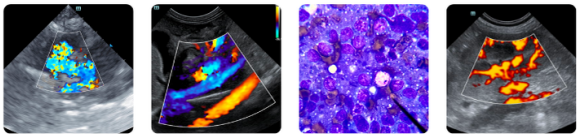


SonoPath FOSTERING THE ART OF VETERINARY MEDICINE™ www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Mook Mitropoulis

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

14 years

WEIGHT

8.4 kgs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Hamilton Region Emergency

REFERRING VET

Dr. Pask

INVOICE

10755

DATE

11/18/2025

PRESENTING CLINICAL SIGNS

Lethargic, Hx of hyperthyroid, O concerned for Diabetes (BG 10.9), - normally a very active cat but O came home 2 hours ago and found him hiding under the couch - quieter than normal 5 other cats in the house so unsure what his litter box habits have been vomited fodd at 10am not one to get in to Fb no toxin exposure Current Medications methimazole 5 mg BID.

Abnormal PE/Chem/CBC/UA Results: N/a Primary Question to Be Answered in This Exam determine cause of sudden change in behavior.

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 overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measures 4.2 cm, and the right kidney measures 4.5 cm.

Adrenal Glands

The right adrenal gland is unable to be well visualized in these images.

The left adrenal gland is normal in size (0.39 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size (1.2 cm thick at the hilus) with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

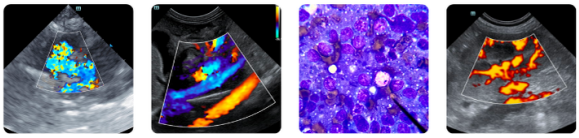
Liver

The 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.

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.

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.



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The visible small intestine demonstrates areas of moderately thick muscularis layer relative to the mucosa. Small intestinal sub-mucosa is slightly irregular, thick, and hyperechoic without evident loss of layering. The lumen of the bowel is diffusely, mildly fluid distended without evidence of an obstructive pattern, plication and/or visible foreign material but subjectively mild hyperperistalsis is noted in some areas.

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

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

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY 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, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling. Additionally, some of the luminal changes are consistent with possible concurrent irritation, secondary to dietary indiscretion or intolerance, bacterial, viral, other infectious disease, parasitic or protozoal disease, toxin, other underlying metabolic disease, etc.

- Splenomegaly– can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

SECONDARY FINDINGS

- Age related kidney changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a general metabolic health screen (CBC, chemistry panel with electrolytes and urinalysis) is recommended.

A re-check T4 is recommended if not recently evaluated.

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.

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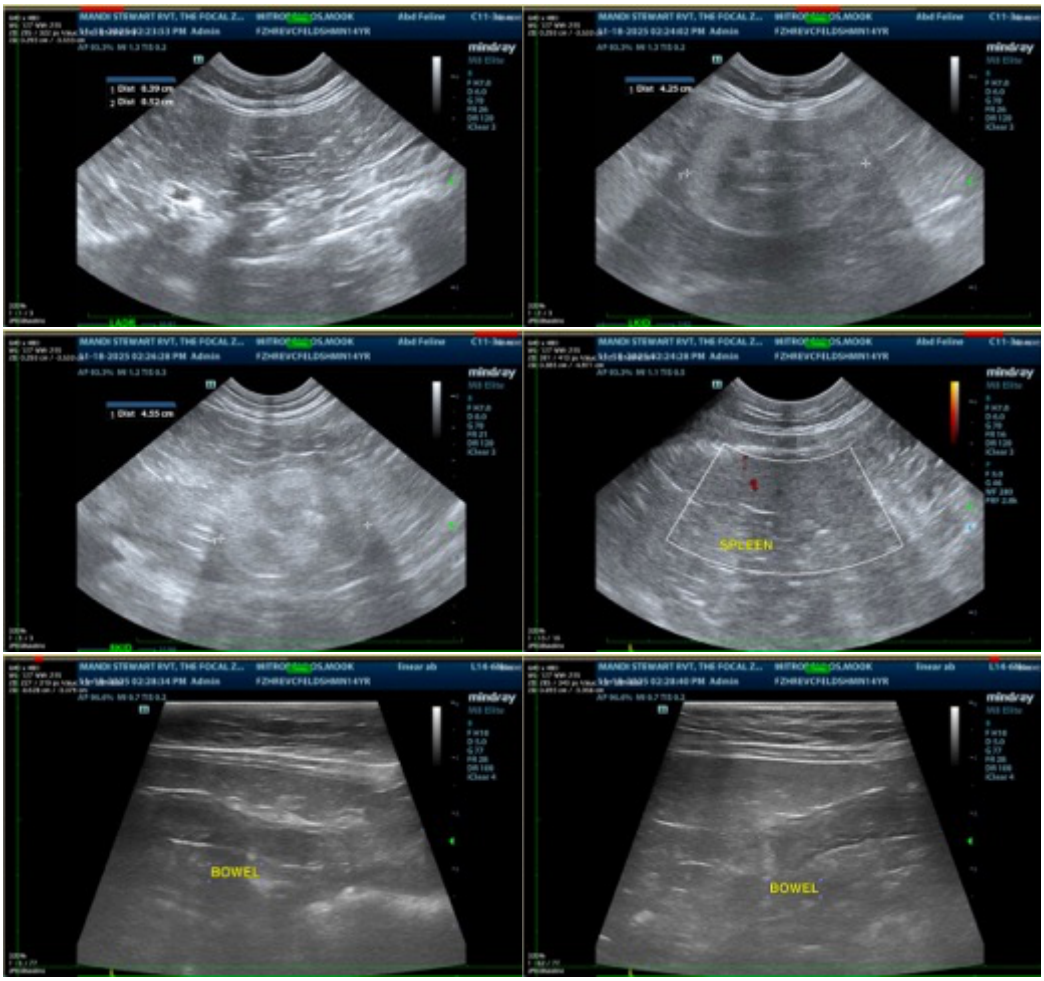
+/- A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

Fine needle aspirates of the spleen could also be considered if patient's coagulation status is appropriate.

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



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