PATIENT

Loki Millner

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

2 Years

WEIGHT

3.5 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Beatties PH Stoney Creek

REFERRING VET

Dr. Salib

INVOICE

12972

DATE

01/05/2026

PRESENTING CLINICAL SIGNS

Appetite is significantly decreased; the owner reports he is not eating very much. He is being offered a digestive food. This morning, it took him 20 minutes to eat half of a Churu treat; he was mostly licking it before eventually consuming some. He is not showing interest in human foods like cooked chicken, which he normally enjoys. The owner has always added a probiotic supplement to all of their cats' food; this is not a new addition. Loki is presenting for a recheck appointment due to concerns about weight loss. The owner reports that he is also experiencing inappetence, lethargy, and continued vomiting. Current Medications none

Abnormal PE/Chem/CBC/UA Results: High WBC, mildly high Glucose and UREA, mildly low Sodium, Potassium and Chloride, very low ALT Negative FIV, FeLv snap Radiographic Findings n/a Primary Question to Be Answered in This Exam further diagnostics needed

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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.

Left kidney is normal in size (3.5 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Right kidney is normal in size (3.6 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

Left adrenal gland is normal in size (0.34 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The area of the right adrenal gland is examined without evident adrenal gland pathology.

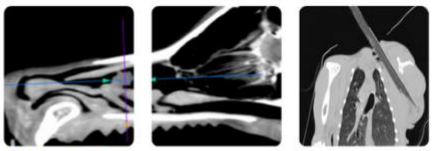
Spleen

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 normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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 moderately 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 mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. The lumen of the colon is diffusely moderately distended with soft stool.

Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

The mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail. There are multifocal scant pockets of free fluid noted.

ULTRASONOGRAPHIC FINDINGS

- Moderate 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.
- Moderate mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Scant 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- 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.
- If not recently evaluated, a routine fecal/giardia exam could be considered as could a fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

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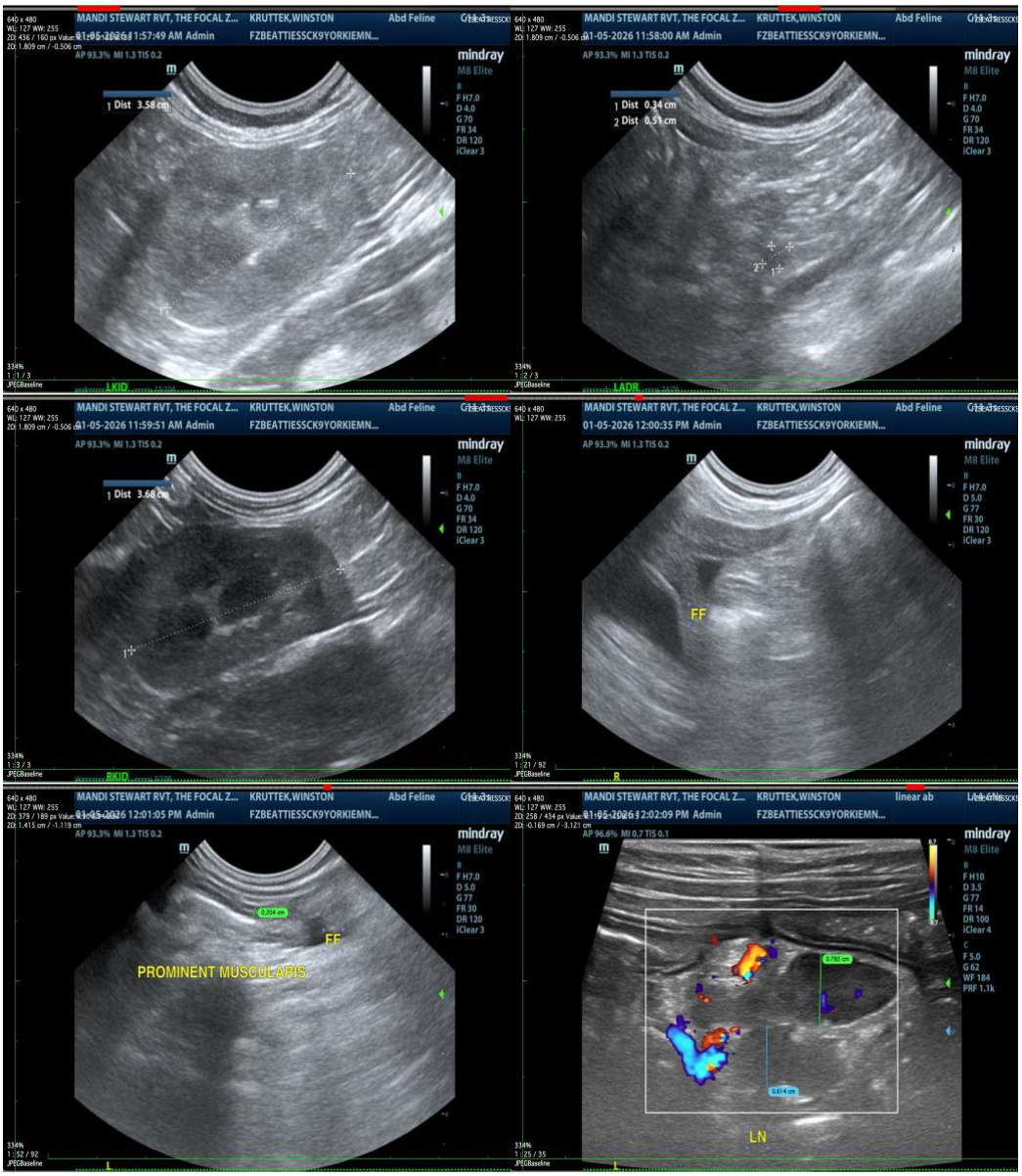
- Ultimately, however, tissue sampling may be necessary for a definitive diagnosis and therefore to further guide medical management. Finally, fine needle aspirates of the mesenteric lymph nodes could be considered if patient's coagulation status is appropriate, but if a cytologic diagnosis is unable to be obtained, ultimately, biopsies of the GI tract being sure it include the ileum, if possible, may be necessary.

- Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.



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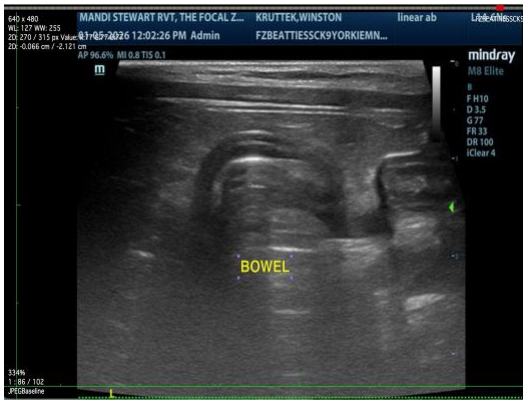

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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