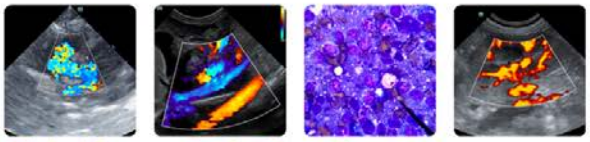


PATIENT

Corky Hitchcock

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

3 Years 3 Months

WEIGHT

3.1 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

Heatherlynn McFarlane, DVM (Internal Med)

INVOICE

71585

DATE

11/5/25

PRESENTING CLINICAL SIGNS

AUS to further evaluate progressive LE, persistent anorexia (last meal 10/30/25), hyperbilirubinemia, icterus, now decreasing Chol and BUN. A week history of hiding, progressive hyporexia to anorexia. No vomiting or diarrhea. Previously has had two similar episodes of decreased appetite, BW showing elevated LE that responds with supportive care, IVF, antibiotics, and steroids. Previous AUS 11/13/24 with Sonopath Interp. Hosp mgmt: Unasyn, Buprenorphine, IVF with KCl supplementation, Mirataz, Ondansetron. Prednisolone 5mg q24hr -- last dose 11/2/25

Abnormal PE/Chem/CBC/UA Results: AUS 11/13/24: Lg, hyperechoic liver, Hepatic changes are non-specific & could be consistent w/ hepatic lipidosis, inflamm/infectious dz, infiltrative neoplasia, or other hepatopathy. Mildly prominent, mottled rt panc limb- mild pancreatitis or recent episode of pancreatic inflamm. Diffusely thickened SI w/ prominent muscularis layer, SI wall changes are most consistent w/an inflamm process (i.e., IBD) w/a low poss of emerging lymphoma. 11/2025: CBC: WBC 8.32, Neu 6.62, Lymph 1.25, Eos 0.39, HCT 36%, PLT 601 H PCV/TS: 34%/7.2, serum icteric Chem: TP 6.3, Alb 3.2, Glob 3.1 -> 2.6, Cr 0.6 L, BUN 12.4 -> 5.6 L, ALT 967 H ->1119 H, ALP 750 H -> 607 H, GGT 31 H -> 35 H, Tbil 3.6 H -> 4.4 H, Chol 143 -> 98 L, Na 158 H, K 4.3, Cl 122, Ca 10 -> 8.7, Phos 3.5, Glu 137 H -> 207 H Snap fPL Negative

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.

The right kidney is normal is size (3.63 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.

The left kidney is normal is size (3.72 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

The right adrenal gland is normal in size (0.38 cm at cranial pole and 0.33 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

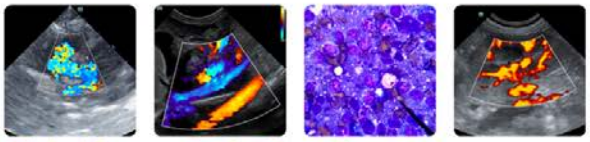
The left adrenal gland is normal in size (0.42 cm at cranial pole and 0.40 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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



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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.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material, or infiltrative disease; however, visualization is partially inhibited by gas.

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 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 no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

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, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.

- 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.

- Chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.

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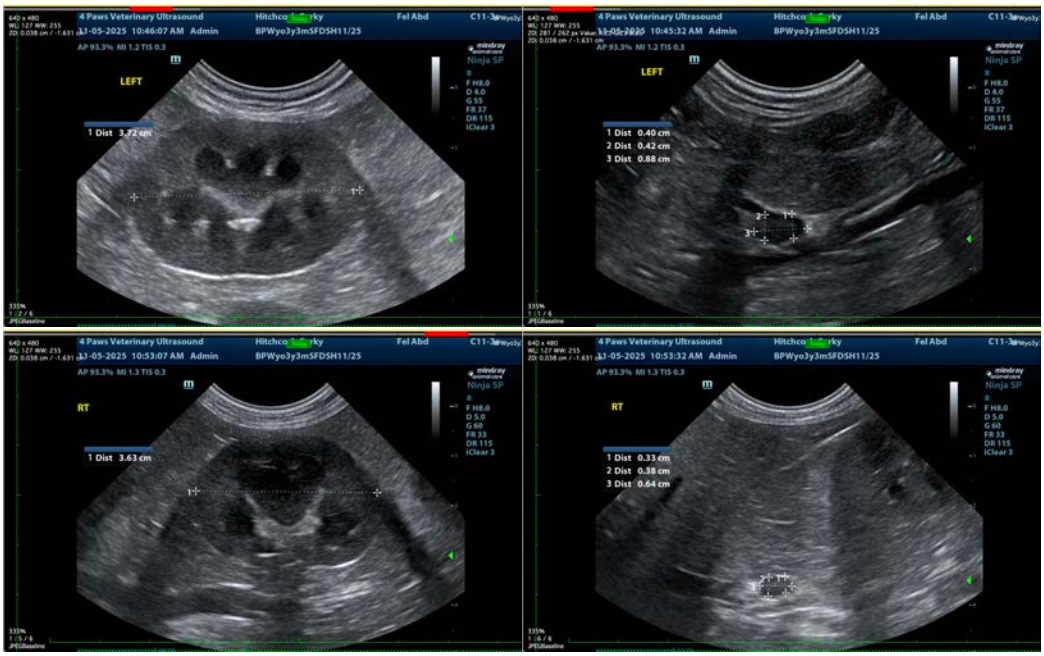
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

As is reportedly already pending, a fine needle aspirate of the liver is recommended to further investigate/rule out infiltrative neoplastic disease such as lymphoma if patient's coagulation status is appropriate.

Ultimately, however, given the bowel changes, I suspect flare ups of hepatic lipidosis, potentially brought on by anorexia secondary to underlying bowel disease. Therefore, pending results of the cytology:

- 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.
- 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.
- Ideally, biopsies of the GI tract, being sure to include ileum if possible, are recommended to definitively diagnose and therefore manage the infiltrative bowel disease.
- If biopsies cannot be obtained, empirical therapies could include a probiotic (if diarrhea is present, such as visbiome or proviable), empirical deworming with a 5-day course of Panacur and, if tolerated, a transition in diet, based on trial-and-error response, beginning with a hydrolyzed protein diet. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several trials may be required.
- Additional considerations could include cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.).



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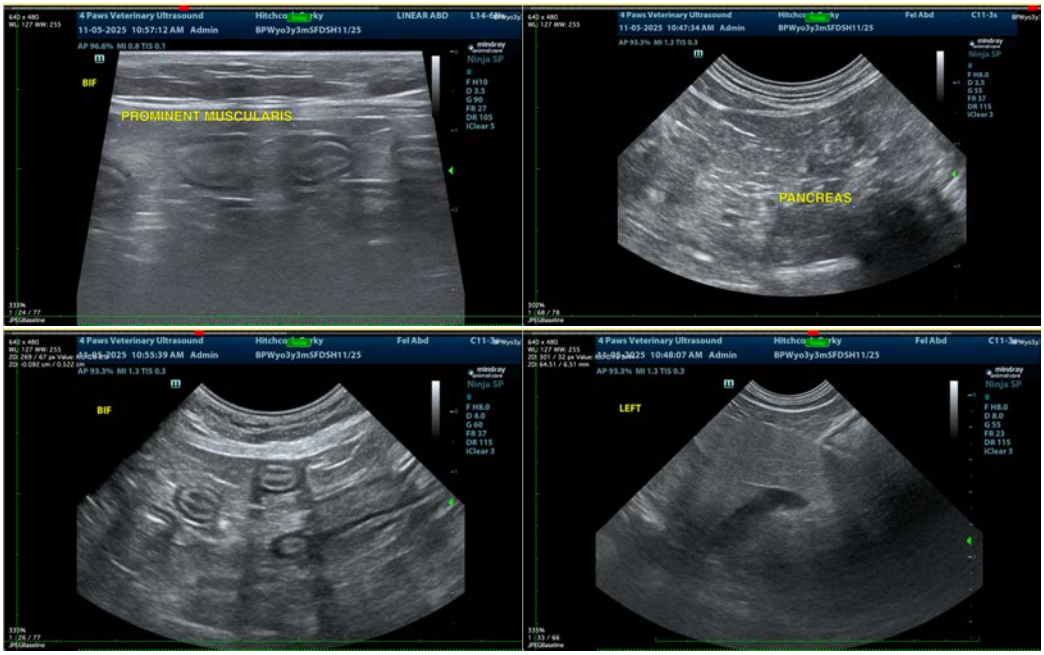

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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