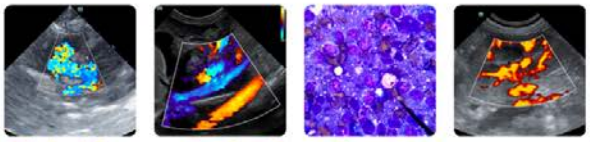


PATIENT

Duffy Marzen

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

18 Years

WEIGHT

3.32 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Wright Veterinary Medical Center

REFERRING VET

Renee Trionfetti, VMD

INVOICE

72729

DATE

2/4/26

PRESENTING CLINICAL SIGNS

Double cavity study. Echo to further evaluate an elevated proBNP (949 H), no prev HM. Time of echo, grade 1/6 intermittent bilateral parasternal, more basilar HM appreciated. AUS to further evaluate weight loss 1.18 lbs, and decreased appetite. BW shows elevated proBNP, elevated SDMA, low USG, proteinuria, mild anemia (chronic). Concern for progression of CKD vs other. PMH: Hyperthyroidism, CKD.

Meds: Methimazole BID. Diet: KD diet and renal support diet

Abnormal PE/Chem/CBC/UA Results: BP Doppler: 190, 190, 190 mmHg 1/29/26 - CBC: Hct 28.3 L, Hgb 9.0 L, normocytic, normochromic, plts 486 H - Chem: SDMA 19 H, Cr 1.1, BUN 26, Phos 4.5-n, Alb 3.1-n, Glob 4.7-n, normal LES - USG 1.011 - UPC: 0.6 - proteinuric - proBNP 949 H - T4: 2.8 on methimazole - FeLV/FIV/HW: Neg x 3 - Feal: NPS

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 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. The left kidney is mildly small at 3.0 cm. The right kidney is normal in size at 3.5 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.30 cm at cranial pole and 0.18 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.30 cm at cranial pole and 0.30 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.

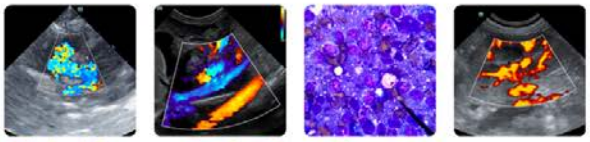
Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is moderately 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 empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.



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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. **This change is most significant in the ileum.* 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.

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. **Again, this change is most prominent in the ileum.*

- 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.

- The liver changes are non-specific but could represent a microscopic hepatopathy, with both benign differentials such as bacterial or lymphoplasmacytic cholangiohepatitis and/or infiltrative neoplasia such as round cell neoplasia i.e., lymphoma versus other being differentials.

- Very mild/subtle chronic kidney disease changes bilaterally, appreciated most visibly by a mildly small left kidney.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

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

Ultimately, biopsies of the GI tract, being sure to include ileum, if possible, may be necessary for a definitive diagnosis and therefore to further guide medical management of the reportedly ongoing weight loss.

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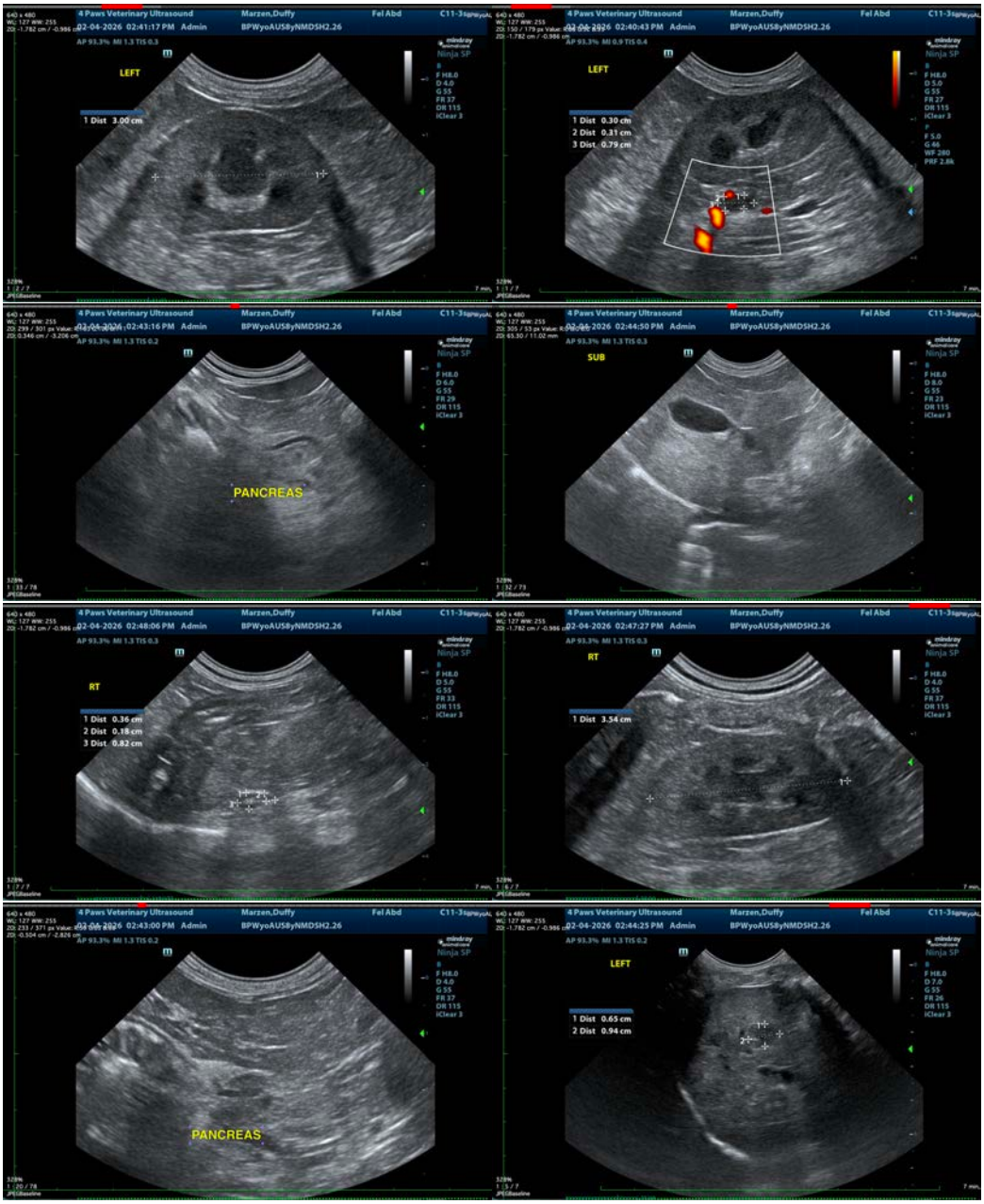
In the meantime, however, given the hypertension and mild proteinuria, if not already in place, treating the hypertension while monitoring the proteinuria for improvement/resolution is recommended.



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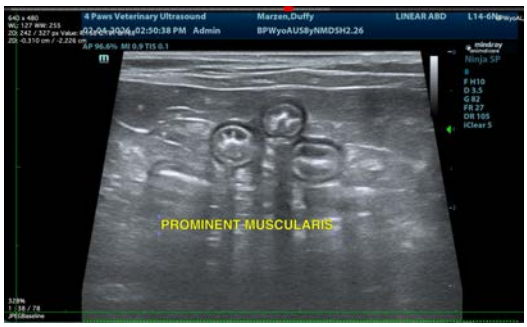

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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