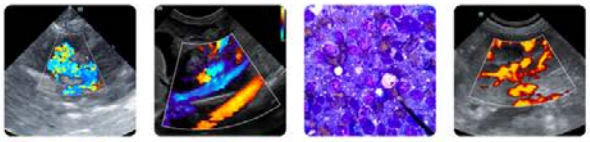


PATIENT

Kiwi Castle

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

11 Years

WEIGHT

4.6 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Jessica Bailes

HOSPITAL NAME

All Creatures Great & Small (Corvallis)

REFERRING VET

Dr. Jessica Bailes

INVOICE

75537

DATE

5/28/26

PRESENTING CLINICAL SIGNS

Prior hx of hyperthyroidism and stage 2 CKD. Currently on TD methimazole BID. Examined 2 weeks ago for evaluation of inappropriate urination and possible hematuria @ home. Chronic vomiting about once/week; possible intermittent diarrhea but difficult to tell as patient lives w/ multiple cats.

Abnormal PE/Chem/CBC/UA Results: Significant progressive weight loss. severe generalized cachexia, voracious appetite @ time of exam. BW/UA results: CHEM: increased ALT (194), increased BUN (38), creat = 1.5, SDMA WNL CBC: Neutrophilia (11280), increased EOS (11280), otherwise WNL TT4: WNL @ 3.0 UA: USG = 1.015 negative proteinuria IS

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 bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. Left kidney is small at 3.14 cm. Right kidney is small-normal at 3.69 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.42 cm at cranial pole and 0.33 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.41 cm at the cranial pole and 0.32 cm at the cauda pole), 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.

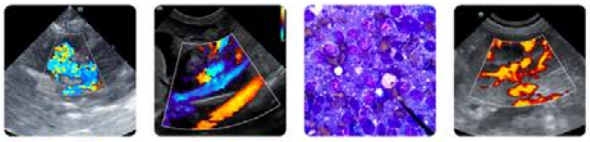
Liver

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.

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.

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 intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

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.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Moderate bilateral chronic kidney disease changes.
- 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A blood pressure is recommended if not recently evaluated.

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

In the meantime, given patient's reported polyphagia in the face of weight loss, eosinophilia, etc., emerging bowel disease cannot be ruled out.

Therefore, 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.

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.

Additionally, if not already evaluated, a thorough evaluation of daily caloric intake is recommended to assure an adequate daily caloric intake is occurring vs an inadvertent reduction in calories due to change in diet and/or feeding schedule, competitive eating environment, etc.

While continuing workup, empirical deworming with a 5-day course of Panacur is recommended.

If tolerated, a transition in diet is recommended, based on trial-and-error response.

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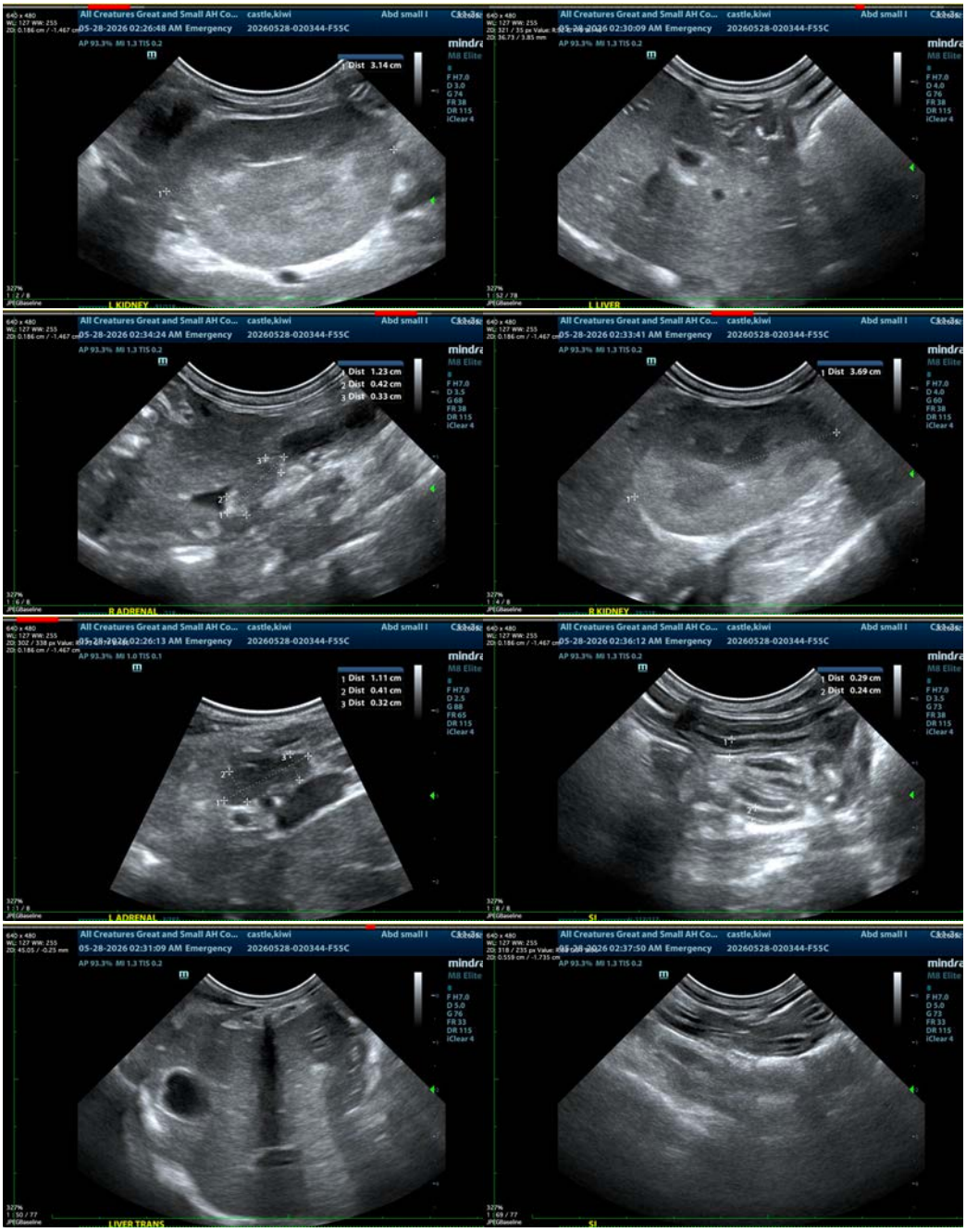
Some options to consider include a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs a fiber response/colitis diet vs a bland, easy to digest or low-fat diet vs other.



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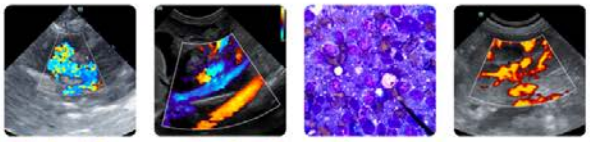

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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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