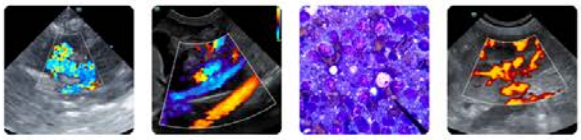


DATE

5/7/26

PATIENT

Binx Baron

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

5/5/09

WEIGHT

7 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Essex Middle River Veterinary Center

REFERRING VET

Dr. Stoll

INVOICE

74984

PRESENTING CLINICAL SIGNS

Patient History: Hx of IBD, managed with RC HP dry and RC PR/PD canned. Hx of hyperthyroidism, managed with Methimazole 2.5mg PO q12hrs. Recently treated for a UTI due to stranguria and pollakiruia, confirmed resolution via UA with culture. Roughly 1-2 week long history of lower than normal energy, yelling for food when food is present, hyporexia with little interest in food, weight loss. PE(abnormalities): Periodontal disease (Grade 0-I). Elevated probnp in Feb (124). BP on 4/3 was 165mmHg and then on 5/2 it was 140mmHG. Currently isn't really eating any food offered to her.

Current Medications: Methimazole 2.5mg PO q12hrs
Labwork Results: Labwork attached, reported as: ProBNP 124 (H); rest of CBC/Chem17 with Lytes/T4 and Free T4 within normal limits
Date of Previous IntraPet Ultrasound: 4/3/25. See attached.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Requested.
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, except for several subtle anechoic “blebs” or densities that appear to attach the wall, including a 0.60 cm x 0.70 cm density near the ventral apex and a 0.40 cm x 0.70 cm anechoic density near the ventrocaudal aspect of the bladder. This could be the same lesion imaged in two different views or may be two separate lesions. 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 measured is small at 2.7 cm. Right kidney is small-normal at 3.5 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.27 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.42 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size (1.2 cm thick at the hilus) with normal smooth margins. Parenchyma is normal in echogenicity with a diffusely coarse/heterogenous echotexture. No discrete sizable focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged (swollen contour) with a diffusely mildly coarse architecture and subtly increased portal markings. Mildly mixed echogenic changes are noted diffusely. 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 diffusely tortuous without evident pathologic distention.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen is mildly distended with primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal chyme. There is 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

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. Duct dilation is appreciated, measuring between the upper end of normal limits at 0.20 cm up to 0.33 cm.

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.

There does appear to be very non-specific, ill-defined, subtly enhanced hyperechoic tissue throughout the abdomen of unknown origin, noted in the area of the pancreas, the liver, the spleen, adjacent to the kidneys, etc.

PRIMARY FINDINGS

- Coarse splenomegaly – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

- The liver changes are non-specific but concerning for a microscopic hepatopathy, with both benign bacterial and/or lymphoplasmacytic cholangiohepatitis, hepatic lipidosis, other infectious or inflammatory hepatopathy, as well as infiltrative neoplasia such as round cell neoplasia versus other being differentials.

- Mild 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.

- Chronic low-grade smoldering pancreatitis is suspected.

- 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.

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

- Moderate bilateral chronic kidney disease changes, most visibly significant in the left kidney.

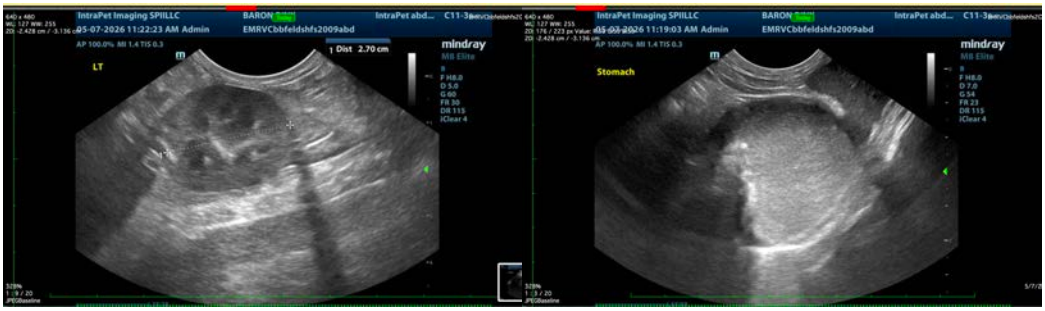
SECONDARY FINDINGS

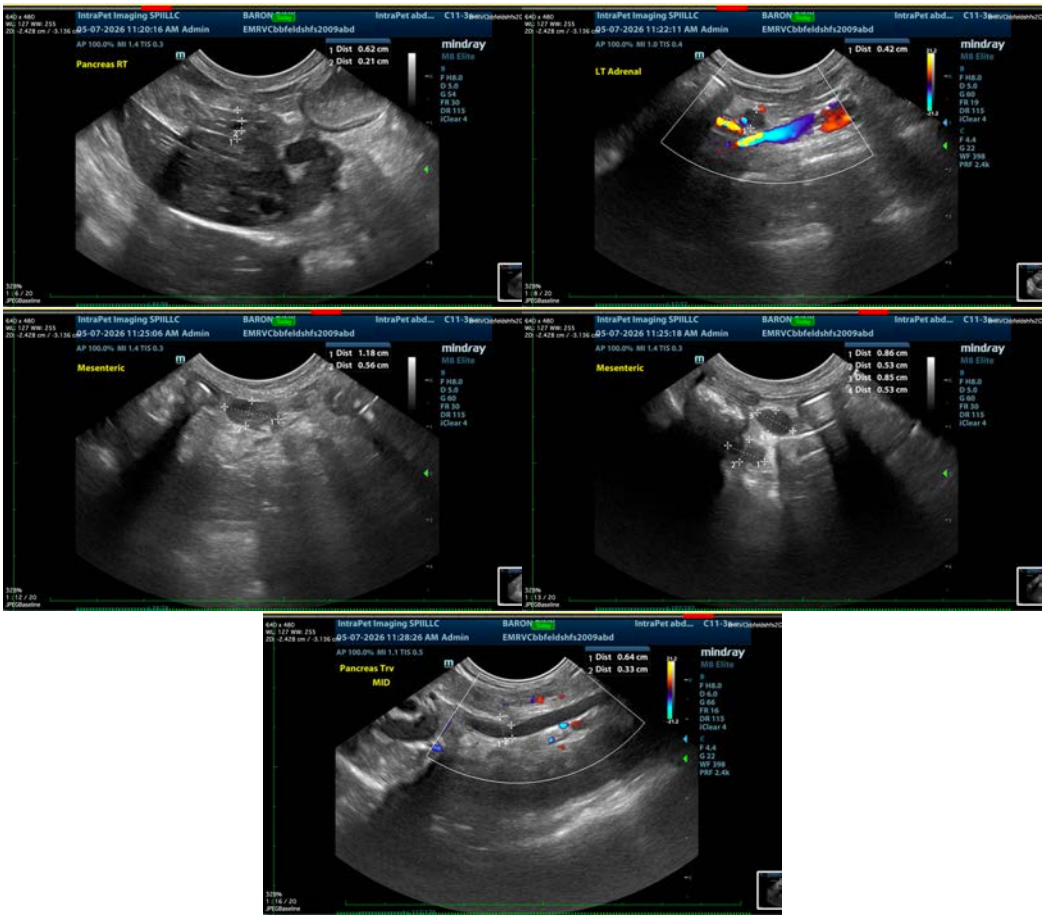
- Suspect possible urachal cyst +/- a ureteral diverticulum versus other. These urinary bladder findings are typicaly congenital, and in a 17 year old cat should be interpreted in combination with any clinical history, as other pathology can't be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the appearance of the hepatobiliary system, pancreas, and bowel, which are relatively static to potentially subjectively mildly progressive compared to the previous study, a flare up of "Triaditis" can certainly be contributing to patient's reported clinical signs. Having said that, given the concurrent splenic changes, an infiltrative neoplastic process can't be ruled out. Therefore, fine needle aspirates of the spleen, liver +/- pancreas and/or abdominal lymph nodes if they can safely be reached could all be considered if patient's coagulation status is appropriate.

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





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
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