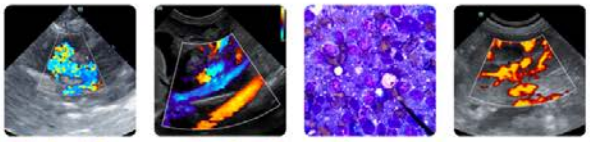

PATIENT

Winston Westview Vet Hospital Cat

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

13 Years 1 Month

WEIGHT

5.1 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Brian Barnes

HOSPITAL NAME

Westview Veterinary Hospital

REFERRING VET

Dr. Brian Barnes

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72407

DATE

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PRESENTING CLINICAL SIGNS

Had I 131 Tx for hyper T4 in April 2025 Losing weight

Abnormal PE/Chem/CBC/UA Results: Non-regenerative anemia CBC: RBC 3.68 (6.54-12.20) HCT 15.8% (N 30.3- 52.3) HGB 5.2 (N 9.8-16.2) Lym 0.61 (N 0.92-6.88) Eos (N 0.06 (N 0.17-1.57) Chem: Creat 258 (N 71-212) Urea 12.6 (N 71-212) T4: 15 (N 10-60) SDMA:18 (N 0-14) Kidney dysfunction (likely chronic kidney disease) with dilute urine and elevated renal biomarkers No evidence of urinary tract infection or crystals, USG 1.013 Anemia has worsened HCT was 24.1 % in Aug 2025 now 15.8

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a large amount of echogenic non-shadowing debris, most consistent with exfoliated cells, crystals, mucous and/or small blood clots likely combined with incidental suspended lipid. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. Left kidney is small at 3.3 cm. Right kidney is normal at 4.2 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.47 cm at cranial pole and 0.40 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 0.39 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.

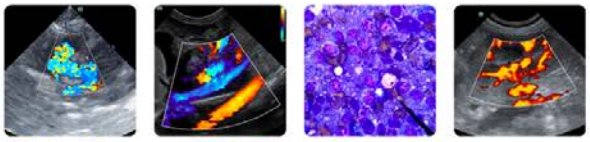
Liver

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 stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no



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evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out.

If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

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

- Mild to moderate chronic kidney disease changes are noted bilaterally.
- 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.
- Suspect concurrent chronic low-grade smoldering pancreatitis.
- Moderate amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further recommendations regarding patient's weight loss are largely dependent on appetite. Given the subtle bowel changes, if appetite is normal or even increased, then further evaluation of digestion and absorption is recommended, beginning with:

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.

Having said that, however, I suspect patient's weight loss is secondary to a decreased appetite likely related to suspected progressive chronic kidney disease. Therefore, management of the chronic kidney disease, including supportive/symptomatic medical management of clinical signs, potentially antiemetics, gastroprotectants, appetite stimulants +/- fluid therapy if decreased water intake is also

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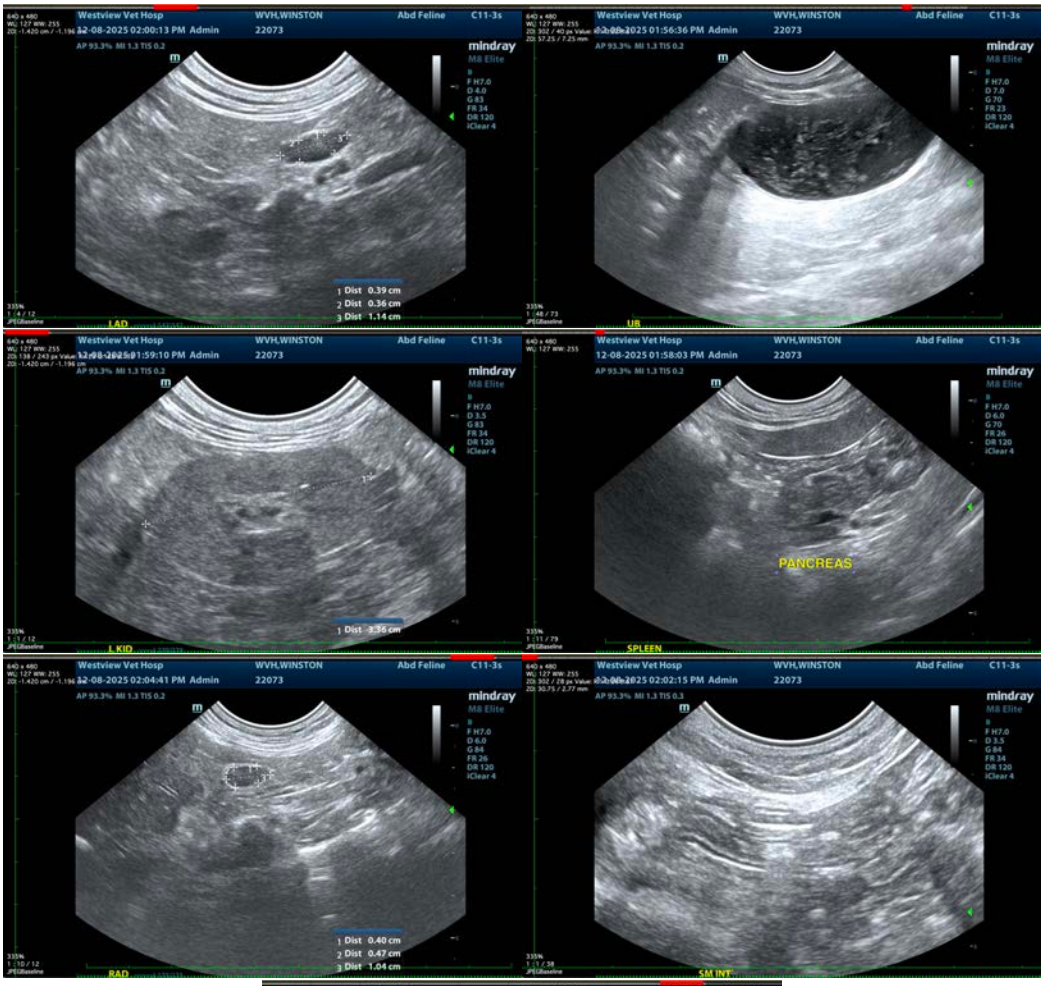
present and/or patient is dehydrated, etc. is recommended. Additionally, management of any electrolyte abnormalities, hypertension, proteinuria, and the anemia are recommended as indicated.

Ultimately, if patient is eating, and/or once appetite improves, transition to a kidney diet may be appropriate.



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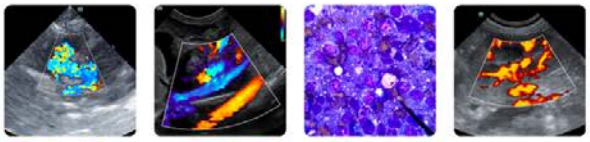

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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