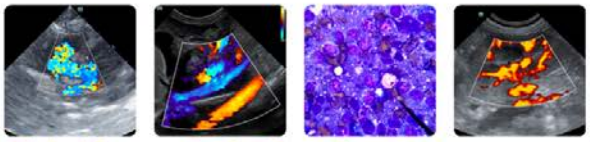


PATIENT

Gracie McFarland

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

9 Years

WEIGHT

3.45 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

Companion Animal Clinic

INVOICE

72345

DATE

1/21/26

PRESENTING CLINICAL SIGNS

AUS to further evaluate decreased appetite. BW shows a mild monocytosis, elevated LES and T. bili, Elevated SDMA and BUN. Started supportive management and a steroid taper. Treatments 1/12 - Dexamethasone inj, Enrofloxacin inj.

Meds: Mirtaz, Prednisolone taper, Enrofloxacin, Gabapentin

AUS Sedation: Butorphanol IV, Dexmedetomidine IV. Antisedan reversal.

Abnormal PE/Chem/CBC/UA Results: rDVM Diagnostics 1/6/25: - CBC: Hct 34%-n, MCHC 29 L, MCV 44-n, Plts 196- clumping noted, Monocytes 705 H - Chem: Alb 3.5-n, AST 219 H, ALT 285 H, ALP 85-n, T. bili 0.9 H, BUN 49 H, Cr 1.1, SDMA 22 H, Chol 96-n, Trig 103-n, Gluc 104-n, Mg 3.1 H, Icterus 1+ - T4: 1.7-n

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. Left kidney is normal in size at 4.2 cm. Right kidney is normal in size at 4.4 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.42 cm at cranial pole and 0.36 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.42 cm at cranial pole and 0.31 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

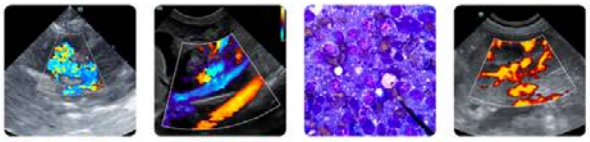
Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.



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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestine demonstrates areas of mildly thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

Pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. No pancreatic duct dilation is noted.

Free Abdomen

There is a small pocket of free fluid adjacent to the spleen.

Medial to the left kidney there is an approximately 2.3 cm x 1.1 cm anechoic density that I suspect is a cystic lymph node versus other. No other lymphadenopathy is noted.

ULTRASONOGRAPHIC FINDINGS

- Mild/emerging inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.
- Concurrent chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- Hyperechoic hepatomegaly – This appearance is most consistent with benign hepatic lipidosis or endocrine/DM hepatopathy. Infiltrative disease such as amyloidosis or round cell neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.
- The small pocket of free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.
- Suspect cystic/reactive renal lymphadenopathy, although other pathology creating the anechoic density, including cyst, hematoma, abscess, less likely infiltrative neoplasia, can't be ruled out.
- Mild to moderate chronic kidney disease changes noted bilaterally.

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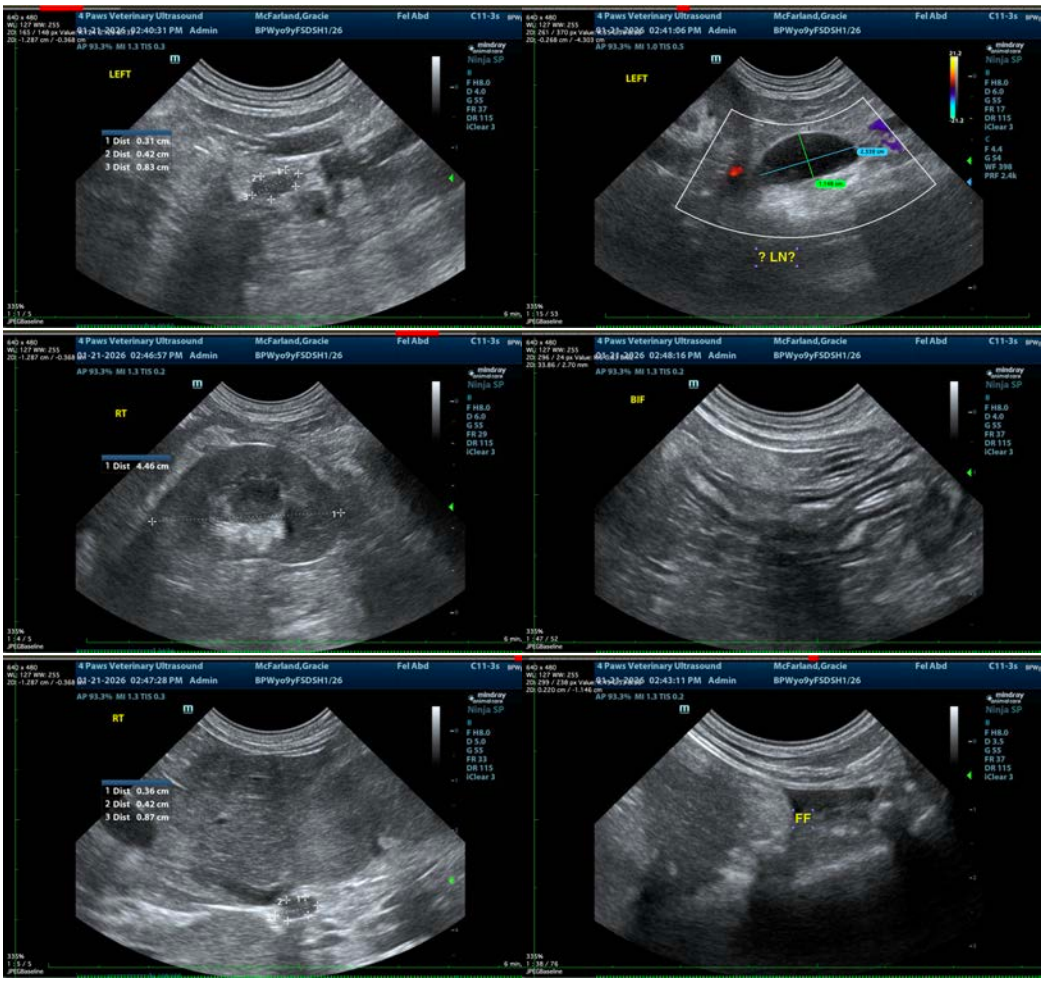
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Fine needle aspirates of the liver +/- sampling of the free abdominal fluid pocket adjacent to the spleen +/- the cystic structure adjacent to the left kidney could all be considered if patient's coagulation status is appropriate. Having said that, the suspected cystic lymph node and potentially the fluid pocket may be too small to reach.

In the meantime, treatment recommendations include fluid therapy, anti-emetics, gastroprotectants, hepatic nutraceuticals such as ursodiol and/or Denamarin, and broad-spectrum antibiotics. Nutritional support is critical to prevent/manage concurrent hepatic lipidosis, so appetite stimulants and/or, if indicated, feeding tube placement is also recommended.



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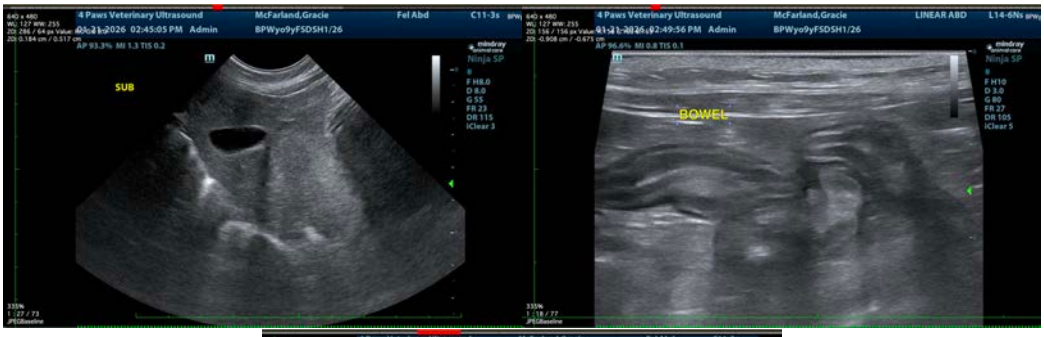

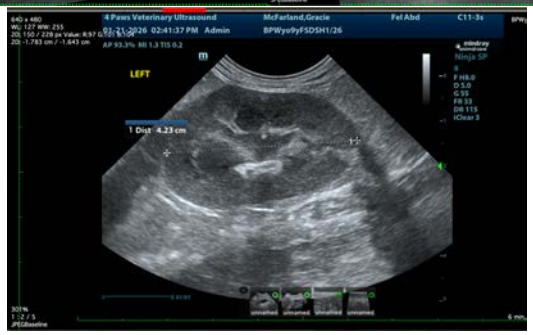

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
info@sonopath.com