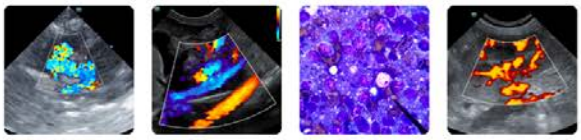


DATE

4/21/26

PATIENT

Shelby GT DiGennaro

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

11/13/14

WEIGHT

18.1 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Pleasantville Animal Hospital of Fallston

REFERRING VET

Dr. Gounaris

INVOICE

74667

PRESENTING CLINICAL SIGNS

Patient History: Initially presented 4/13/2026 for sneezing clear nasal discharge that began 4/11. Decreased appetite, lethargy on Sunday. Normal vomiting or diarrhea reported. Normal bowel movement Sunday. Appetite returned to normal the morning of 4/13. Physical exam 4/13 normal vitals, mild serous nasal discharge bilaterally, BCS 8/9 with moderate muscle wasting, generalized weakness, mm pink, dental disease with a fractured and potentially infected upper premolar, peripheral LN palpate normally. Weight loss noted from previous visit in 2024 - owners mention they had tried to get him to lose weight. No significant findings on diagnostics. Discussed monitoring for development of symptoms and follow up exam with survey rads if anorexia returns. 4/20 presented for decline over the weekend. Stopped eating on Saturday. Still drinking. No vomiting or diarrhea. No signs of labored breathing reported. Became acutely weak, unable to stand. Physical exam revealed tachycardia, normal respiratory rate and effort, icteric mm, Weak but palpable femoral pulses, rectal temperature 102.6, shocky and unable to stand on presentation. Repeat blood work showed mild increase in ALP and marked increase in Tbili. Survey radiographs - moderately full bladder but easy to express on palpation. No significant abnormalities observed. Hospitalized for several hours for IVF. Shock bolus administered, moderate improvement in mentation but still overall weak and unable to stand. Owner declined referral to ER for continued hospitalization and overnight care/monitoring. History of seizures - well controlled on phenobarbital daily.

Current Medications: None.
Labwork Results: Labwork not attached, reported as: 4/13: CBC – unremarkable. Chemistry - mild ALP elevation 111 (10-90), BG 170 (70-150), AST 56 (12-43), GGT low. T4 - 1.5 (1.5-4.8). Phenobarbital - 36.8 (10-45). 4/20: CBC - unremarkable (low normal RBC, lymphocytes). Chemistry - ALP 125, Tbili 2.4, BUN 8, Glu 172, Na 140
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Decliend at this time.
Imaging Performed by: Stephanie Warga RDCS, RVT.

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 (4.5 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 (4.3 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 (0.25 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.37 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is largely normal in appearance (shape, echotexture and echogenicity); however, it is volume contracted. Hydration status assessment is recommended.

Liver

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. 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. *Incidentally, the gallbladder appears to be bilobed, which is a non-pathologic anatomic variant.

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

The pancreas is prominent/enlarged in size, diffusely irregular in shape, and hypoechoic to surrounding tissues. Parenchyma is diffusely coarse with an almost nodular appearance in some views and diffusely mixed echogenic remodeling noted. No pancreatic duct dilation is noted. No definitive peripancreatic enhanced tissue is present.

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

- Chronic low-grade smoldering pancreatitis is suspected with concurrent pancreatic nodular hyperplasia being a possibility. Infiltrative neoplasia is thought less likely but can't be ruled out without tissue sampling.

- Hyperechoic hepatomegaly – This appearance is most consistent with benign hepatic lipidosis or endocrine/DM hepatopathy. Infiltrative disease such as amyloidosis or round cell neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.

- 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The appearance of the hepatobiliary system, pancreas, bowel, etc. could all represent ongoing "Triaditis", although given patient's severe reported clinical presentation, more severe disease including potentially infiltrative neoplastic disease, decreased hepatic function, or other underlying neurologic disease, etc. can't be ruled out. Further recommendations include:

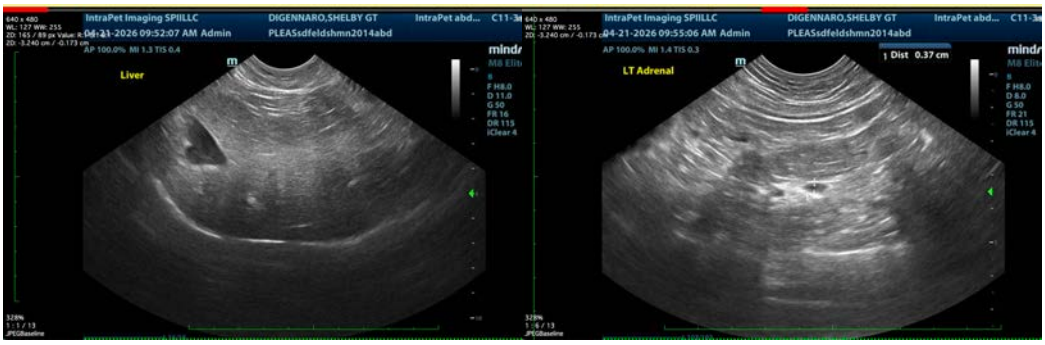
Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

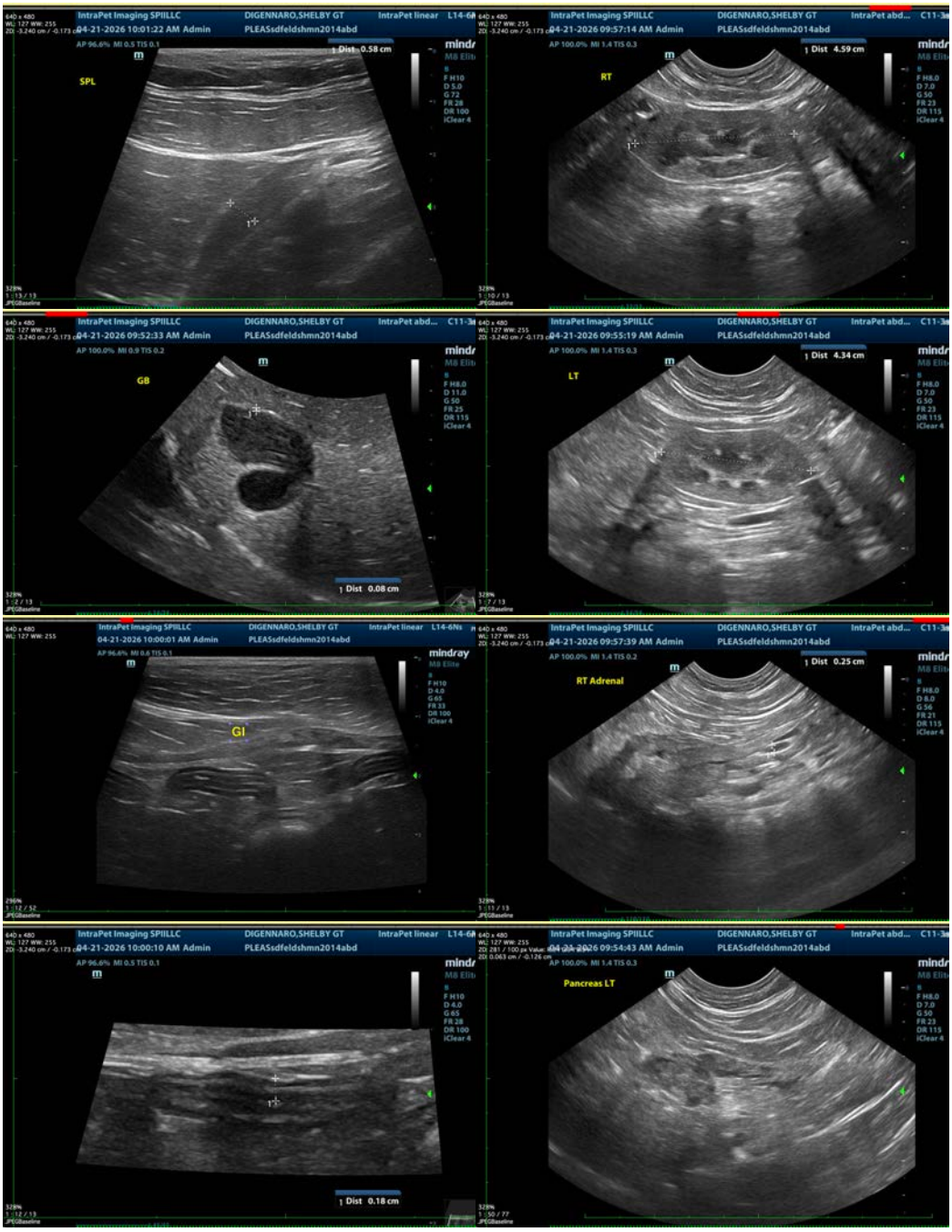
Fine needle aspirates of the liver and pancreas could be considered if patient's coagulation status is appropriate.

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.

In the meantime, given the mild drop in red blood cell count at the same time as the mild increase in total bilirubin, continued monitoring for possible ongoing hemolysis and anemia is recommended.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.

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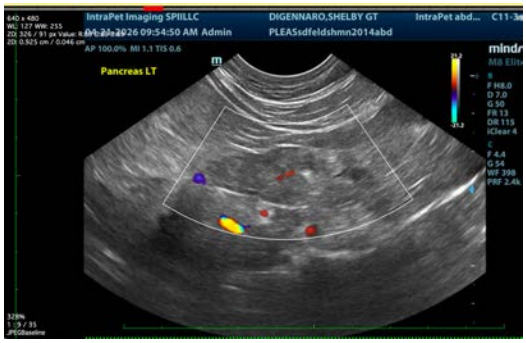
Pancreas LT



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