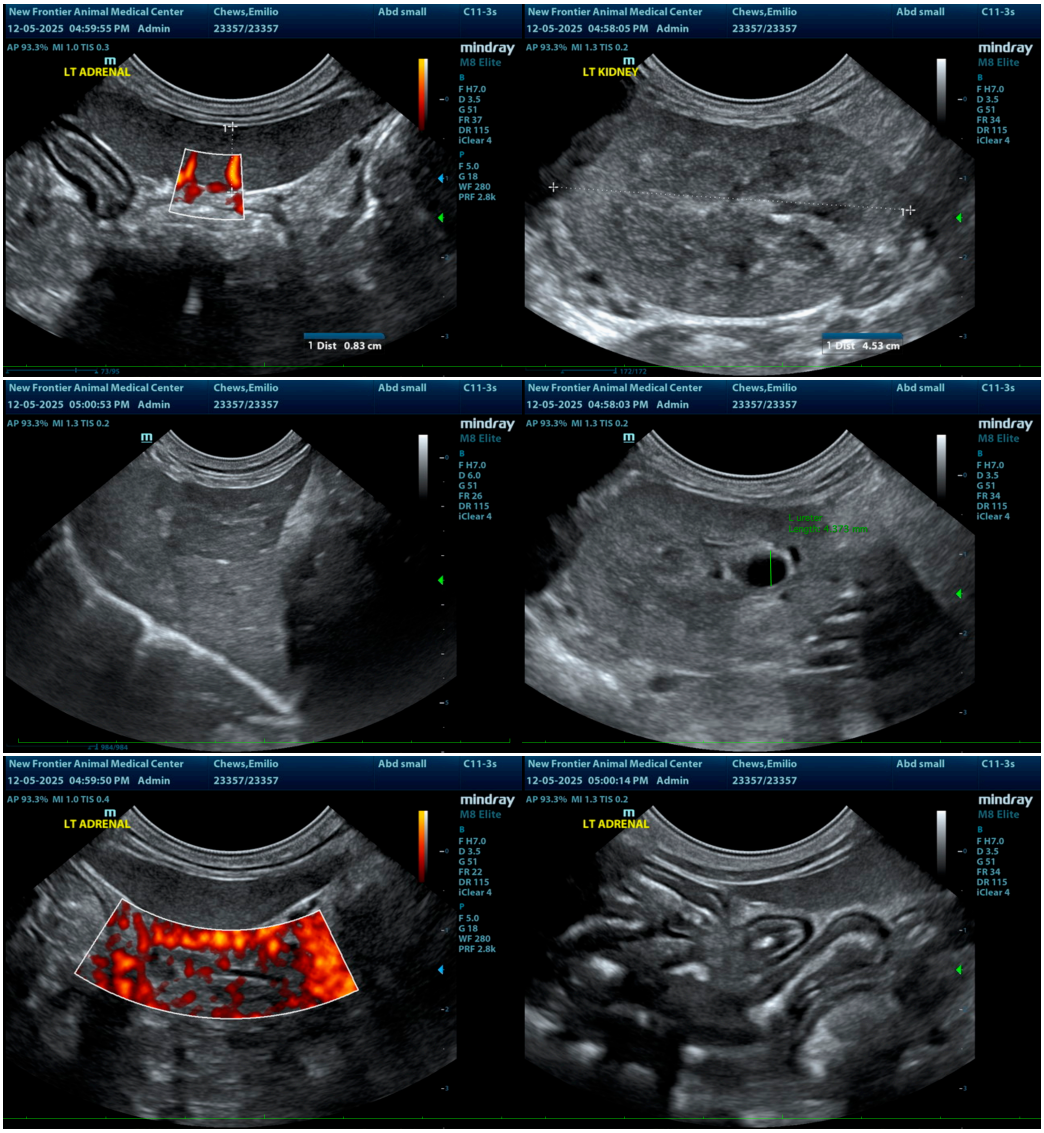
An fPLI is recommended for further evaluation of active pancreatitis as an underlying cause for the clinical signs.

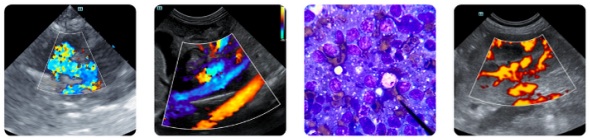
Consider a CBC with a pathology review for further evaluation of the changes to the white blood cell population.

Serial monitoring and imaging of the lower urinary tract is recommended to evaluate for potential chronic urinary obstructions. This would be especially important if there's a sudden increase in renal values or azotemia.



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



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can be of any further assistance please contact me.

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info@SonoPath.com