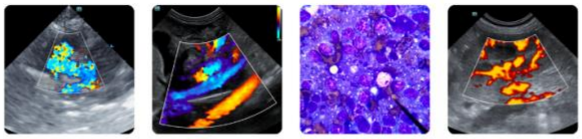


PATIENT

Lily Brower

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

12 Years

WEIGHT

3.8 kg

INTERPRETED BY

Beth Johnson, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Alpine Animal Hospital

REFERRING VET

Dr. Lindsy S

INVOICE

12476

DATE

11/24/25

PRESENTING CLINICAL SIGNS

Wt loss ~3lb since last seen in 2022. Acting normal but appetite may be a bit decreased. . Working diagnosis Concern for primary GI dz

Abnormal PE/Chem/CBC/UA Results: Chem SDMA 20.9, Creat 1.2, BUN 24, Phos 1.4, Ca 7.5 CBC Thrombocytopenia (clumped), mild neutropenia, lymphocytosis T4 1.3 UA USG 1.056 UPC 0.3 Sed some RBC's (cysto) LABS attached

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 or normal size measuring 3.4 cm in length, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted. A nonobstructive nephrolith is noted in the left kidney.

Right kidney is small in size measuring 2.6 cm in length, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed.

Adrenal Glands

Left adrenal gland is normal in size (0.33 cm at cranial pole and 0.32 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.35 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

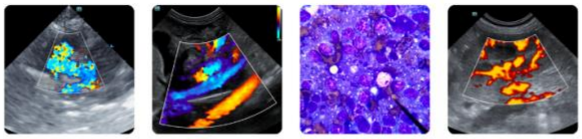
Spleen is subjectively large in size with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal. The spleen measured 1.06 cm thick.

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.

Gastrointestinal



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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 marked/significantly 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

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is a trace amount of anechoic free fluid noted primarily adjacent to the spleen.

Cranio-abdominal/pancreaticoduodenal and medial iliac lymphadenopathy are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

Mesenteric lymphadenopathy are enlarged with swollen irregular capsular contour and loss of normal length to width ratio (rounded in shape). Nodes are hypoechoic with loss of normal parenchymal detail.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Marked/significant 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.
- Mesenteric lymph nodes – concerning for infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture. The other enlarged lymph nodes are less significantly enlarged and may be reactive although infiltrative neoplasia cannot be ruled out.
- 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

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- Pancreatic age-related remodeling– Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.

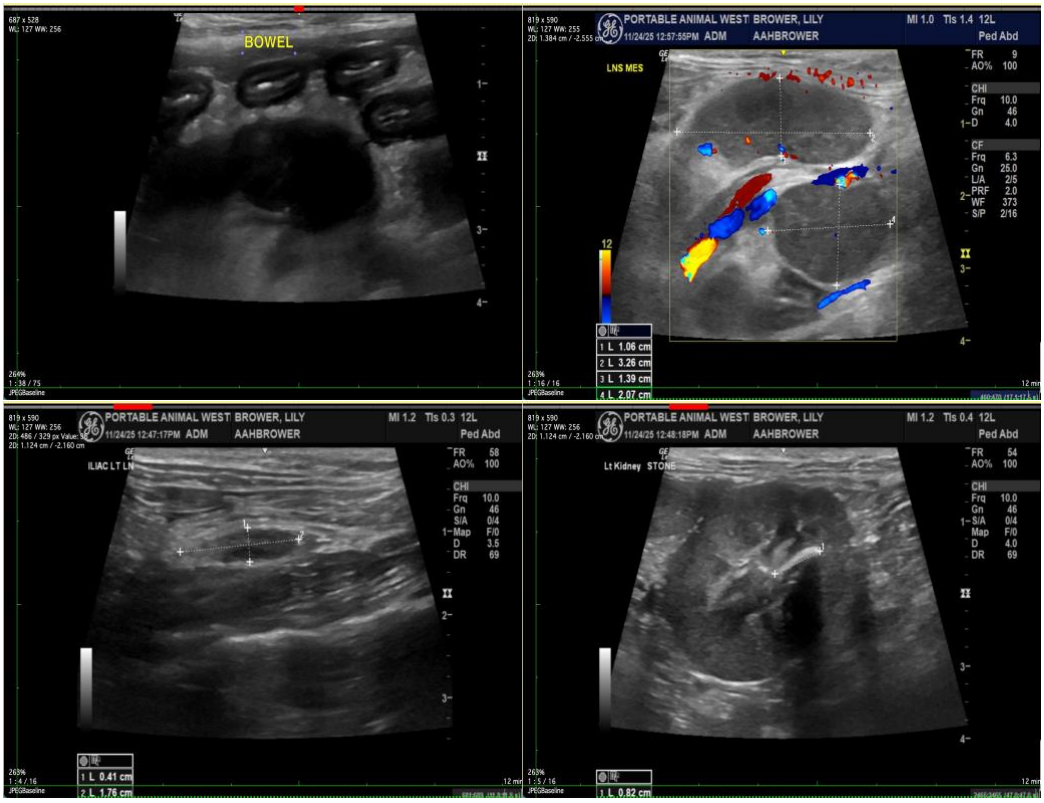
- Chronic kidney disease changes with a nonobstructive nephrolith in the left kidney.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- The appearance of the bowel does not demonstrate characteristics of malignancy which would make infiltrative neoplasia higher on the list of differentials. Having said that, however, the lymphadenopathy is concerning for infiltrative neoplasia such as lymphoma. Therefore, tissue sampling is recommended beginning with fine needle aspirates of the enlarged lymph nodes and spleen if patient's coagulation status is appropriate. Ifa cytologic diagnosis is unable to be obtained, however, ultimately, biopsies of the GI tract being sure to include the ileum if possible may be necessary for a definitive diagnosis and to therefore further guide medical management.

- 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.

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



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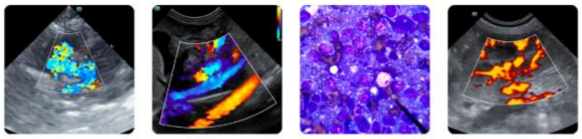
530-786-8340



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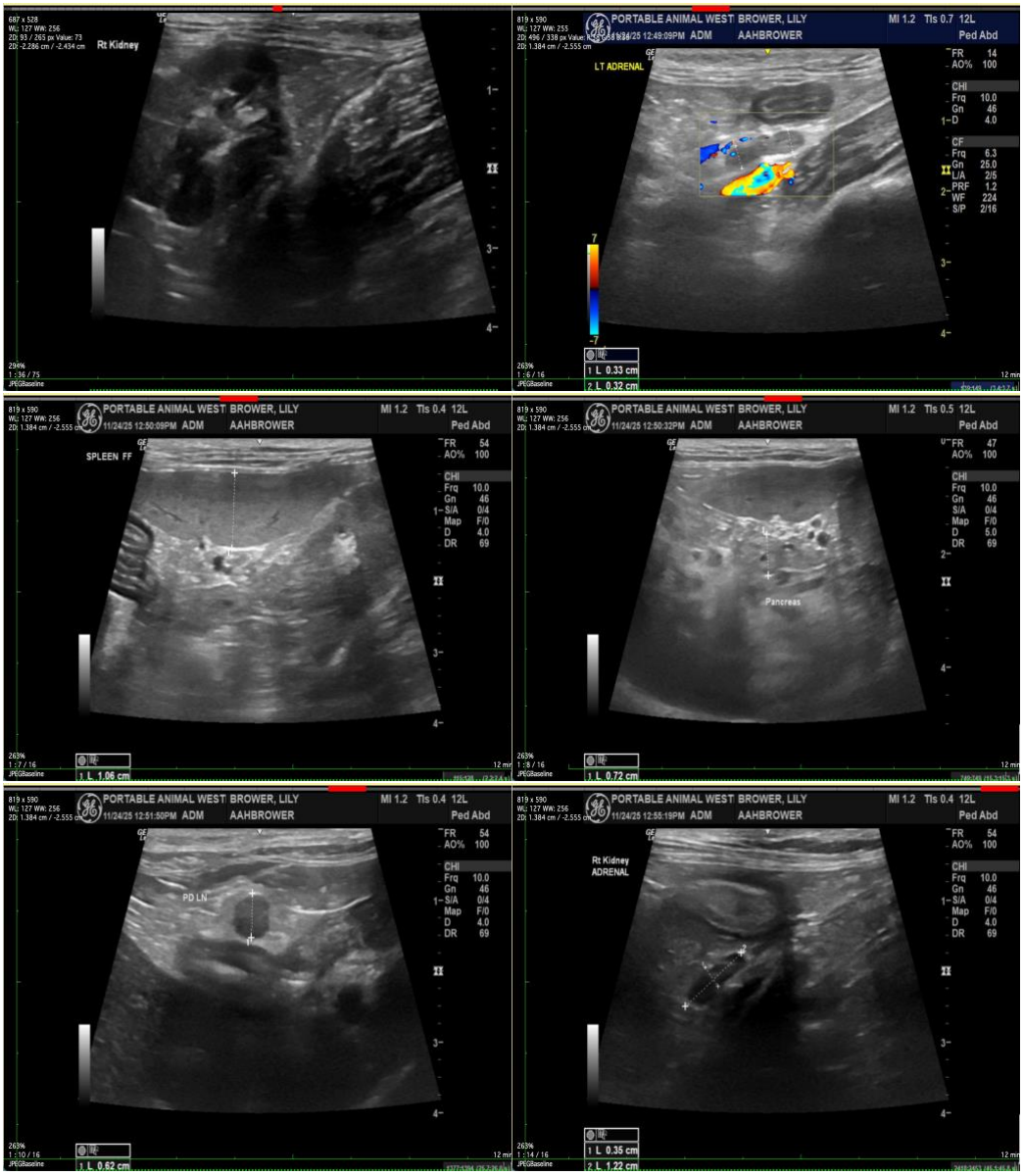

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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