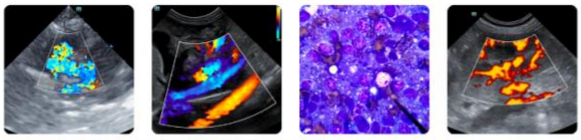


DATE

04/21/26

PATIENT

Jasper Dugan

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

03/04/07

WEIGHT

6.3 pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Jacksonville Veterinary Hospital

REFERRING VET

Dr. Thai

INVOICE

15320

PRESENTING CLINICAL SIGNS

Patient History: Long hx of hyperthyroidism-txed with transdermal methimazole. Recently has lost some weight (appetite/water intake no change). Vomiting/spitting up about 3 times per week; sometimes clear, occasionally brown; may go a week without (no diarrhea). Hx of intermittent chronic sneezing with yellow to green nasal discharge for years. On PE-muscle wasted topside-has lost the weight he gained over the year (about a lb), abd palp-sl thickened intestines, grade 2-3/6 sys murmur, sl unkempt coat, sneezing fit during exam

Current Medications: Methimazole transdermal 2.5 mg bid longterm. Started Azithromycin 40 mg sid for 5 days, then 40 mg q 3 days a couple of wks ago.
Labwork Results: Labwork attached, reported as: Vetscreen/CBC: alb low normal 2.9, BUN 46, creat 1.9, SDMA 13.7, liver values WNL. HCT 32%, mild decrease lym 882, no increase in WBC. T4 4. From previous BW in the past year-BUN and creat. trending up, HCT trending down slightly, alb has been 3.7 and 3.5 in march and may of 2025
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with primarily adequate contents. Along the mid to caudal inner dorsal wall is an irregular mildly heterogeneous echogenic density measuring approximately 2.0 cm long by 0.7 cm thick that in some views appears to have blood flow but is difficult to determine normal wall blood flow versus blood flow to the density making it tough to differentiate tissue versus adhered mucus, debris, blood clots, etc. No cystoliths are observed.

Kidneys are bilaterally small in size, 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 measured 3.0 cm in length. The right kidney measured 3.2 cm in length.

Adrenal Glands

Left adrenal gland is normal in size (0.39 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.39 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size with normal smooth margins. Parenchyma is normal in echogenicity with a diffusely coarse/heterogenous echotexture. No discrete sizable focal nodules or masses are observed. Splenic vasculature appears normal. The spleen measured 1.0 cm thick at the hilus.

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. Visible vasculature and biliary tree appear normal without distension or congestion. Additionally in the right caudal liver is an approximately 1.1 cm by 1.9 cm cystic primarily hyperechoic nodule/mass.

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/emerging 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

- Coarse splenomegaly- can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- The diffuse liver changes are nonspecific with differentials representing both benign microscopic hepatopathies i.e. bacterial or lymphoplasmacytic cholangiohepatitis, hepatic lipidosis, other or infiltrative neoplastic disease such as round cell neoplasia i.e. lymphoma versus mast cell versus other and can't be differentiated without tissue sampling.
- Mild/emerging inflammatory bowel disease 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. This change is very mild/subtle and could be in part normal patient variant in a senior cat.

- Chronic low grade smoldering pancreatitis can't be ruled out should be suspected in the face of appropriate clinical signs.
- Moderate bilateral chronic kidney disease changes.
- As described above, the urinary bladder density could represent tissue in which case both benign inflammatory cystitis changes as well as infiltrative neoplastic disease are differentials. Non-tissue density i.e. blood clot, mucus, debris can't be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

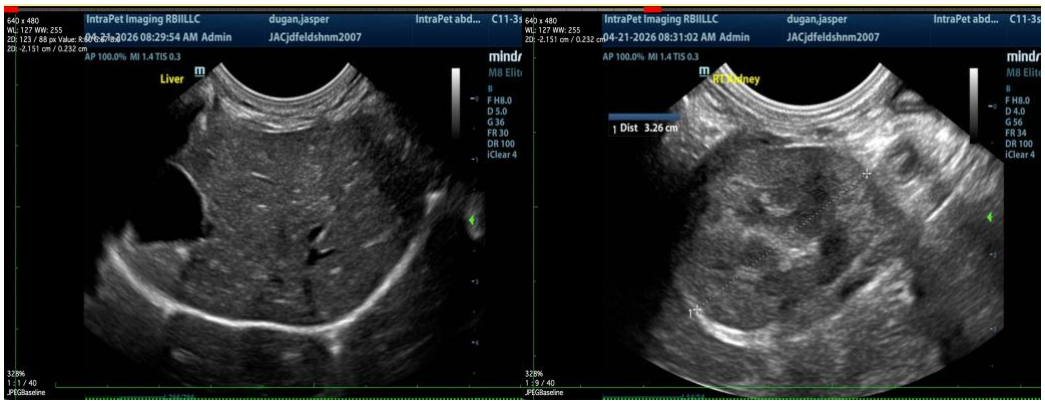
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

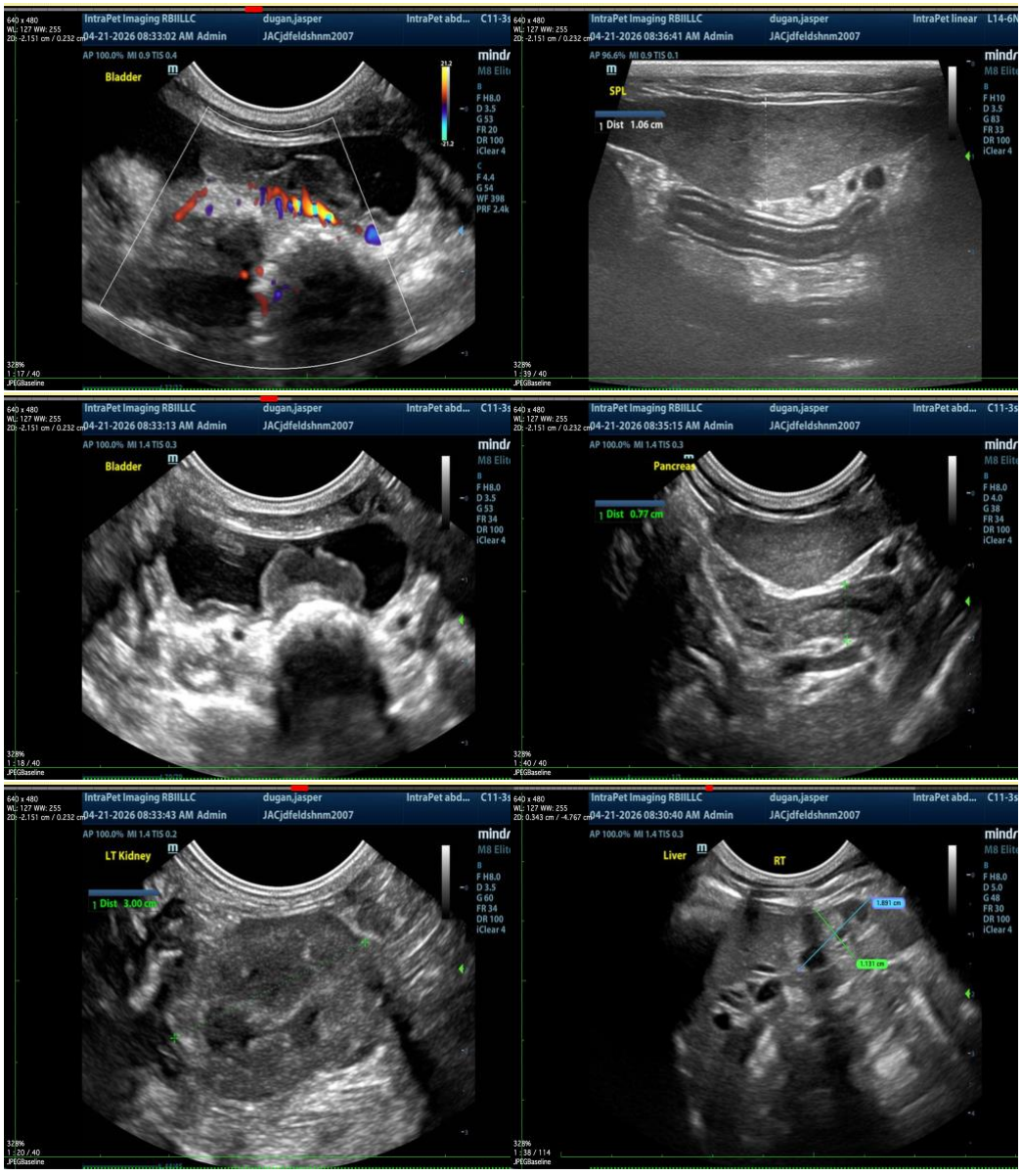
Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

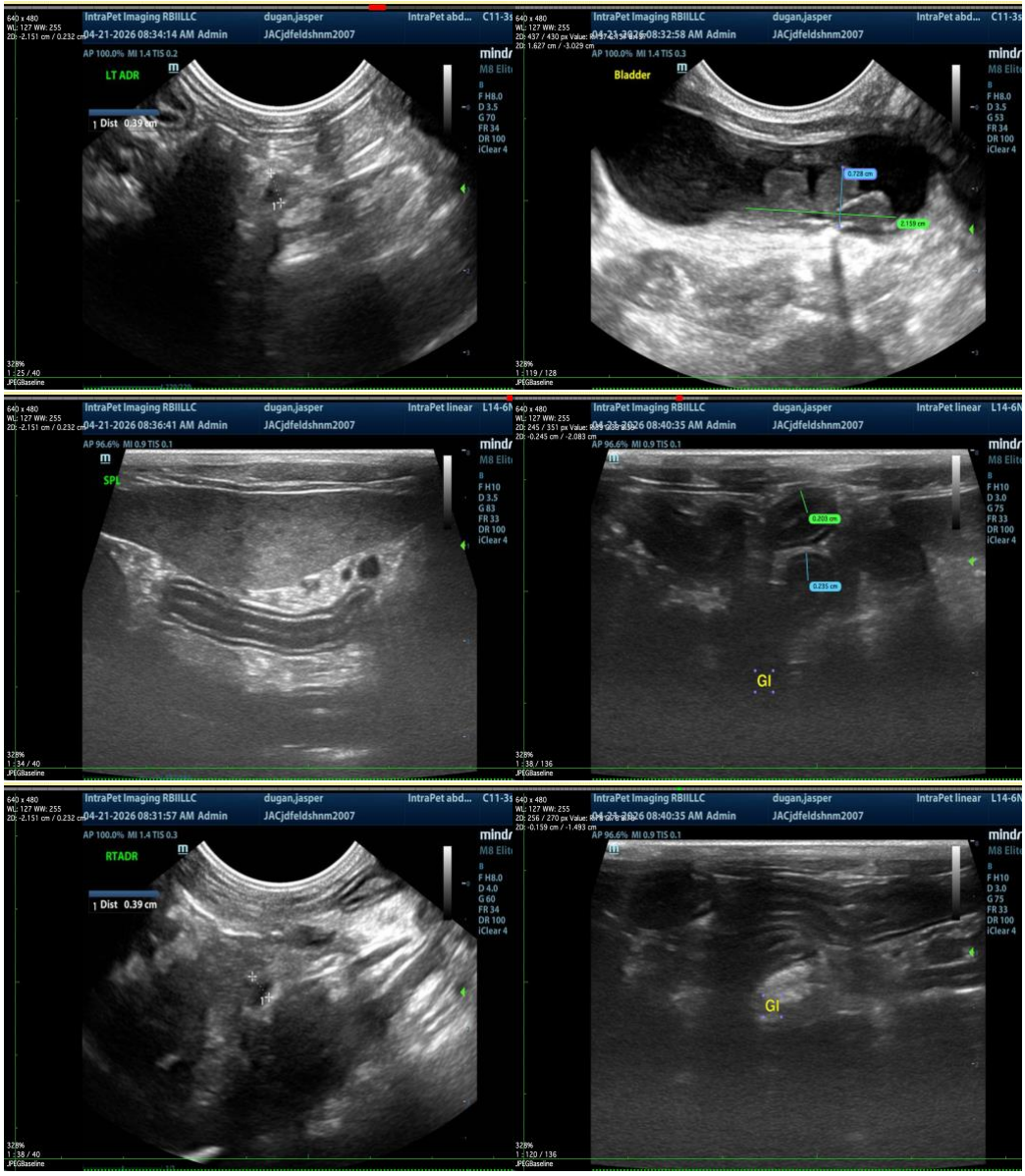
If not recently evaluated, urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

Fine needle aspirates of the spleen and liver +/- urinary bladder mass (with some risk for tumor seeding/trailing of the bladder mass) could be considered if patient's coagulation status is appropriate.

In the meantime, in addition to supportive/symptomatic medical management of clinical signs, additionally more aggressive hyperthyroidism management could be considered given the high normal t4 combined with weight loss nausea etc. which could be in part secondary to hyperthyroidism.




IntraPet Imaging RBIILLC
dugan,jasper
04-21-2026 08:33:02 AM Admin
JACjdfeldshnm2007
Bladder
IntraPet Imaging RBIILLC
dugan,jasper
04-21-2026 08:36:41 AM Admin
JACjdfeldshnm2007
SPL
Dist 1.06 cm
IntraPet Imaging RBIILLC
dugan,jasper
04-21-2026 08:33:13 AM Admin
JACjdfeldshnm2007
Bladder
IntraPet Imaging RBIILLC
dugan,jasper
04-21-2026 08:35:15 AM Admin
JACjdfeldshnm2007
Pancreas
Dist 0.77 cm
IntraPet Imaging RBIILLC
dugan,jasper
04-21-2026 08:33:43 AM Admin
JACjdfeldshnm2007
LT Kidney
Dist 3.00 cm
IntraPet Imaging RBIILLC
dugan,jasper
04-21-2026 08:30:40 AM Admin
JACjdfeldshnm2007
Liver
RT



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