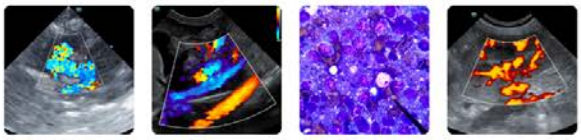


DATE

4/14/26

PATIENT

Dozer McCabe

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

6/26/14

WEIGHT

10.8 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Everhart Veterinary Hospital Cross Keys

REFERRING VET

Dr. Notarangelo

INVOICE

74451

PRESENTING CLINICAL SIGNS

Patient Name: Dozer McCabe
Exam Type: Abdomen
Species/Breed: Feline DSH
Sex: MN
Weight: 10.8lbs
Date of Birth: 6/26/2014
Hospital: Everhart Veterinary Hospital Cross Keys
Referring DVM: Dr. Notarangelo
Date of exam: 4/14/2026

Patient History: Weight loss , intermittent vomiting thin BCS, thickened intestines? ravenous appetite V+ R/O hyperthyroid vs IBD, Lab work was not suggestive of Hyperthyroid so clients wanted to proceed with the ultrasound.

Current Medications: MAROPITANT CITRATE 24MG TABLET 3/20/2026, GABAPENTIN 100MG/ML SUSPENSION PER ML CHICKEN FLAVOR 2/24/2026
Labwork Results: Labwork submitted. Reported as within normal limits, nothing linked to weight loss
Date of Previous IntraPet Ultrasound: No previous.
Sedation: torb required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Andi Parkinson RDMS

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.

The right kidney is normal is size (4.04 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 (3.96 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 (0.33 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 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 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 mildly 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.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Very mild/subtle 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.

- Concurrent chronic low-grade smoldering pancreatitis is suspected.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The bowel changes are mild/subtle, and chronic smoldering pancreatitis typically does not result in polyphagia, but given the clinical history, further evaluation of digestion and absorption is recommended, beginning with a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory for further evaluation of GI and pancreatic function.

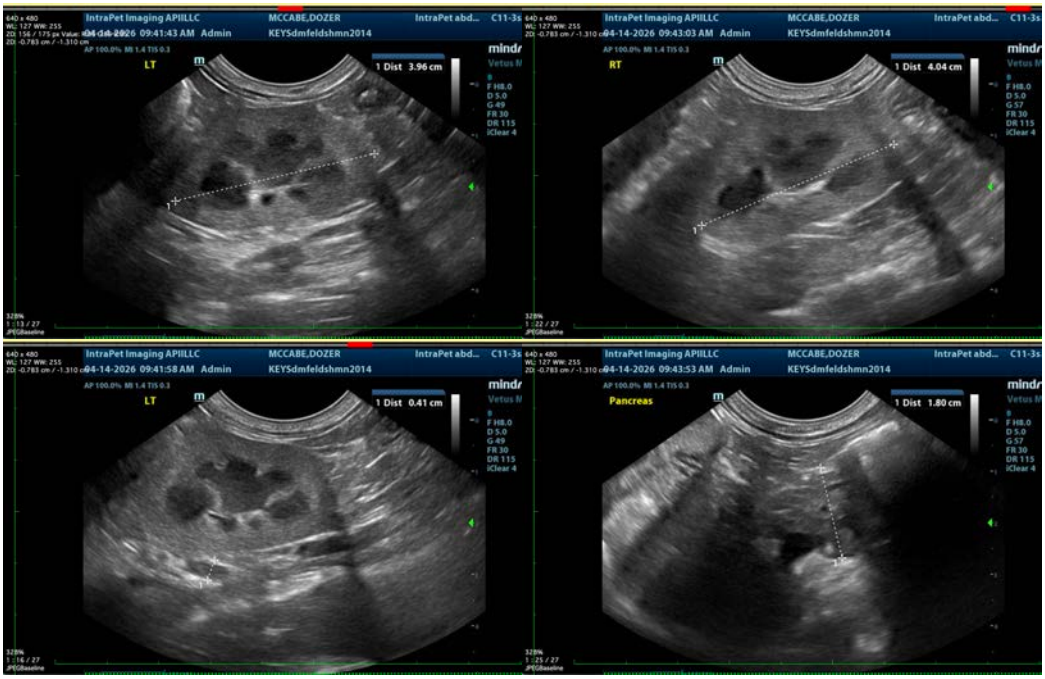
In the meantime, if not recently evaluated, a thorough evaluation of daily caloric intake is recommended to assure an adequate daily caloric intake is occurring vs an inadvertent reduction in calories due to change in diet and/or feeding schedule, competitive eating environment, etc.

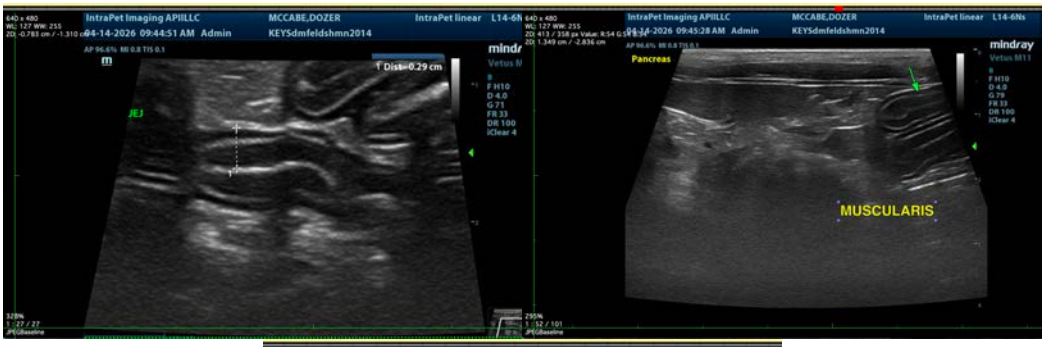
Additional diagnostics to consider include a routine fecal/giardia exam.

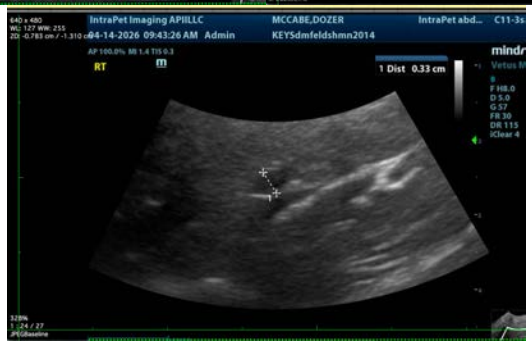
A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

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

In the meantime, if tolerated, a transition in diet is recommended, based on trial-and-error response. Some options to consider include a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs a fiber response/colitis diet vs a bland, easy to digest or low-fat diet vs other.







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