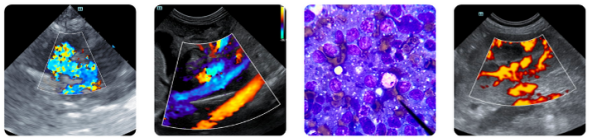


PATIENT

Squeak Kelly

SPECIES

Feline

BREED

Himalayan

SEX

Spayed Female

AGE

15 years 3 months

WEIGHT

3.25

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Brian Barnes

HOSPITAL NAME

Westview Veterinary Hospital

REFERRING VET

Dr. Brian Barnes

INVOICE

10953

DATE

12/17/2025

PRESENTING CLINICAL SIGNS

Always has been a picky eater, worse lately Getting worse Loosing weight Stools ok Giving 3 in 1 probiotics Vomited twice in one day, had have a Turkey burger.

Abnormal PE/Chem/CBC/UA Results: CBC: WBC: 29.06 (N 2.87-17.02) Neuts 14.3 (N 2.3-10.29) Bands suspected Lymp 9.47 (N 0.92-6.88) Mono 1.85 (N 0.05-0.67) Eos 3.22 (N 0.17-1.57) Chem: GGT 5 (N 0-4) Lipa 1534 (N100-1400) T4: 40 (N 10-60) SDMA:13 (N 0-14) PL: >50 (N 0-4.4) U/A: Cystocentesis, Dark yellow, Slightly Cloudy, USG 1.043, pH 7.0, Pro 30, Glu/ Ket/ Bil/ Bld Negative, UBG normal, , SEDI: WBC 2/HPF, RBC 3/HPF, Bac 0, Non-SEC <1/HPF, Cast 0, Crystals 0 Potentially significant proteinuria UPCR 0.08)Values <0.5 no significant proteinuria AUS for evaluatio liver massses, large spleen, Int LN chains enlarged.

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 3.68 cm, and the right kidney measures 3.44 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.34 cm at cranial pole and 0.28 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.36 cm at cranial pole and 0.4 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

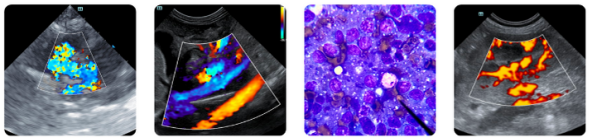
Spleen

Spleen is subjectively large in size with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a mildly coarse/heterogenous 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, except for multifocal nodules/masses of mixed echogenicity, primarily hyperechoic in echogenicity but containing multiple cysts of varying sizes. Two representative nodules measure 2.2 cm in diameter, and 1.1 cm in diameter. 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.



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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. In some views, layering is less distinct than normal with an almost diffusely hazy appearance. 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.

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.

PRIMARY FINDINGS

- The bowel changes described above can be seen with both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. Given the less distinct than normal layering in some loops, infiltrative neoplasia such as lymphoma may be ranked higher on the differential list.
- Significantly reactive lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Concurrent chronic low grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- Scalloped spleen – can be associated with benign or malignant infiltrative disease. Common causes include a reactive spleen secondary to immune stimulus or early infiltrative round cell neoplasia such as lymphoma or mast cell tumor.
- Feline biliary cystadenomas – In a senior cat, this liver lesion is most consistent with a/multiple benign biliary cystadenomas. Malignancy cannot be ruled out but is considered less likely give lack of clinical signs and/or laboratory changes.

SECONDARY FINDINGS

- Age related kidney changes.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

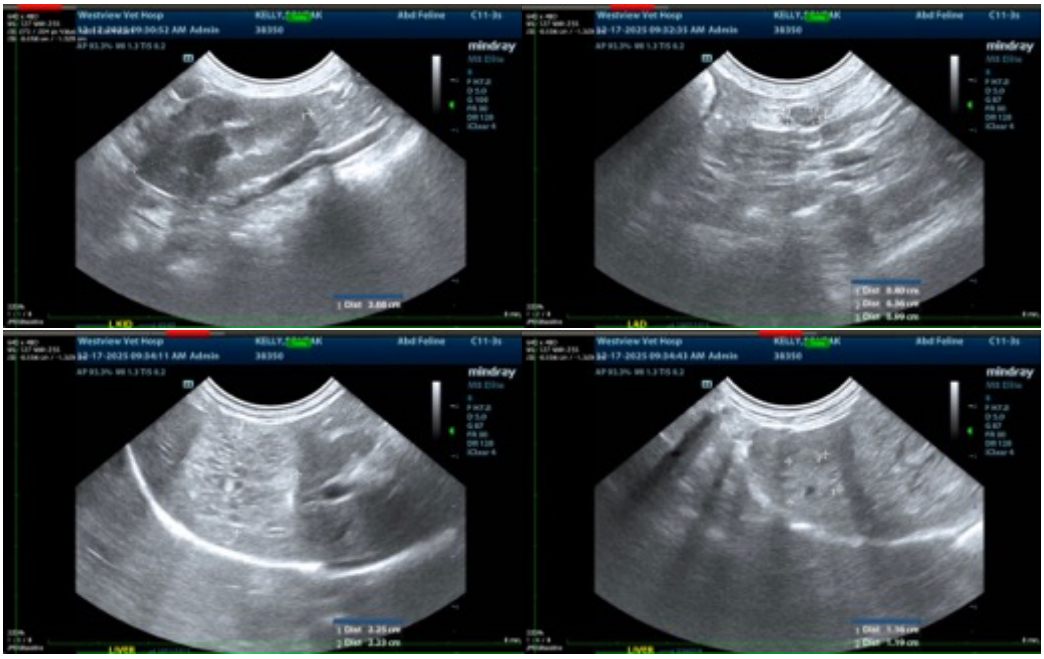
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Tissue sampling is recommended. Fine needle aspirates of the enlarged lymph nodes, spleen +/- liver could be considered if patient's coagulation status is appropriate.

In the meantime, further evaluation of the lymphocytosis could also be considered beginning with a pathology review. Ultimately, if a diagnosis is unable to be obtained, biopsies of the GI tract being sure to include ileum, if possible, may be necessary for a definitive diagnosis and therefore to further guide medical management.

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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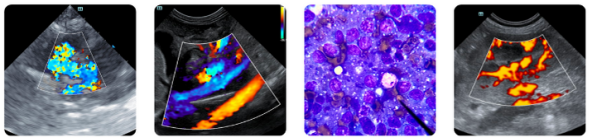

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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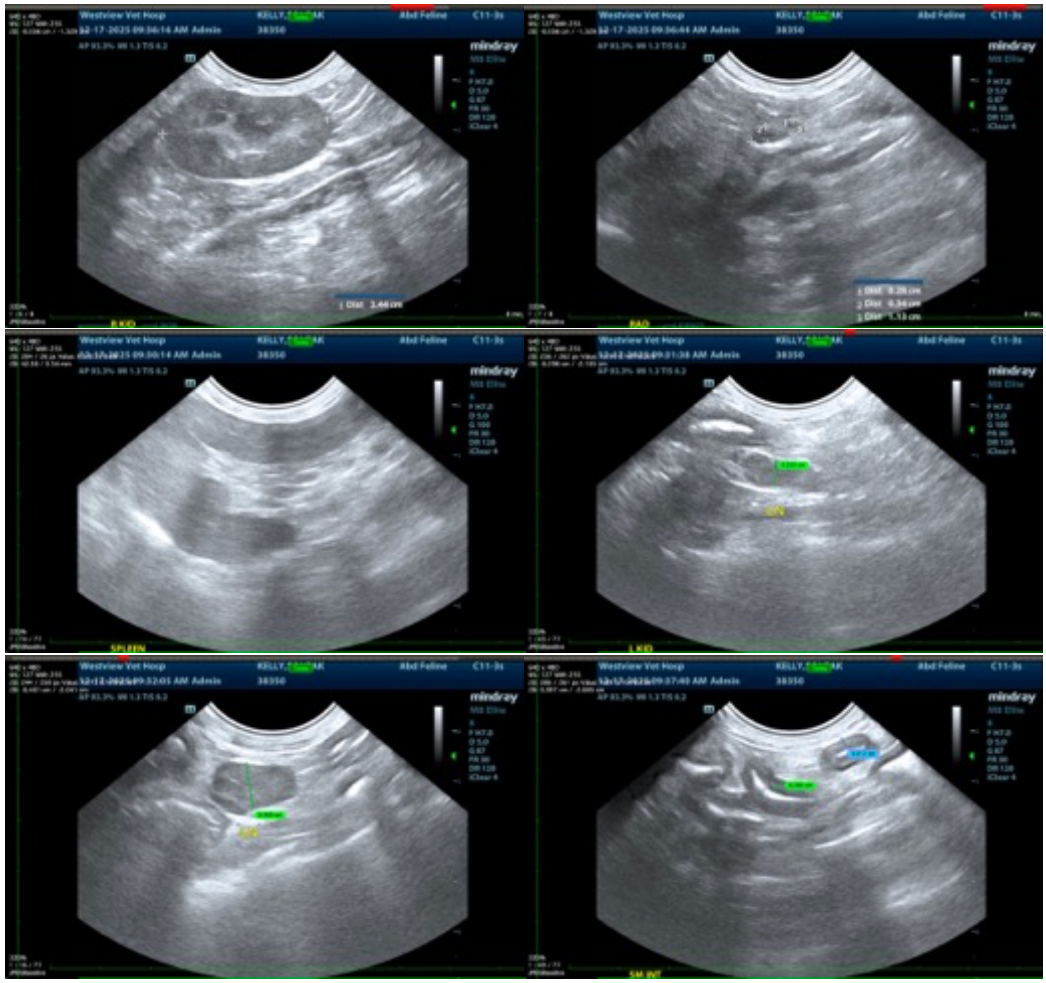

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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