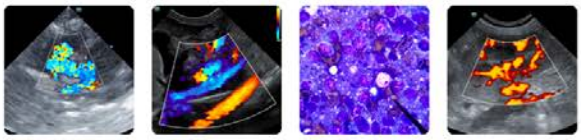


DATE

2/3/26

PATIENT

Stallion Warble

SPECIES

Feline

BREED

DMH

SEX

Neutered Male

AGE

12/19/14

WEIGHT

8.5 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Cat Sense Feline Hospital and Boarding

REFERRING VET

Dr. Sinclair

INVOICE

72678

PRESENTING CLINICAL SIGNS

Patient History: Stallion is a friendly feral cat who presented for making a weird sound at night, not sure if it is a cough. He is thin with a weight loss of 2# since 2018. His small intestines were prominent/thickened. He has such a loud purr his heart and lungs were unable to be ausculted. Radiographs show cardiomegaly, hepatomegaly and significant aerophagia/gas throughout the SI (from purring?). Bloodwork was fairly normal except for an elevated BNP. I am suspicious of possible neoplasia of his liver and intestinal tract and potential cardiomyopathy.

Current Medications: Doxcycyline 25mg bid
Labwork Results: Labwork attached, reported as: BNP=372; radiographs: hepatomegaly, cardiomegaly
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.

The right kidney is normal is size (4.03 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.

The left kidney is normal is size (3.65 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

The right adrenal gland is normal in size (0.36 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.34 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The spleen measures just at the upper end of normal limits for size (1.0 cm thick at the hilus) 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

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. In the mid right liver there is an approximately 0.60 cm x 0.90 cm discrete homogeneous hyperechoic nodule. 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 intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

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. Mild duct dilation is present measuring 0.26 cm dilated.

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

- Hyperechoic hepatomegaly – This appearance is most consistent with benign hepatic lipidosis or endocrine/DM hepatopathy. Infiltrative disease such as amyloidosis or round cell neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.

- Subtly 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.

- Chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.

- Moderately reactive lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

SECONDARY FINDINGS

- Very mild amount of echogenic urinary bladder debris.

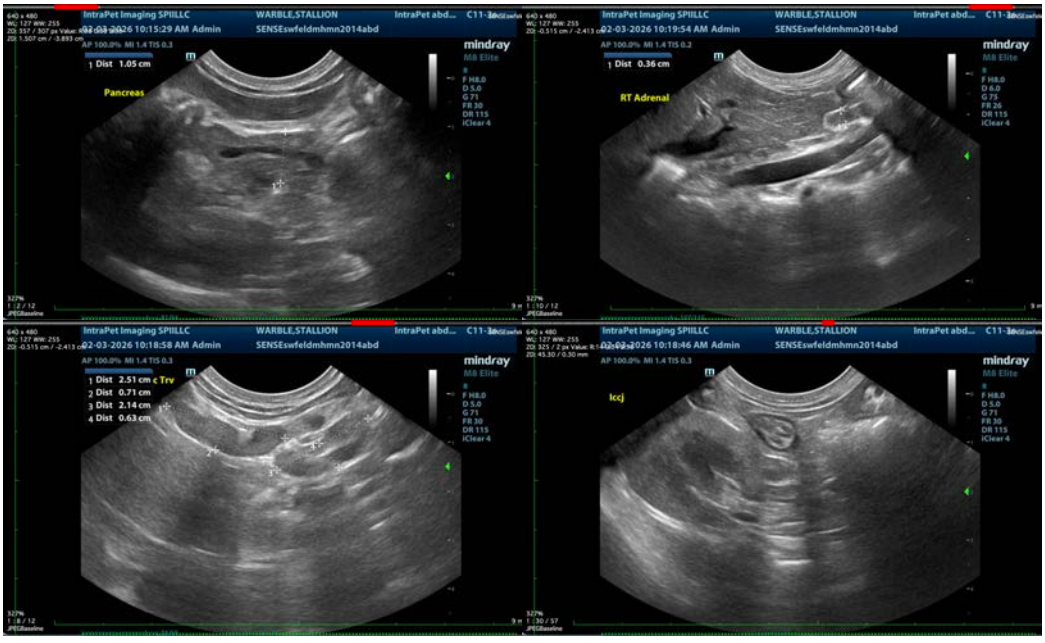
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

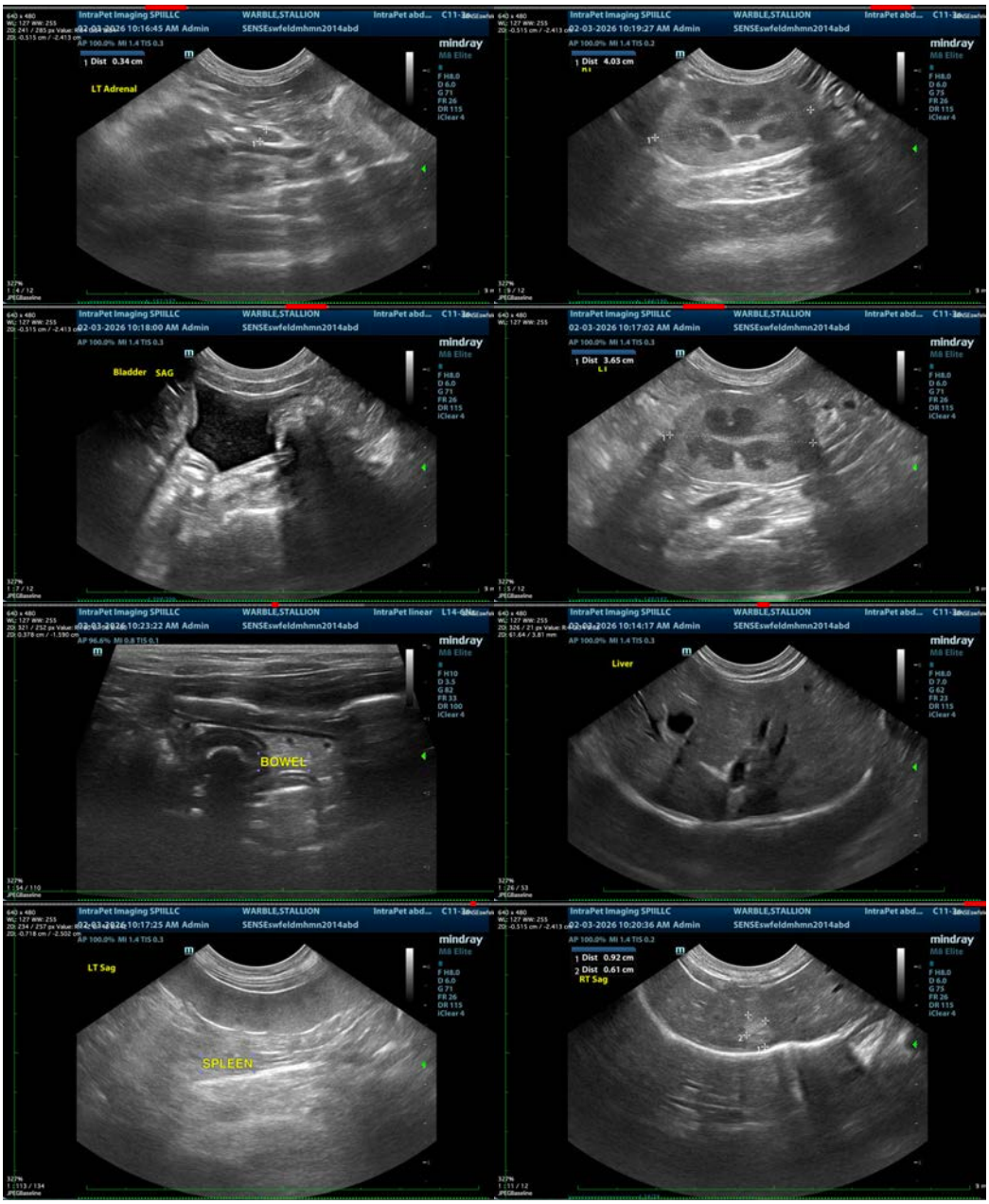
Given patient's history, as is reportedly already pending, a full cardiac evaluation is recommended.

In the meantime, especially given concurrent neutropenia, further workup for infectious disease versus infiltrative neoplastic disease is recommended, beginning with fine needle aspirates of the liver, spleen, and mesenteric lymph nodes if patient's coagulation status is appropriate. If a diagnosis is not made, comprehensive infectious disease evaluation is warranted. Pending that result, if the neutropenia persists without a diagnosis, bone marrow evaluation could be considered.

Further evaluation, given patient's weight loss specifically is largely dependent on appetite. If appetite is normal or even increased and not recently evaluated, then additionally 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.

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





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