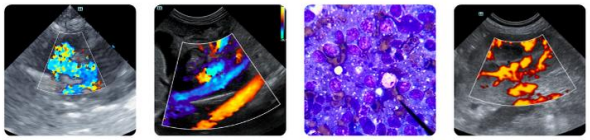


PATIENT

Dumbledor Maniago

SPECIES

Feline

BREED

DSH

SEX

Male Castrated

AGE

13Y, 8M

WEIGHT

9.6

INTERPRETED BY

Beth Johnson, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Christensen

HOSPITAL NAME

Tranquility Veterinary Clinic

REFERRING VET

Castellani

INVOICE

73763

DATE

2-16-26

PRESENTING CLINICAL SIGNS

- In December presented for weight loss. Upon running BW it was found that P had high ionized calcium.

Abnormal PE/Chem/CBC/UA Results: BW from Dec 30th 2025: SDMA increased (18), BUN increased (49), Calcium increased (12.9), ionized calcium increased (1.39), UA isosthenuric (1.015).

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 (Left 3.59 cm, right 3.55 cm) 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.

Adrenal Glands

The left adrenal gland is normal in size (0.24 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The right adrenal gland is normal in size (0.26 cm at cranial pole and 0.21 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size (measures just over the upper end of normal thickness at 1.04 cm thick) 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.

Liver

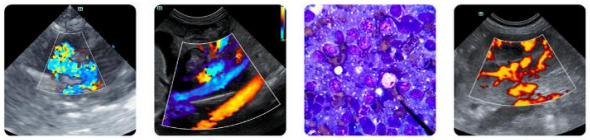
Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

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 primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal chyme. There is 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,



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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 is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Pancreatic duct dilation is noted. Enhanced hyperechoic ill-defined surrounding fat 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 or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.
- Suspect mild acute pancreatitis- potentially mild acute on chronic low grade smoldering pancreatitis flare up.
- Mild 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.
- Similarly, the liver changes are mild and nonspecific with differentials including benign hepatopathy such as bacterial cholangiohepatitis, simple plasmacytic hepatitis, potentially hepatic lipidosis vs infiltrative neoplasia such as round cell neoplasia i.e. lymphoma vs other.

Secondary

- Age related kidney changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given patients reported hypercalcemia, a malignancy panel (PTH, PTHrP, iCa) to Michigan State College of Veterinary Medicine is recommended for further investigation of the reported hypercalcemia.

FNA of the liver and spleen could be considered if patient's coagulation status is appropriate.

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.

Additionally, if not recently evaluated, as ultimately weight loss recommendations are dependent on caloric intake, a thorough evaluation of daily caloric intake is recommended to assure an adequate daily caloric intake is occurring vs an inadvertent reduction in calories due to change in diet and/or feeding schedule, competitive eating environment, etc.

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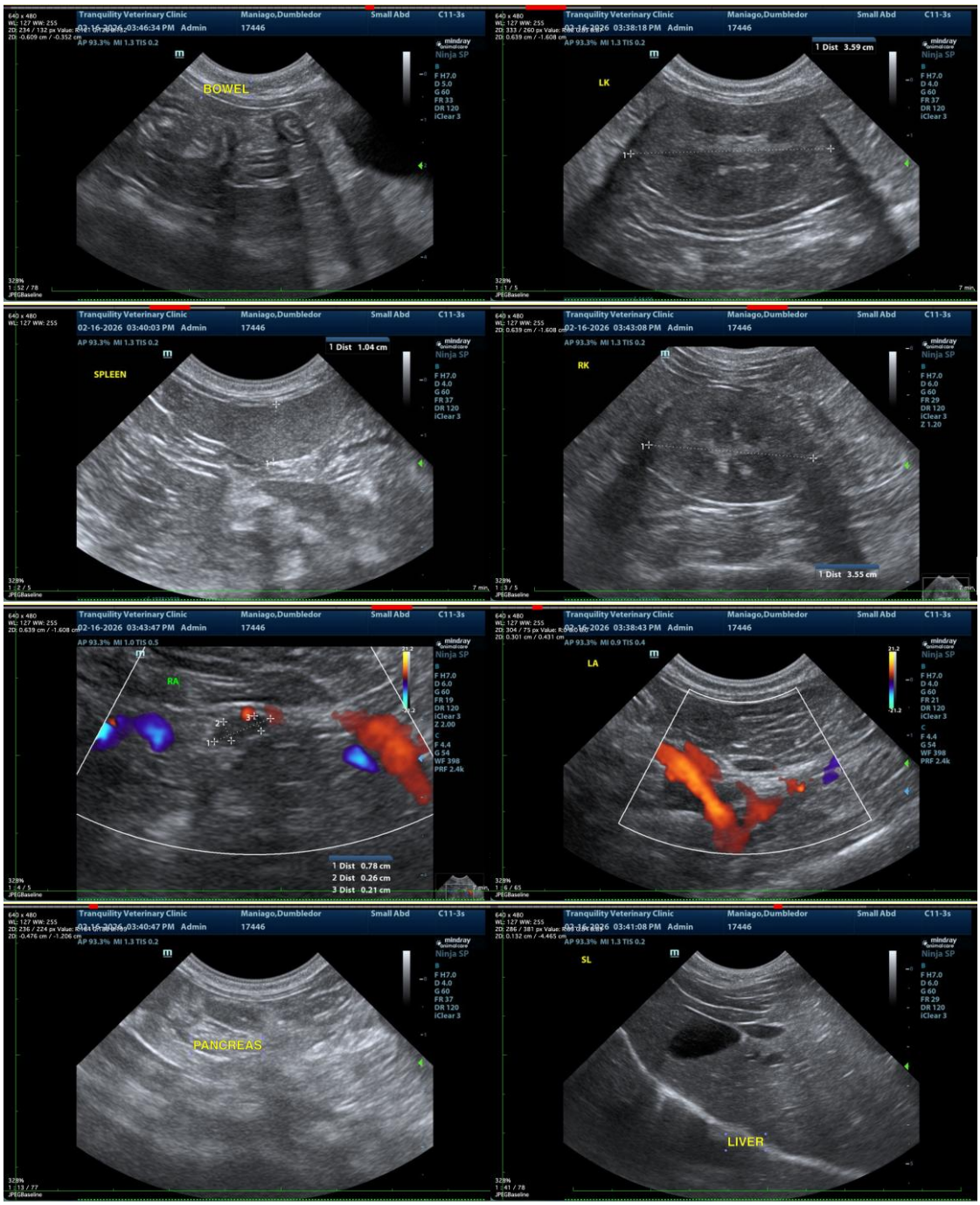
Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.



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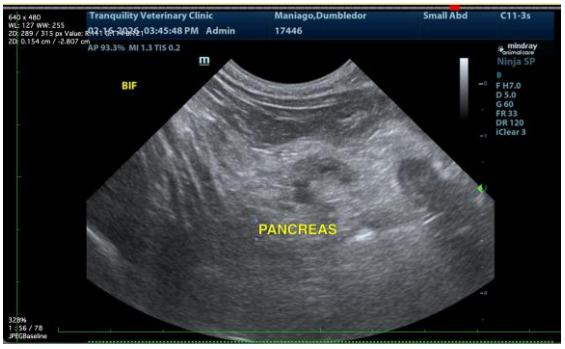

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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