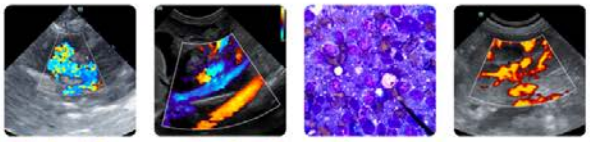


PATIENT

Boots Blanos

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered Male

AGE

10 Years

WEIGHT

11.26 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

MEW

HOSPITAL NAME

Weddington Animal Hospital

REFERRING VET

Dr. Ed Faulkner

INVOICE

75452

DATE

5/26/26

PRESENTING CLINICAL SIGNS

10yo MN DSH presents for further evaluation of weight loss (12.38 lb in Dec). P has had a historical 2/6 heart murmur. PE otherwise unremarkable. No current meds. Indoor only. FF neg in Oct.

Abnormal PE/Chem/CBC/UA Results: (5/22/26) CBC no remarkable abnormalities Chem AST 216 ALT 904 ALP 199 Tbili 0.9 cholesterol 235 amylase 1528 PSL 29 T4 2.0 U/A unable to collect

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 occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also 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.

The right kidney is normal is size (4.1 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 (4.2 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 areas of the adrenal glands are examined without evident adrenal gland pathology.

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.

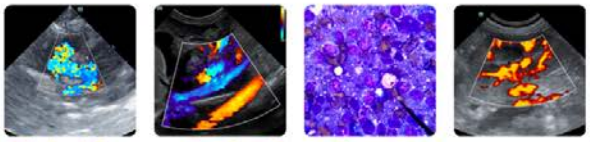
Liver

The 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.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. The cystic and common bile duct are subjectively mildly tortuous without visible distention noted.

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.



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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 that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

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

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.

- Moderate reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

SECONDARY FINDINGS

- Mild amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is not a definitive ultrasonographically visible intraabdominal explanation for patient's reportedly increased liver enzymes. However, a microscopic hepatopathy including benign bacterial or lymphoplasmacytic cholangiohepatitis, hepatic lipidosis, other benign infectious or inflammatory hepatopathy, or infiltrative neoplasia such as round cell neoplasia versus other are all differentials that can't be differentiated without tissue sampling. Therefore, fine needle aspirates of the liver +/- the enlarged mesenteric lymph nodes could be considered if patient's coagulation status is appropriate.

Given the bowel changes combined with the concurrent reported weight loss, further evaluation of digestion and absorption is also recommended, beginning with a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory for further evaluation of GI and pancreatic function.

Bile acids could be considered if patient's total bilirubin is not increased. Ultimately, pending results of above, biopsies of the GI tract, being sure to include ileum, if possible, as well as liver biopsies may be necessary for definitive diagnosis and to further guide medical management.

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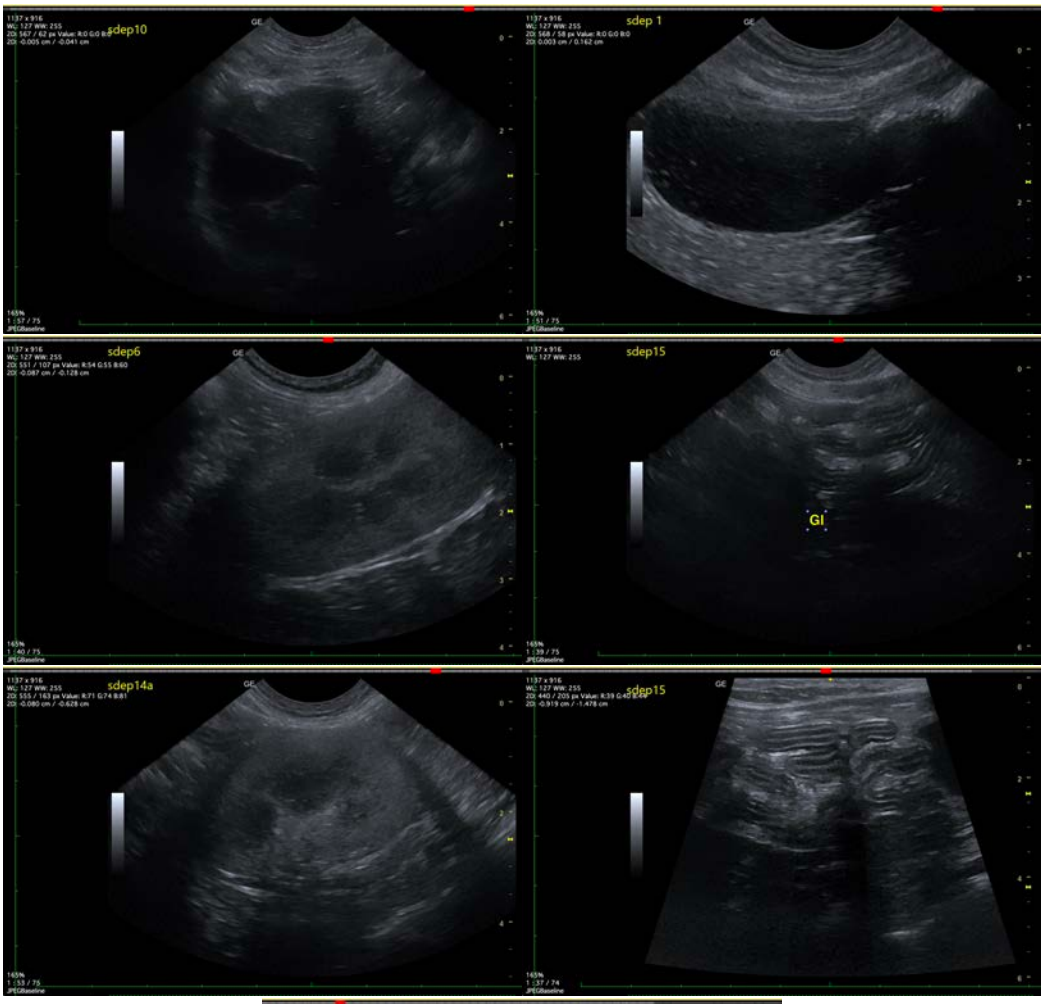
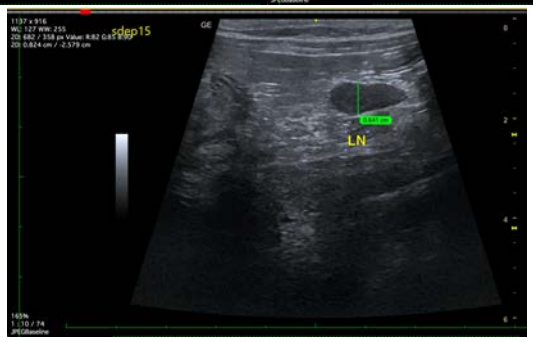
Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.





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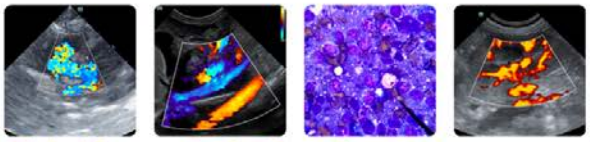

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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