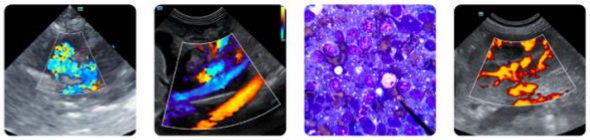


PATIENT

Soda Seward

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

12 Years

WEIGHT

3.8 kg

INTERPRETED BY

Beth Johnson, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

Heatherlynn McFarlane, DVM, DACVIM (Internal Med)

INVOICE

36489

DATE

4/6/26

PRESENTING CLINICAL SIGNS

- AUS to further evaluate vomiting, hyporexia, and weight loss (~2lbs in 6 months). Clinical signs began ~6months ago and improved with a dietary switch to Hills I/D but recently vomiting became progressive and began to develop loss of appetite. Evaluated 9/2025 where blood work was overall unremarkable with a normal T4 (1.4). Abdominal radiographs were also unremarkable. Treated supportively with SQF and SQ cerenia. Re-evaluated again 3/3/26 where repeat blood work remained unremarkable. qPL normal at 1.1. Started on empiric prednisolone. Since then, vomiting has improved significantly.
- Medications: Prednisolone (3mg/mL) 1mL q48hr (off Prednisolone now ~ 1-2 wks), OTC multi-vitamin which contains 200mcg of Vit B12 and other Vit Bs.
- Diet: Hills I/D, tiki cat
- Exam is overall unremarkable other than a mildly low normal BCS. Normal formed feces on rectal examination.
- Abnormal PE/Chem/CBC/UA Results: 3/3/26 AXR: Gastric luminal wall seems to be thickened (possibly artifact due to empty lumen?). Colon contains normal fecal material with some gas, no evidence of excessive distention. SI lumen is uniformed throughout with no obvious obstruction material or pattern appreciated. Bladder is intact. Unremarkable L renal silhouette, unable to visualized R kidney due to ascending colon superimposing. Chem: TP 7.3, Alb 2.6, Glob 4.7, Creat 1.2, BUN 20, ALT <10 (L), ALP 14, GGT 0, Tbil 0.3 (0-0.9), Chol 136, Ca 8.5, Phos 4.0, Glu 104 TT4: 1.8 Quantitative PL: 1.1 (0-4.4) Sept 2025 CBC: WBC 11.55K, Neut 6.29K, Lymph 4.57K, Eos 0.29K, HCT 41.2%, PLT 371K

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

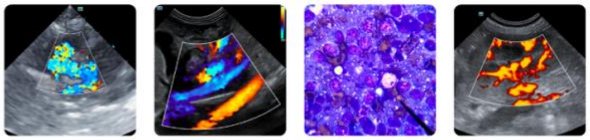
Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a large amount of echogenic non-shadowing debris, most consistent with exfoliated cells, crystals, mucous and/or small blood clots likely combined with incidental suspended lipid. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is small/normal in size (3.58 cm). The left kidney is irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted. A pinpoint nonobstructive mineral density can't be ruled out.

Right kidney is normal in 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 mineral or infarcts observed. Trace pyelectasia is noted in the right kidney.

Adrenal Glands

Left adrenal gland is normal in size (0.31 cm at cranial pole and 0.35 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.



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Right adrenal gland is normal in size (0.35 cm at cranial pole and 0.29 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

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 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.

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.

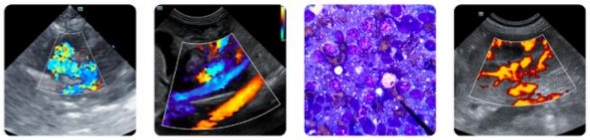
Free Abdomen

There is no visible free peritoneal effusion noted in these images.

The 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.

ULTRASONOGRAPHIC FINDINGS

- 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.
- Concurrent chronic low grade smoldering pancreatitis can't be ruled out.



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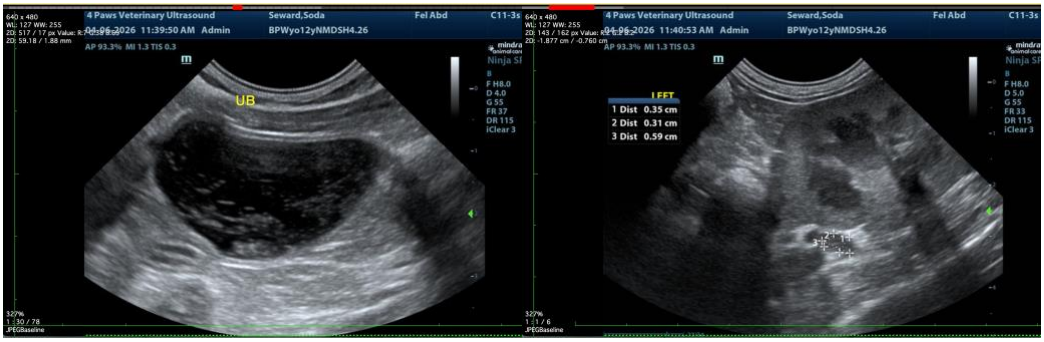
- Mildly to moderately reactive mesenteric lymphadenopathy- infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Mild chronic kidney disease changes, primarily noted in the left kidney with incidental nonobstructive mineral also in that kidney.
- A moderate to large amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

The bowel changes are mild/subtle, but given patient's history, are likely in part altered or potentially reduced from the previous steroid history. Therefore, pending patient's ongoing clinical status:

- 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.
- Ideally, biopsies of the GI tract, being sure to include ileum, if possible, are recommended to definitively diagnose and therefore manage the infiltrative bowel disease.
- If biopsies cannot be obtained, empirical therapies could include a probiotic (if diarrhea is present, 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 with a hydrolyzed protein diet. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several trials may be required.
- Additional considerations could include cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.).



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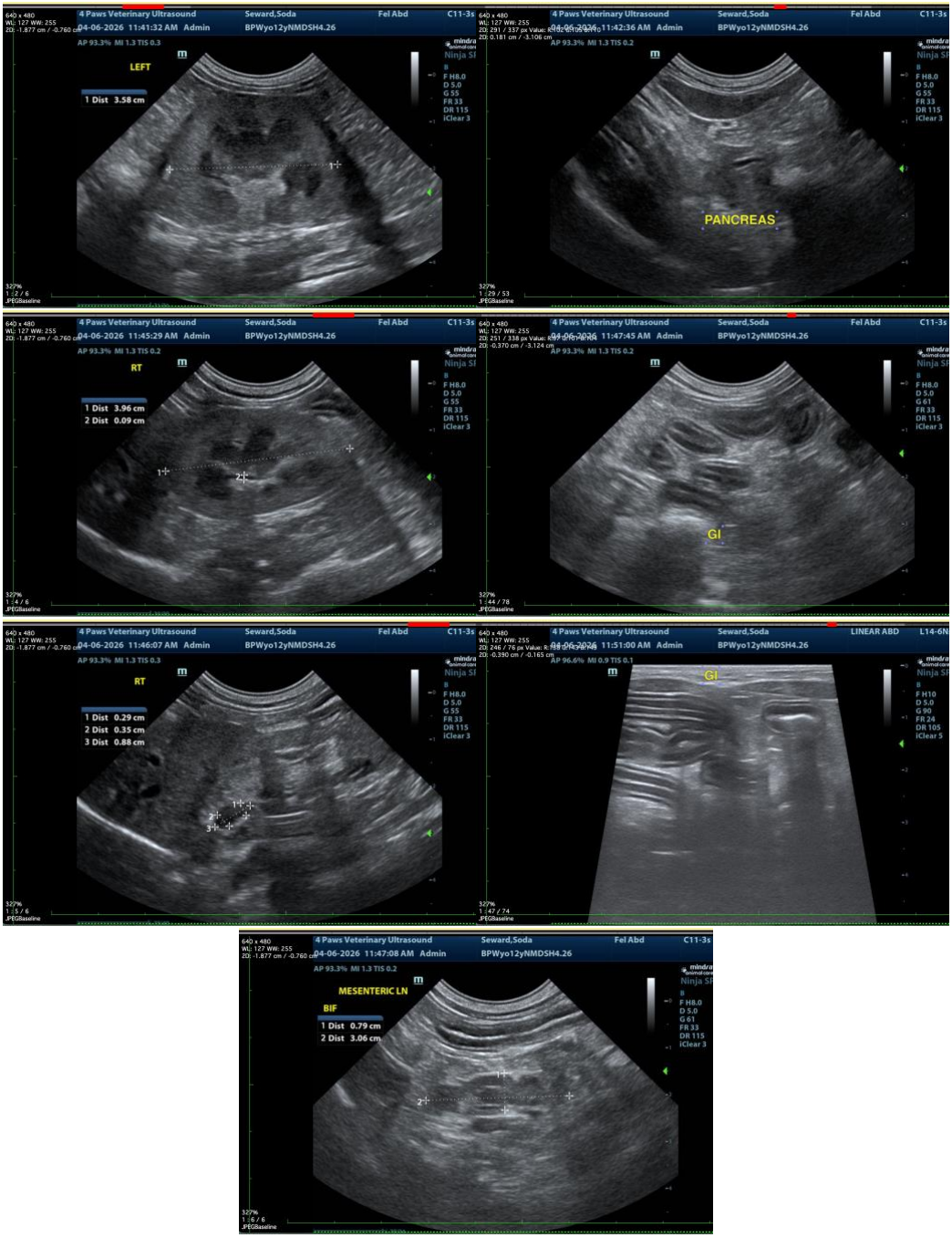

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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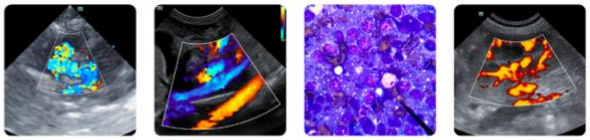

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