PATIENT

Sadie Copenharve

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

13 years

WEIGHT

3.75 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Grass Valley Veterinary Hospital

REFERRING VET

Dr. Yoffe

INVOICE

11834

DATE

4/30/2026

PRESENTING CLINICAL SIGNS

P has had a decrease in appetite for about 2 weeks. P has not been interested in eating her her favorite cat treats and she has not been very interested in her food. O has also noticed that P water intake has been decreased. P has been on W/D for a few years now and has lost weight from being on the diet, but O has noticed P losing more weight recently. O has also noticed that P appears weaker. When O pets P she will lose her balance. Working diagnosis: Renal failure / Other metabolic dz / Diabetes / Other endocrine (thyroid) / Neoplasia.

Abnormal PE/Chem/CBC/UA Results: Very dehydrated Amylase 1504 HIGH PrecisionPSL 41 HIGH WBC 24.1 HIGH Neutrophils 92 HIGH Lymphocytes 3 LOW Absolute Neutrophils 22172 HIGH Absolute Lymphocytes 723 LOW.

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 mineral or infarcts observed. Trace pyelectasia noted bilaterally. Left kidney measures 3.82 cm, and the right kidney measures 3.76 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.5 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.39 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

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.

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 subjectively tortuous in appearance and mildly proximally dilated with some intraluminal echogenic contents. There is no evidence of effusion or inflammation.

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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 proximal ascending colon right at the ileocecal colic junction is mildly thick measuring 0.24 cm thick, with normal intact layering. The remaining colon is normal, and the lumen is empty with no evidence of obstruction or foreign material.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is a scant pocket of free fluid adjacent to the spleen.

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- 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 gallbladder debris – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness, however, it can also be associated with hepatobiliary disease in cats and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.
- Mild/emerging 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.
- The mildly thick ascending colon likely represents the same differentials as the small bowel which trends in appearance toward benign.
- Concurrent chronic low grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- Scant 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

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oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.

SECONDARY FINDINGS

- Mild age-related kidney changes with trace bilateral pyelectasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

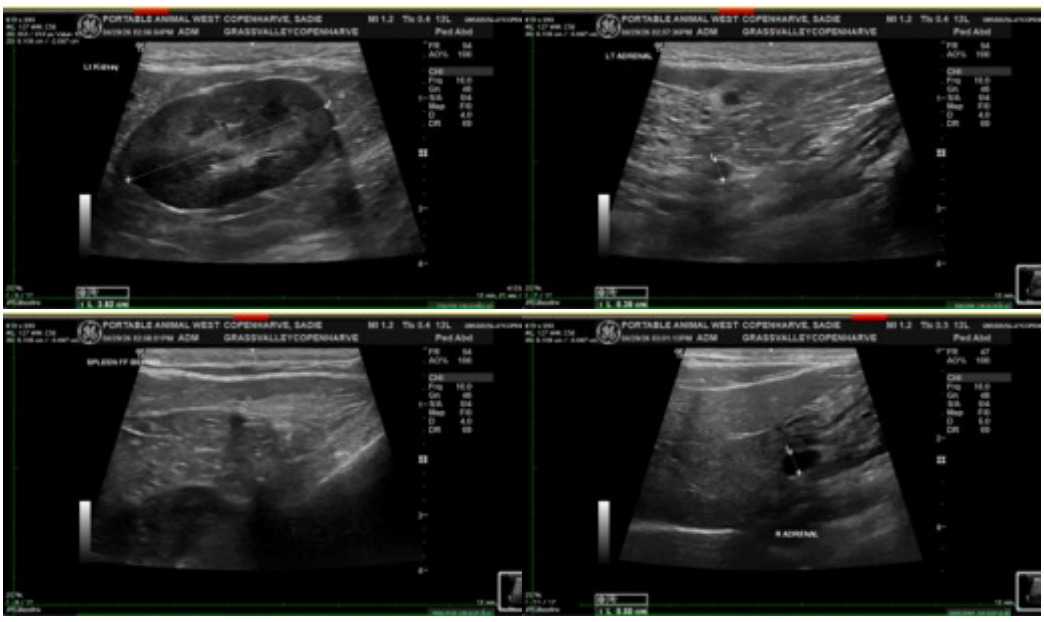
"Triaditis" is a differential for these images, given the hepatobiliary, pancreatic, and bowel changes. Having said that, infiltrative disease including potentially infiltrative neoplastic disease can't be ruled out. Therefore, tissue sampling can be considered beginning with fine needle aspirates of the liver if patient's coagulation status is appropriate.

Ultimately, however, biopsies of the GI tract, being sure to include ileum and colon, may be necessary for a definitive diagnosis and therefore to further guide medical management. In the meantime, 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 routine fecal/giardia exam is recommended if not recently evaluated.

As could 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.

Pending results of above, further evaluation for possible pain (dental, orthopedic, other), upper respiratory disease or oropharyngeal disease, cardiac disease and/or neurologic disease vs other as possible causes for decreased appetite and/or unintentional weight loss is also recommended.



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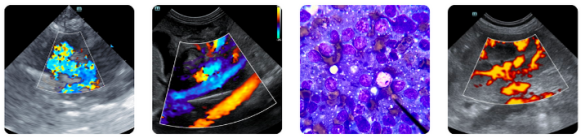

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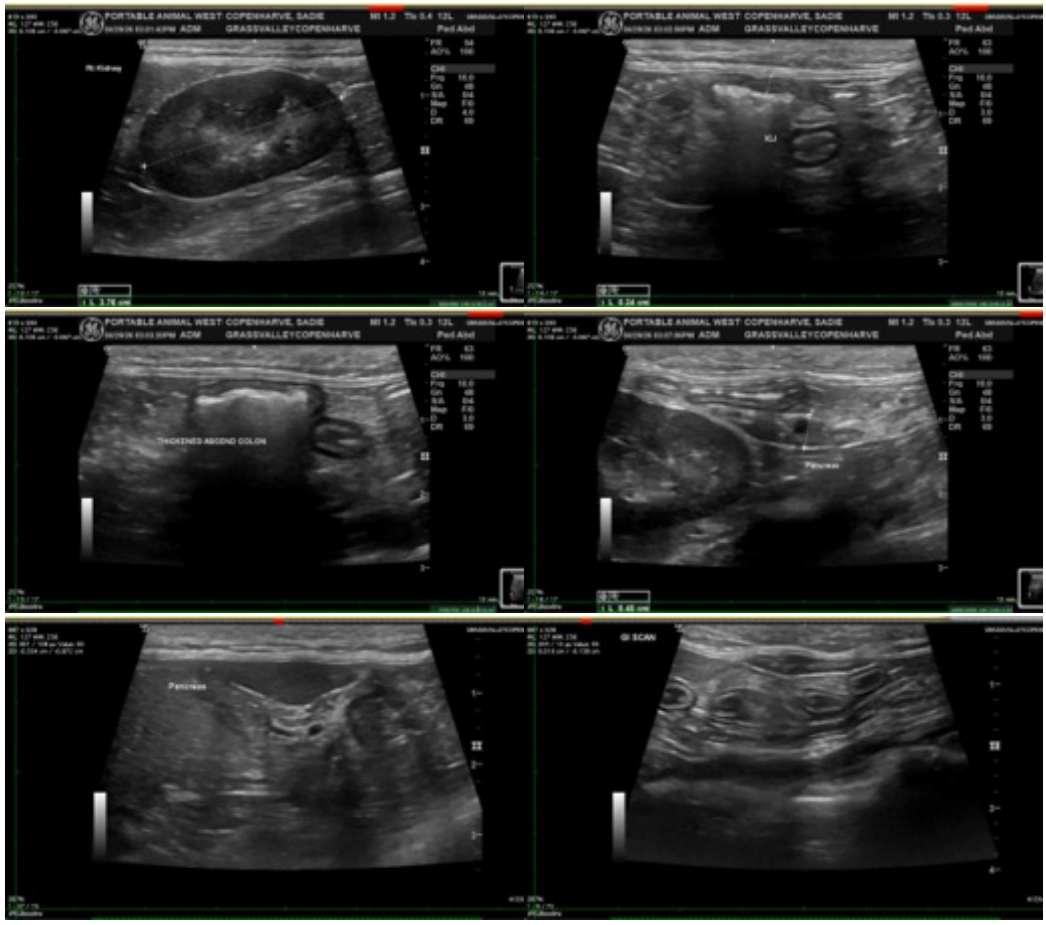

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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