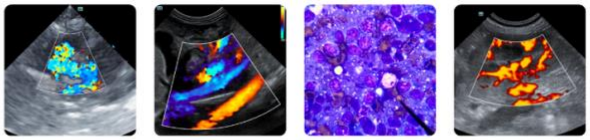


PATIENT

Freddy Higgins

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

5 Years

WEIGHT

10.38 pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Christina CVT

HOSPITAL NAME

Animal Health Veterinary Clinic

REFERRING VET

Dr. Collazos

INVOICE

13853

DATE

02/17/26

PRESENTING CLINICAL SIGNS

- P presented on 2/11/26 mfor weight loss (~4# over a month per O), decreased appetite and lethargy. No vomiting or diarrhea, not on any meds. Icteric on exam, fever of 102.9.
- Gave SQ fluids, Dex inj, Cerenia inj, B12 inj and Convenia inj. Sent home with Mirtazapine.
- P energy has improved some with energy level and is eating slightly better but still icteric and now has fever of 104.9.

Abnormal PE/Chem/CBC/UA Results: HGB - 8.9 FELV/FIV negative TP - 9.5, Globulin - 7.2, Albumin - 2.3, TBILI - 3.3, Amylase - 1349 T4 - 1.2

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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.

Left kidney is normal in size (4.0 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.

Right kidney is normal in size (4.3 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

Left adrenal gland is normal in size (0.48 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is unable to be well visualized in these images.

Spleen

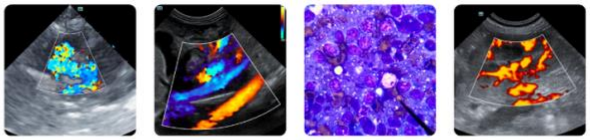
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged (swollen contour) with a diffusely mildly coarse architecture and subtly increased portal markings. Mildly mixed echogenic changes are noted diffusely. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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



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The visible stomach wall is normal in thickness and layering. The lumen of the stomach I 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, 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 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.
- Hypoechoic hepatomegaly- This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Patient's reported clinical signs, based on imaging, are likely at least in part if not totally secondary to benign mild to moderate acute pancreatitis +/- concurrent smoldering bowel disease. Having said that, infiltrative neoplastic disease such as round cell neoplasia i.e. lymphoma affecting the bowel +/- the liver versus other can't be ruled out therefore recommendations include:

Fine needle aspirates of the liver are recommended 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.

Given the hyperglobulinemia, if a diagnosis is not made cytologically, comprehensive infectious disease evaluation including evaluation for FIP is recommended as is further evaluation of the hyperglobulinemia via electrophoresis. Ultimately if a diagnosis is not obtained, biopsies of the GI tract being sure to include ileum, if possible, may be necessary.

In the meantime, treatment recommendations include fluid therapy, anti-emetics, gastroprotectants, hepatic nutraceuticals such as ursodiol and/or Denamarin, and broad-spectrum antibiotics. Nutritional support is critical to prevent/manage concurrent hepatic lipidosis, so appetite stimulants and/or, if indicated, feeding tube placement is also recommended.

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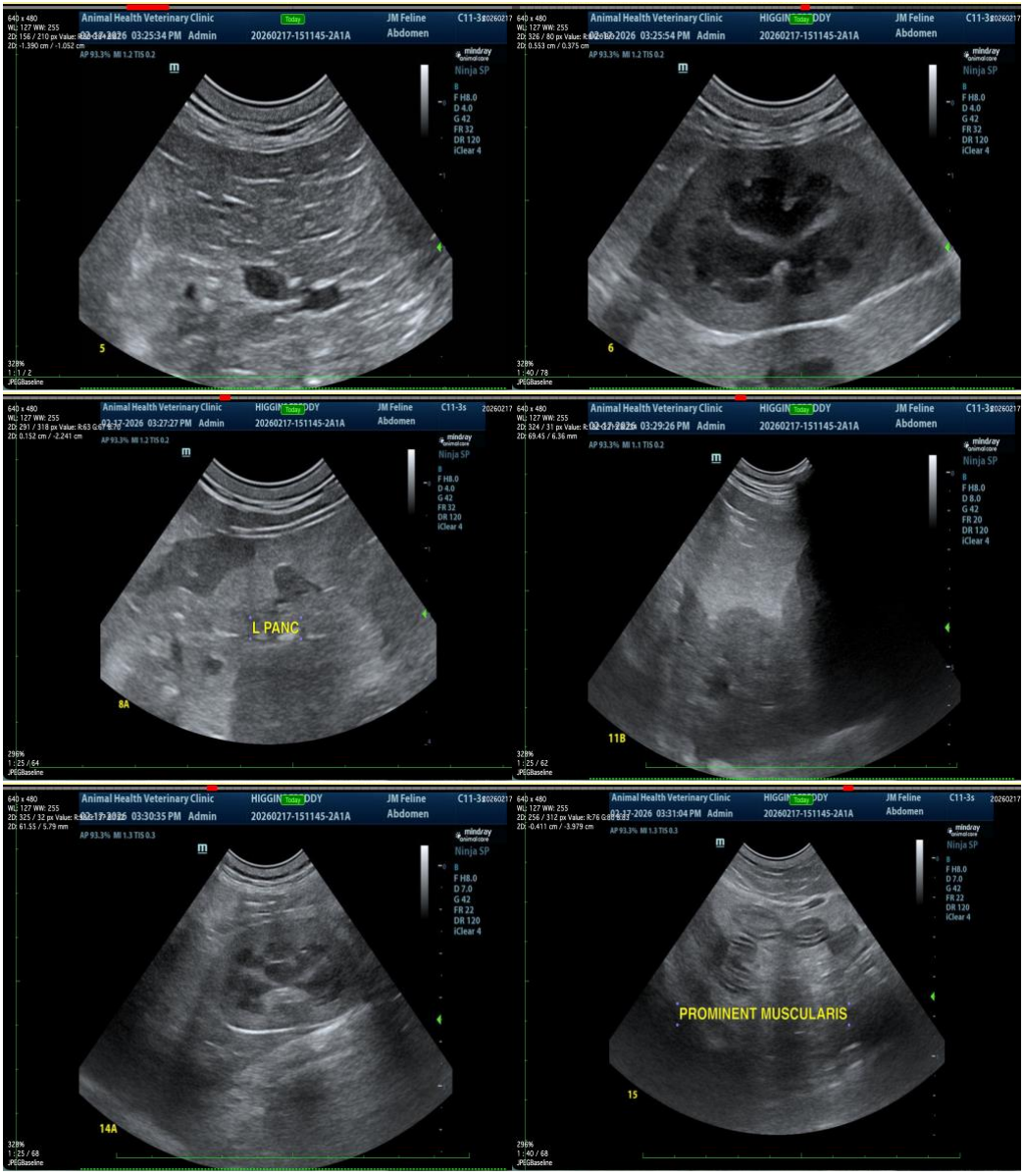

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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