PATIENT

Josephine Hauser

SPECIES

Feline

BREED

Persian

SEX

Spayed Female

AGE

10 Years

WEIGHT

7.54 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Pamela Harrigan, RDCS, Certified Vet Sonographer

HOSPITAL NAME

Falmouth Animal Hospital

REFERRING VET

Lilan Hauser, DVM

INVOICE

72458

DATE

12/10/25

PRESENTING CLINICAL SIGNS

Sudden increase in chronic azotemia; ongoing weight loss. On K/D diet for past 3 years, not Miratazto drive appetite.

Abnormal PE/Chem/CBC/UA Results: WBC 3.7, neut 2.3, toxic neutrophils. RBC 6.21. SDMA 36, creat 3.0, BUN 47. USG 1.019, pH 5.5, rbcs 20-30. T4 2.3 WNL

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 small (2.03 cm), irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is trace pyelectasia present. No mineral is observed.

The left kidney is normal is size (3.4 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 (0.36 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.29 cm at cranial pole and 0.32 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large 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. The spleen is folded upon itself, which is a positional non-pathologic variant.

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. The cystic and common bile duct are diffusely tortuous in appearance without pathologic distention noted in these images at this time.

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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 bowel is unable to be well visualized in these images, and full, zoomed out sweeps using the linear probe would be helpful, but in the loops of bowel visible at the edge of images while particular organs are being zoomed in on demonstrate suspected areas of significantly/marked 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.

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. Mild pancreatic duct dilation is noted measuring 0.30 cm dilated.

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

- Suspect (based on peripheral imaging of other abdominal organs) 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.
- Concurrent chronic low-grade smoldering pancreatitis can't be ruled out.
- The hepatobiliary changes suggest concurrent possible hepatobiliary disease, with both benign hepatopathy such as bacterial or lymphoplasmacytic cholangiohepatitis, hepatic lipidosis, other infectious or reactive hepatopathy, as well as infiltrative neoplasia such as round cell neoplasia i.e., lymphoma being differentials.
- Moderate chronic kidney disease changes affecting primarily the right kidney where there is also trace pyelectasia noted.

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.

While the appearance of the hepatobiliary system, pancreas and bowel could indicate a benign inflammatory "Triaditis", infiltrative neoplasia can't be ruled out. Therefore, tissue sampling is recommended. Fine needle aspirates of the liver, spleen +/- pancreas could be considered if patient's coagulation status is appropriate, or ultimately biopsies of the GI tract, being sure to include ileum, if possible, may be necessary for definitive diagnosis and therefore to further guide medical management.

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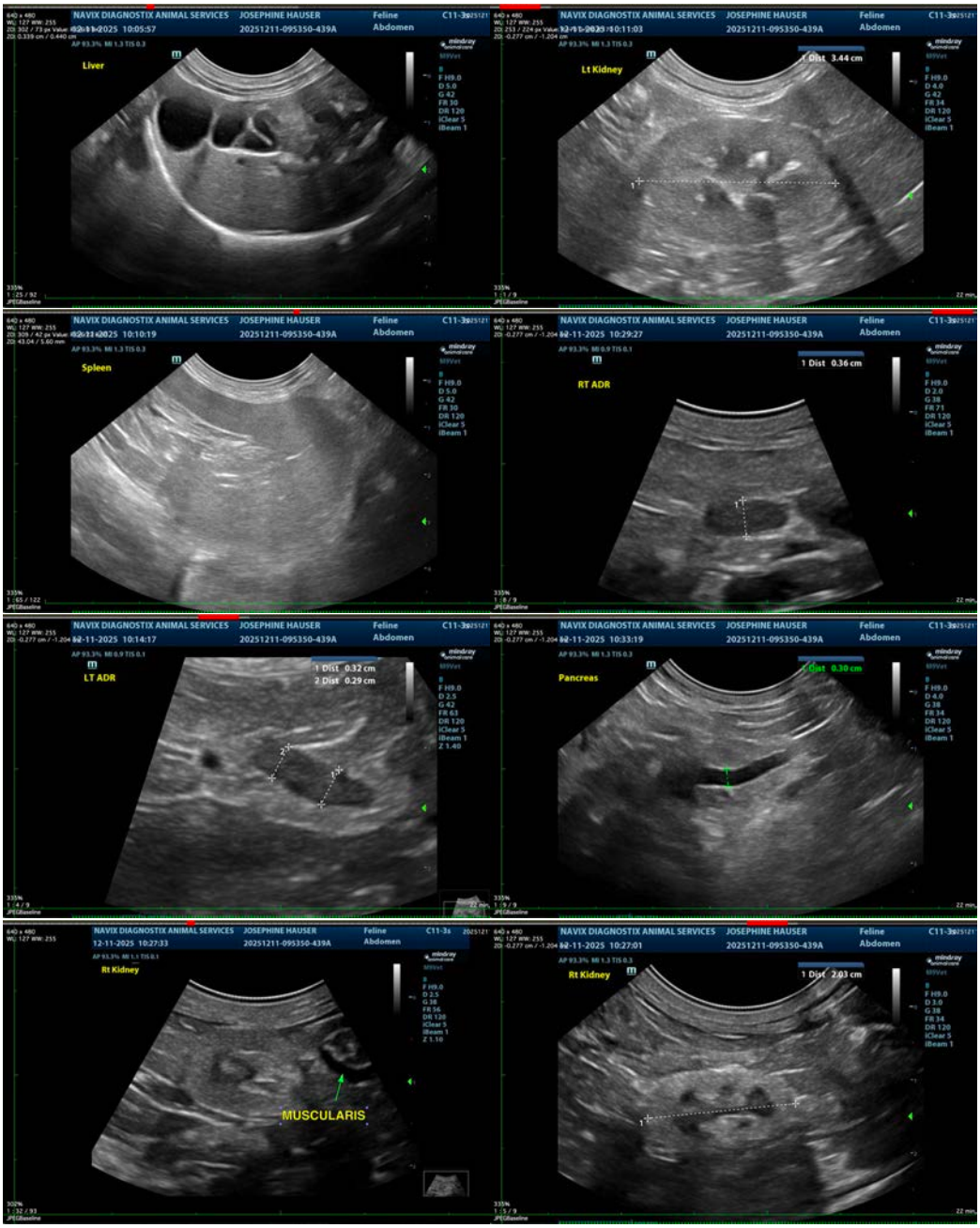
Other than supportive/symptomatic medical management of clinical signs, further diagnostic and treatment recommendations are largely dependent on results of the above.



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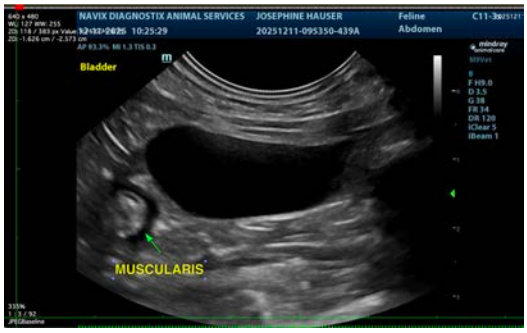

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@sonopath.com