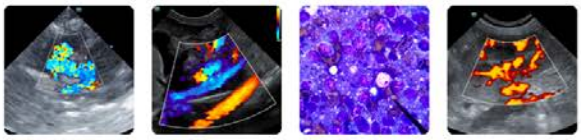




**DATE**

2/19/26

**PATIENT**

Daphne Cross

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Spayed Female

**AGE**

5/1/10

**WEIGHT**

14.5 lbs

**INTERPRETED BY**

Beth Johnson, DVM DACVIM

**HOSPITAL NAME**

Fullerton Animal Hospital

**REFERRING VET**

Dr. Unger

**INVOICE**

73113

## PRESENTING CLINICAL SIGNS

**Patient History:** Patient presented for an ear exam and hearing loss. Weight loss was noted on exam. Patient also has a history of hyperthyroidism and is currently managed on methimazole 2.5 ml BID. Pet also is a chronic vomiter. Ears appeared relatively normal with intact TM's. Cytology showed a 1= yeast otitis AU. Bloodwork was sent at the time of the visit revealing a significantly elevated WBC with no apparent cause. No murmur detected on exam but elevated BNP on labs.

**Current Medications:** Felimazole 2.5 mg PO BID started 3/15/24, Tresaderm BID x 10 days started 1/21-finished, Convenia injection given 1/24/26
**Labwork Results:** Labwork attached, reported as: Cardiopet proBNP (Feline) 173 (0 - 100 pmol/L)prev 110 Platelets 633 (100 - 440 K/µL ), WBC 37.0 (3.9 - 19.0 K/µL), Neutrophils 33.263 (2.62 - 15.17 K/µL), Monocytes 1.11 (0.042 - 0.467 K/µL)
**Date of Previous IntraPet Ultrasound:** No previous.
**Sedation:** Torbugesic.
**Stat Report:** Not requested.
**Imaging Performed by:** Stephanie Warga RDCS, RVT.

## 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 occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also 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 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 3.83 cm. Right kidney measures 3.76 cm.

### *Adrenal Glands*

The right adrenal gland is normal in size (0.43 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.41 cm), 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 enlarged with mildly irregular margins. Parenchyma is moderately heterogeneous, characterized by multiple ill-defined, primarily hyperechoic cystic nodules/masses/densities throughout the 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 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*

Pancreas is prominent in size with swollen irregular contour. Parenchyma is heterogenous characterized by hyperechoic tissue remodeling intermixed with ill-defined hypoechoic nodules. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

### *Free Abdomen*

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

## PRIMARY 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.

- Pancreatic nodular hyperplasia – Infiltrative neoplasia cannot be ruled out but is considered less likely. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.

- Suspect feline biliary cystadenomas – In a senior cat, these liver lesions are most consistent with multiple benign biliary cystadenomas. Malignancy is less common but can't be definitively ruled out without additional information.

## SECONDARY FINDINGS

- Age related kidney changes.
- Mild amount of echogenic urinary bladder debris.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the changes noted above, three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Fine needle aspirates of the pancreas and liver could be considered if patient's coagulation status is appropriate.

Further evaluation of patient's weight loss is largely dependent on appetite. Assuming appetite is normal or even increased, further evaluation of digestion and absorption is recommended, especially given the concurrent bowel changes, beginning with:

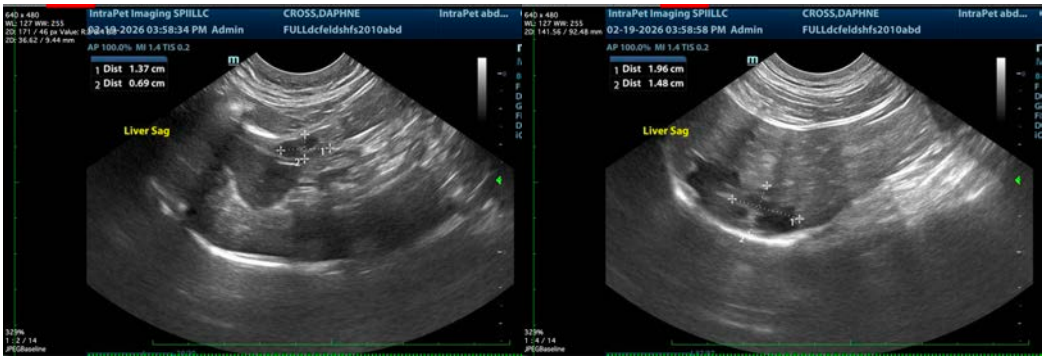
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

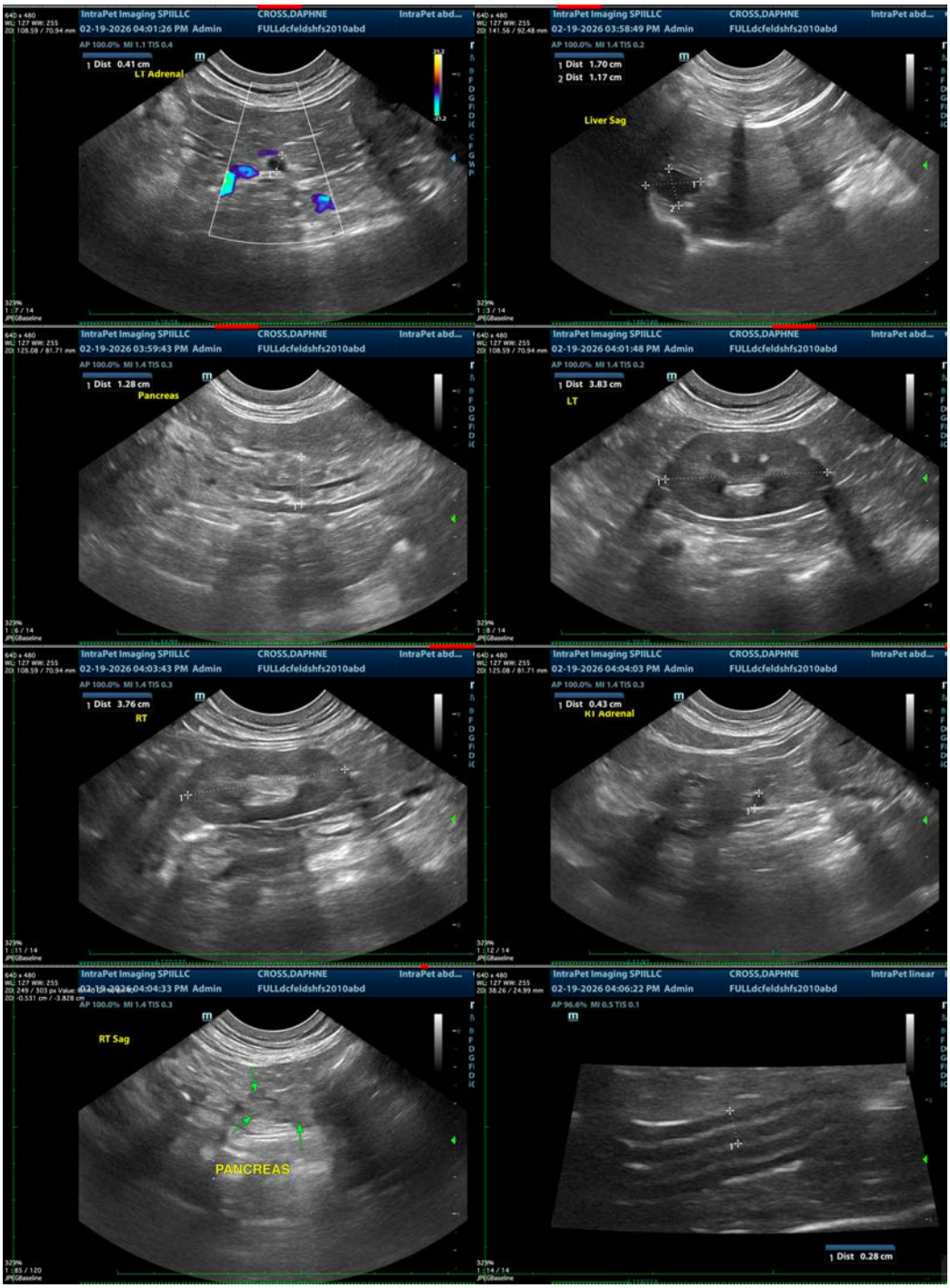
Additionally, urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended.

Further cardiac evaluation, likely a full echocardiogram, is also recommended.

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 pending results of the above workup.

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

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IntraPet linear
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Dist 0.28 cm

**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