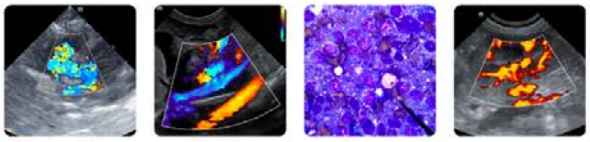


PATIENT

Randall Minnich

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

2 Years

WEIGHT

3.46 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Firefly Veterinary Urgent Care

REFERRING VET

Gina Watzka, DVM

INVOICE

72772

DATE

2/5/26

PRESENTING CLINICAL SIGNS

AUS to further evaluate weight loss, poor appetite (hasn't eaten in 2 days), lethargy, history of acute-on-chronic vomiting; also has had low temperature, relative bradycardia, and elevated lactate recently - r/o underlying heart disease vs high vagal tone (poss related to GI?). History of FLUTD; managed currently on c/d and Prozac. O describes as chronic inappropriate urination with more recent hematuria. Recent UC showed Staph. BW notes low iCa, elevated lactate, low BUN, hyperglycemia, low USG, + gluc

Meds: - finishing last 2 days of Simplicef; - Prozac

Abnormal PE/Chem/CBC/UA Results: 1/22/2026 EPOC: pH 7.314, iCa 1.17 L, lac 5.38 H, BG 222 H CBC: Hct 37%, plt 160 Chem 15: BG 205 H, Cr 0.5 L, BUN 17, alb 3.2, glob 3.6, norm LES qPL: 1.1 rads: sig gastric material w/diffuse mod SI dilation & persistent radiopaque material in cranial abd 1/23/2026 PCV/TP: 46/7.8 EPOC: pH 7.251, iCa 1.17 L, lac 6.27 H, BUN 10L, Cr 0.54, BG 342 H 18-20 hr fast rad DACVR: no obstruction, dorsal/cranial opacity is likely adrenal mineralization (incidental finding in cats) UA: 1.014, 1,000 glucose 2/5/2026 CBC: Hct 50%, WBC 7.95, neut 2.24k L, lymph 4, plt 226 Chem 15: BG 234 H, Cr 0.9, BUN 26, Phos 3.3, Ca 8.9, TP 5.5 H, alb 2.5, glob 3, A:G 0.8, ALT 24, ALP <10 L, tbili 0.4 EPOC: pH 7.3, K 3.3 L, lactate 6.8 H SNAP ProBNP: Abnormal FIV/FeLV: Neg GI Panel to Texas A&M: Pending

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 (3.9 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 (3.6 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.

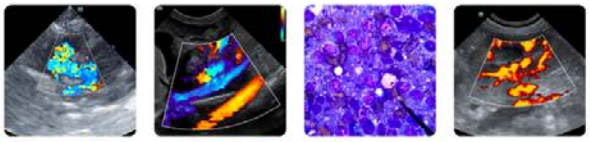
Adrenal Glands

The right adrenal gland is normal in size (0.31 cm at cranial pole and 0.39 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.28 cm at cranial pole and 0.33 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.



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Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. 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 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 markedly/significantly 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 (enlarged) in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. No pancreatic duct dilation is noted.

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.

ULTRASONOGRAPHIC FINDINGS

- Marked/significant 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.
- Markedly reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Concurrent chronic low-grade smoldering pancreatitis can't be ruled out as a contributing factor and should be suspected in the face of appropriate clinical signs.
- Mild to moderate amount of echogenic urinary bladder debris.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A routine fecal/giardia exam is recommended if not recently evaluated.

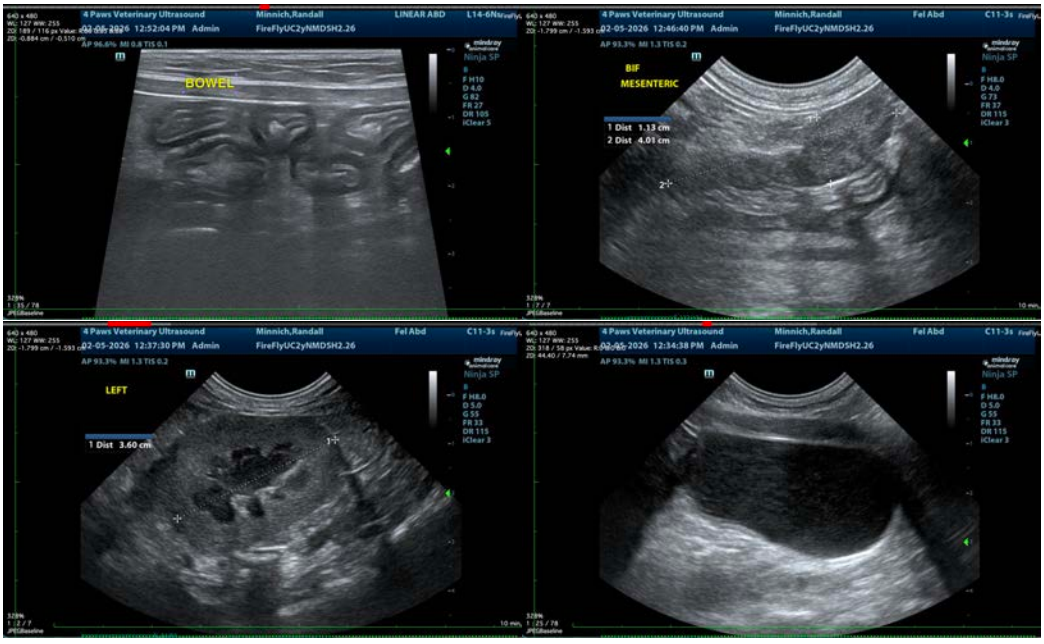
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

Fine needle aspirates of the enlarged lymph nodes could be considered if patient's coagulation status is appropriate, but if a diagnosis is not obtained, 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.

If biopsies cannot be obtained, empirical therapies could include a probiotic (if diarrhea is present, such as visbiome or proviable), empirical deworming with a 5-day course of Panacur and, if tolerated, a transition in diet, based on trial-and-error response, beginning with a hydrolyzed protein diet. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several trials may be required.

Additional considerations could include cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.).



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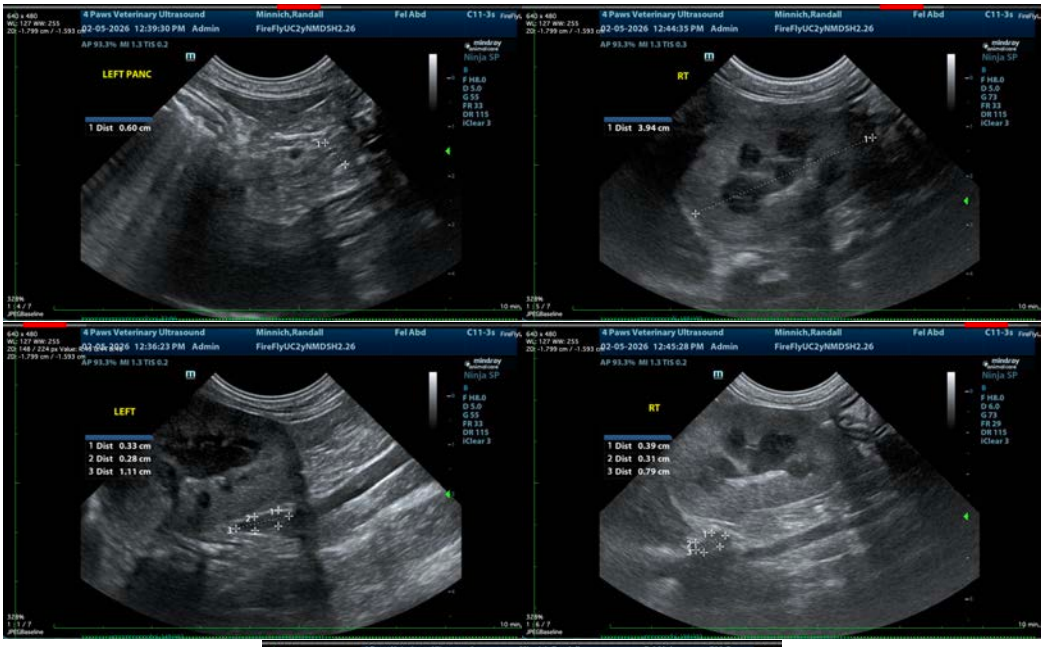

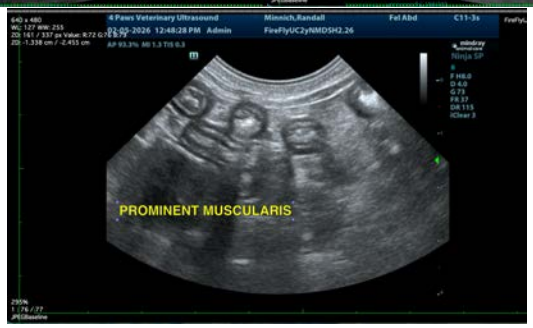

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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