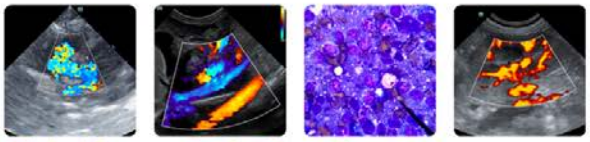


PATIENT

Star Readinger

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

14 Years 9 Months

WEIGHT

3 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

VCA Sinking Springs

INVOICE

74496

DATE

4/15/26

PRESENTING CLINICAL SIGNS

AUS to further evaluate liquid diarrhea, weight loss and leukocytosis characterized by a mature lymphocytosis, neutrophilia, monocytosis, and mildly elevated CPK. Evaluating for a possible ultrasonographically detectable inflammatory component. Presented to rDVM about 1 week ago for liquid D+ about 1 week, still E/D. PE noted grade 2-3/6 HM, weight loss, borborygmi, fluid filled intestines and yellow paste-like stool on the anus.

- Meds: Proviable Forte Kit, Metronidazole
- Diet: I/D canned, Biome Feline

Abnormal PE/Chem/CBC/UA Results: CBC: Hct 33%-n, WBC 23.4H, Neut 12,402H, Lymph 10,296H, Mono 702H, plts 453H Path review: Mature lymphocytosis. Magnitude may suggest reactive lymphocytosis (chronic inflammation; hyperT4; epi/physiologic v lymphocytic neoplasia cannot be excluded. Mature neutrophilia & monocytosis present, suggests inflammatory &/or stress/glucocorticoid/epinephrine response; no neutrophilic left shift or toxic change noted. Polychromasia minimal. No overt pathologic RBC morphologic abnormalities, no RBC parasites observed. Platelets are clumped; adequate. No infectious agents Chem: Alb 2.7-n, norm LES, Cr, BUN, Gluc 109-n, CPK 667H T4: 1.5-n Keyscreen: NPD UA: USG 1.051, pH 6, Pro 2+, Bld 2+, RBC 4-10/hpf, CaOx Dihyd crystals 21-50/hpf, CaOx mono-hyd 4-10/hpf. Bact- susp contamination

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 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 3.88 cm. Right kidney measures 4.33 cm.

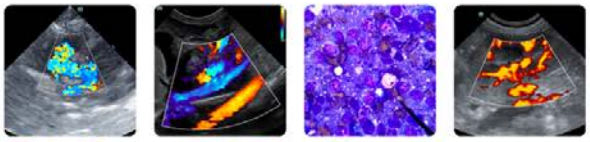
Adrenal Glands

The right adrenal gland is normal in size (0.24 cm at cranial pole and 0.30 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.38 cm at cranial pole and 0.31 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

Liver is subjectively enlarged (swollen contour) with a diffusely mildly coarse architecture and subtly increased portal markings. Mildly mixed echogenic changes are noted diffusely. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. The cystic and common bile duct are diffusely tortuous in appearance and mildly dilated, measuring 0.58 cm dilated. There is no evidence of intraluminal mineral or tissue all the way to the level of the duodenal papilla.

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 (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 a very scant/trace amount of free fluid noted, primarily between liver lobes.

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

- 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.

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

- Similarly, concurrent chronic low-grade smoldering cholangiohepatitis/Triaditis could be contributing to clinical signs and should be suspected in the face of appropriate laboratory changes, etc. Other infiltrative disease affecting the liver including potential round cell neoplasia such as lymphoma can't be ruled out without tissue sampling.

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- Mildly reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- The trace free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.

SECONDARY FINDINGS

- Moderate age related kidney changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

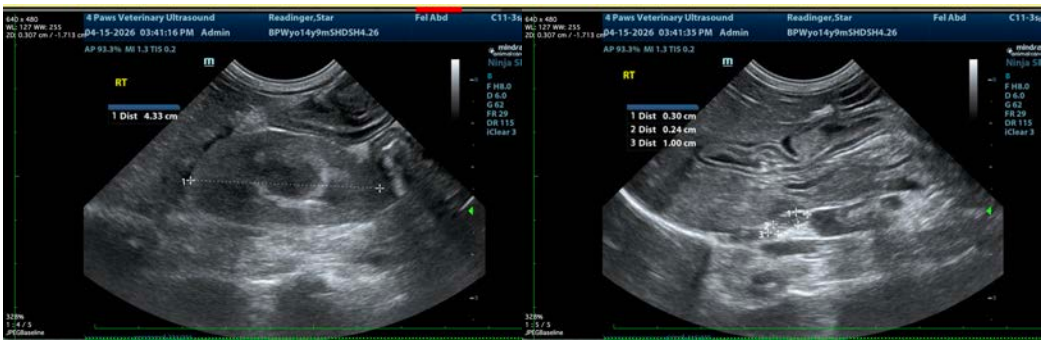
A routine fecal/giardia exam is recommended if not recently evaluated.

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 liver could be considered if patient's coagulation status is appropriate. Ultimately, however, if a cytologic diagnosis is unable to be obtained and clinical signs persist beyond management, 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, supportive/symptomatic medical management of clinical signs is recommended, including a probiotic (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 possibly with a gastrointestinal biome diet vs a hydrolyzed protein diet vs other. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several brand attempts may be required.



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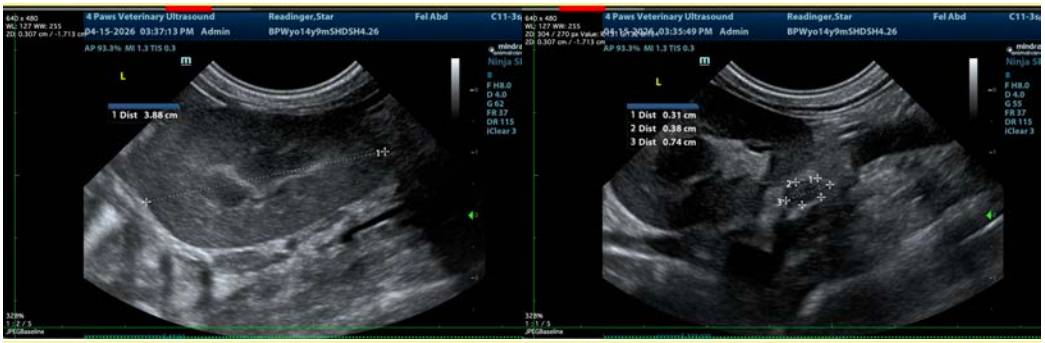

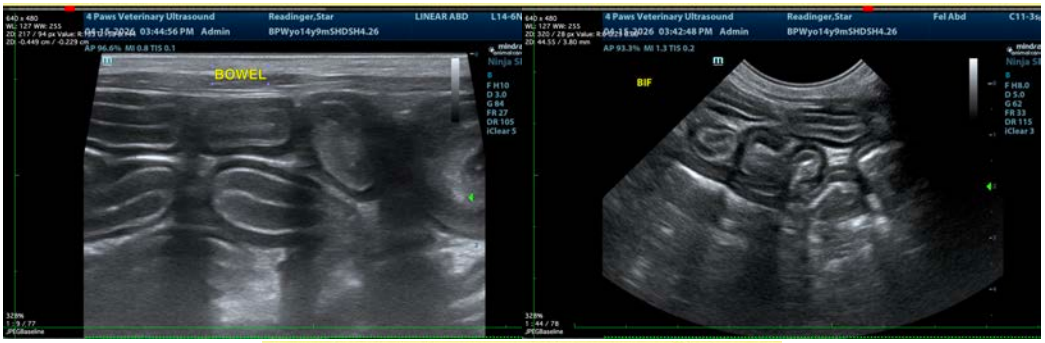

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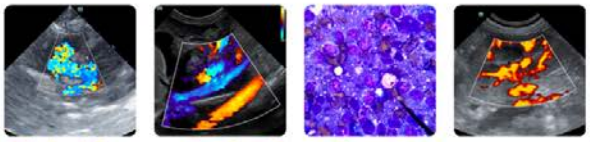

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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