PATIENT

Shadow Bogles

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

11 Years

WEIGHT

3.5 kg

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

East Credit VH

REFERRING VET

Dr. Gardiner

INVOICE

12365

DATE

11/21/25

PRESENTING CLINICAL SIGNS

Findings: - tachycardia 308 BPM - Murmur - weight loss - Has been inappetant, vomiting, occ diarrhea, history of constipation Current Medications - Proviable DC, 3ml lactulose BID, 1/4 tsp restoralx BID, 100mg of Gaba for u/s today

Abnormal PE/Chem/CBC/UA Results: See attached Blood pressure results Anesthetic machine LH #1 approx. 1 - 1.5h post 100mg gabapentin 134/100 mean 109 152/102 mean 110 161/86 mean 111 133/96 mean 109 146/109 mean 121 126/91 mean 105 Doppler: RH #1 - approx. 1.5h post Gabapentin (100mg) 58, 50, 40, 48, 66, 60 Avg - 53.6mm Hg

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Mobile debris present in the urinary bladder. No evidence of inflammatory or neoplastic changes were noted.

The kidneys have a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present. The right kidney measured 3.96 cm in length. The left kidney measured 3.49 cm in length.

Adrenal Glands

Adrenal glands were visualized on still images only. They appear to have normal shape, size, position and echogenicity for this breed and age though this could not be confirmed on cine loops. The left adrenal gland measured 0.28 cm in thickness. The right adrenal gland measured 0.43 cm in thickness.

Spleen

The spleen was normal with a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma and smooth capsule, with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

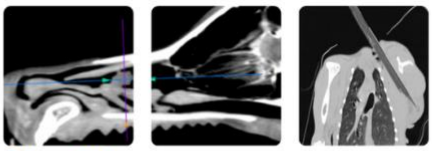
There are two relatively small partially cavitated nodules/small masses visible in the liver with one measuring 1.39 cm x 1.35 cm and the other measuring 1.27 cm x 1.23 cm. The remainder of the liver parenchyma is unremarkable.

Gallbladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is slightly increased, and wall layering is distinct with a slightly



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prominent muscularis layer. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The visible right and left limbs of the pancreas are prominent and slightly enlarged with no surrounding inflammation, free fluid or fluid accumulations visible.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

ULTRASONOGRAPHIC FINDINGS

- Prominent pancreas with no overt signs of active pancreatitis.
- Mildly thickened small intestines with prominent muscularis layer.
- Aging renal changes with left nephrolith.
- Two small cavitated liver nodules/masses.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Mass in the liver is most concerning for neoplasia. Benign tumors are more common in the cat and may be of hepatocellular, cholangiocellular, mesenchymal, or neuroendocrine origins. Differentials include biliary cystadenoma, cholangiocellular carcinoma, hepatocellular carcinoma, hepatocellular adenoma (hepatoma), hemangiosarcoma, leiomyosarcoma, and fibrosarcoma among other things. This is not a likely cause of reported severe tachycardia or chronic GI signs and is likely incidental in this patient. FNA could be attempted though cavitated masses have a risk of bile and/or blood contamination. Removal could be considered. Consultation with a veterinary surgeon is recommended. Abdominal CT prior to surgery may be considered to determine the full extent of the lesions.

Aspirate should be attempted for further information. Ultimately surgical removal should be considered because of risk of rupture and abdominal hemorrhage, and this may be both diagnostic and curative. Pre-operative abdominal CT may be considered for surgical planning; to confirm hepatic origin and thoracic CT could be used to screen for thoracic metastasis that may be missed on thoracic radiographs. Serial monitoring with follow up sonograms could be considered to monitor for progression if definitive removal is not desired at this time.

Small intestinal changes are most consistent with infiltrative disease of the small intestine with inflammatory bowel disease or GI lymphoma being the top differentials. No overt neoplastic criteria present in the bowel given that curvilinear layering is still intact. Ultrasound cannot differentiate between small cell lymphoma and inflammatory bowel disease and GI biopsies are recommended for definitive diagnosis, especially if there is a poor response to empirical efforts or recurrence of clinical signs after initial control. Endoscopic biopsy is less invasive but may miss lesions due to inability to obtain samples from all sections of the GI tract, especially the jejunum which is the most common site of development of disease. Surgical biopsies are more likely to be diagnostic but are more invasive. A

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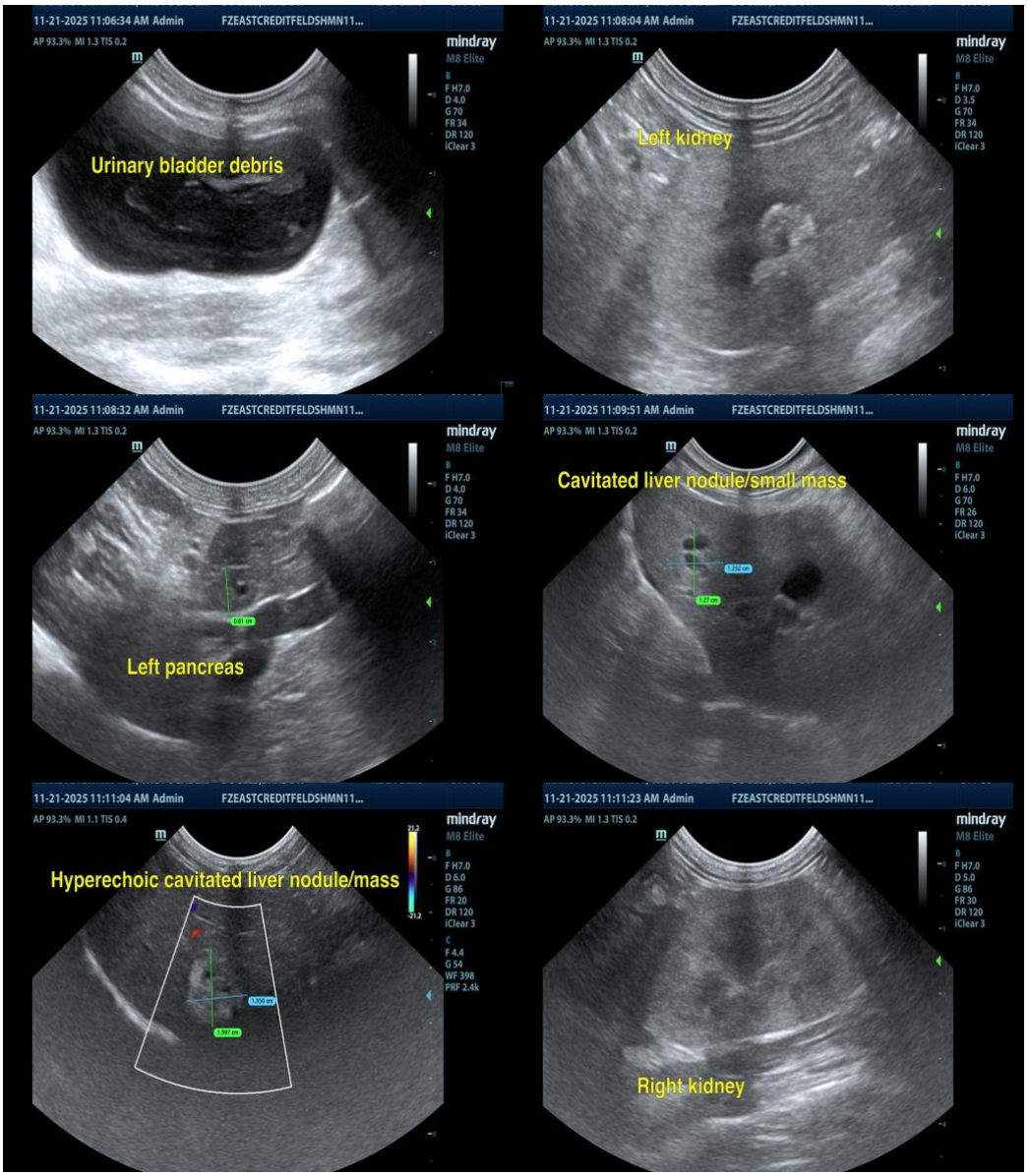
GI panel (PLI/TLI/cobalamin/folate) will help determine the severity of SI dysfunction, and need for vitamin supplementation.

Empiric treatment for IBD includes diet trial with either hydrolyzed or select protein diet, vitamin b-12 supplementation, GI support as needed (anti-nausea, appetite stimulant). Treatment with steroids (budesonide vs prednisolone) is often required – biopsies should be acquired prior to treatment with steroids. Steroids may ultimately be tapered to the lowest effective dose or discontinued in some cases.

Pancreatic changes are consistent with chronic pancreatitis. There are no signs of active inflammation on ultrasound though acute pancreatitis contributing to the GI signs cannot be ruled out with ultrasound alone. An fPLI may help determine the severity of current pancreatic inflammation.



The Focal Zone
FUELED BY SONOPATH VETERINARY ULTRASOUND

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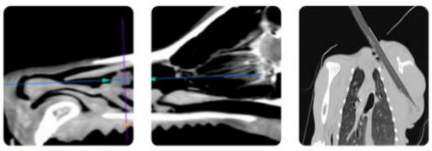

Teleradiology
Educational Teleconsultation Services™

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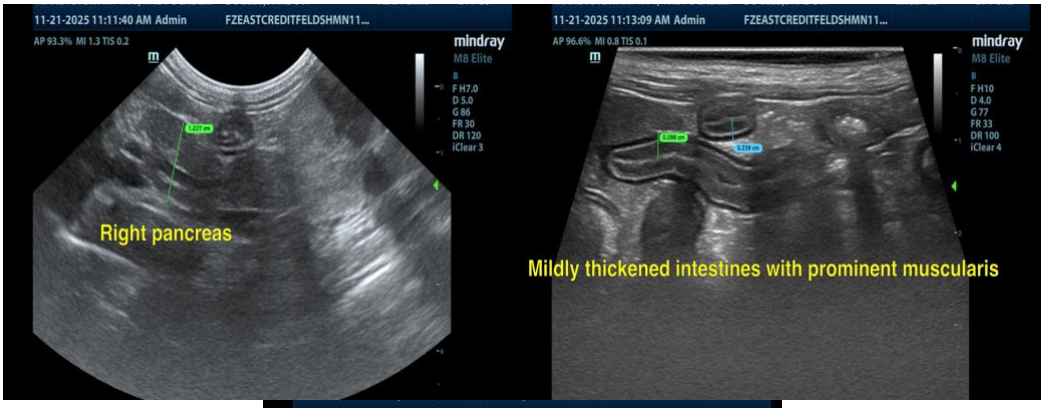

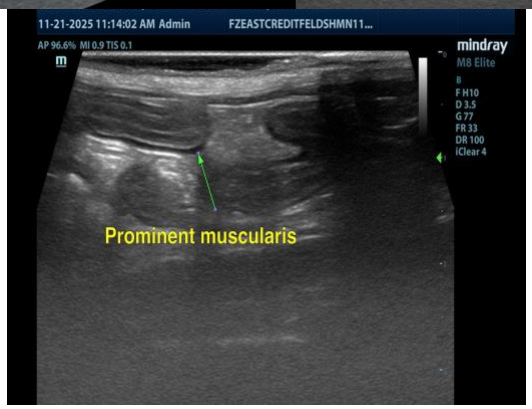

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com