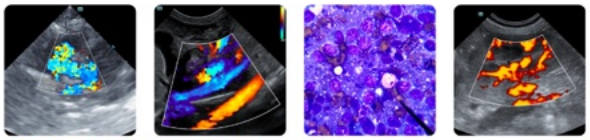


PATIENT

Oreo Kelley

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

14 years

WEIGHT

11.8 lbs

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Jenny Wenrich, DVM

HOSPITAL NAME

Straley Veterinary Associates

REFERRING VET

Dr. Wenrich

INVOICE

71187

DATE

2/3/26

PRESENTING CLINICAL SIGNS

- Chronic weight loss (2 lb. in 4 months), anorexia, lethargy
- PE: pale mm, muscle atrophy over spine, CBC: mild nonregenerative anemia, inflammatory leukogram, Chemistry/T4: unremarkable, 3 view thoracic radiographs: unremarkable

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for this age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The left kidney measured 3.9 cm. The right kidney measured 4.0 cm.

Adrenal Glands

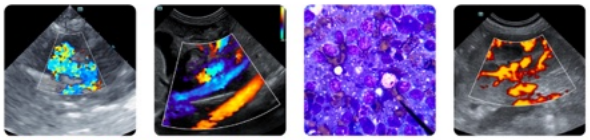
Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes was noted.

Liver

The **liver** revealed hyperechoic, nodular changes were noted in the left liver. The margins were ill-defined. The region in question measured 2.0 x 1.6 cm with mild disruption of architecture. The remainder of the liver presented mild, coarse architecture and increased portal markings. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal.



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Gastrointestinal

The **gastrointestinal** presentation revealed mild uniform prominence of the gastric mucosa as well as areas of "ropey" small intestinal wall. The muscularis layer was hypertrophied inverting the normal ratio (1:3). The intestinal submucosa was slightly irregular, thickened and hyperechoic suggestive of low grade, chronic inflammation. No evidence of obstruction was present. Chronic inflammatory bowel disease is probable with a low possibility of an early neoplastic event such as lymphoma or, less likely, dry form FIP can at times be found on biopsy of these presentations. Full thickness tissue biopsies via open laparotomy, ideally guided by intraoperative ultrasound in order to obtain the most representative mural sample, would be necessary to rule more significant disease than IBD. The mesenteric lymph node was mildly enlarged and measured 1.8 x 1.0 cm.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

ULTRASONOGRAPHIC FINDINGS

IBD GI pattern with mesenteric lymphadenopathy, reactive. Chronic inflammatory bowel, malassimilation versus emerging round cell neoplasia is possible.

Hepatic remodeling with undefined nodule in the left cranial liver. Differentials for the liver nodule include hyperplasia, cystadenoma or carcinoma.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

FNA of the left liver nodule and mesenteric lymph node with cytology and culture is indicated. Otherwise, full thickness surgical biopsies of the GI tract, liver and lymph nodes should be considered. CBC path review is warranted +/- bone marrow aspirate given the anemia.

Maldigestion panel, three view chest radiographs and full CNS examination is recommended to examine for occult disease that could be responsible for the weight loss. Evaluation for competitive eating environments should also be considered.

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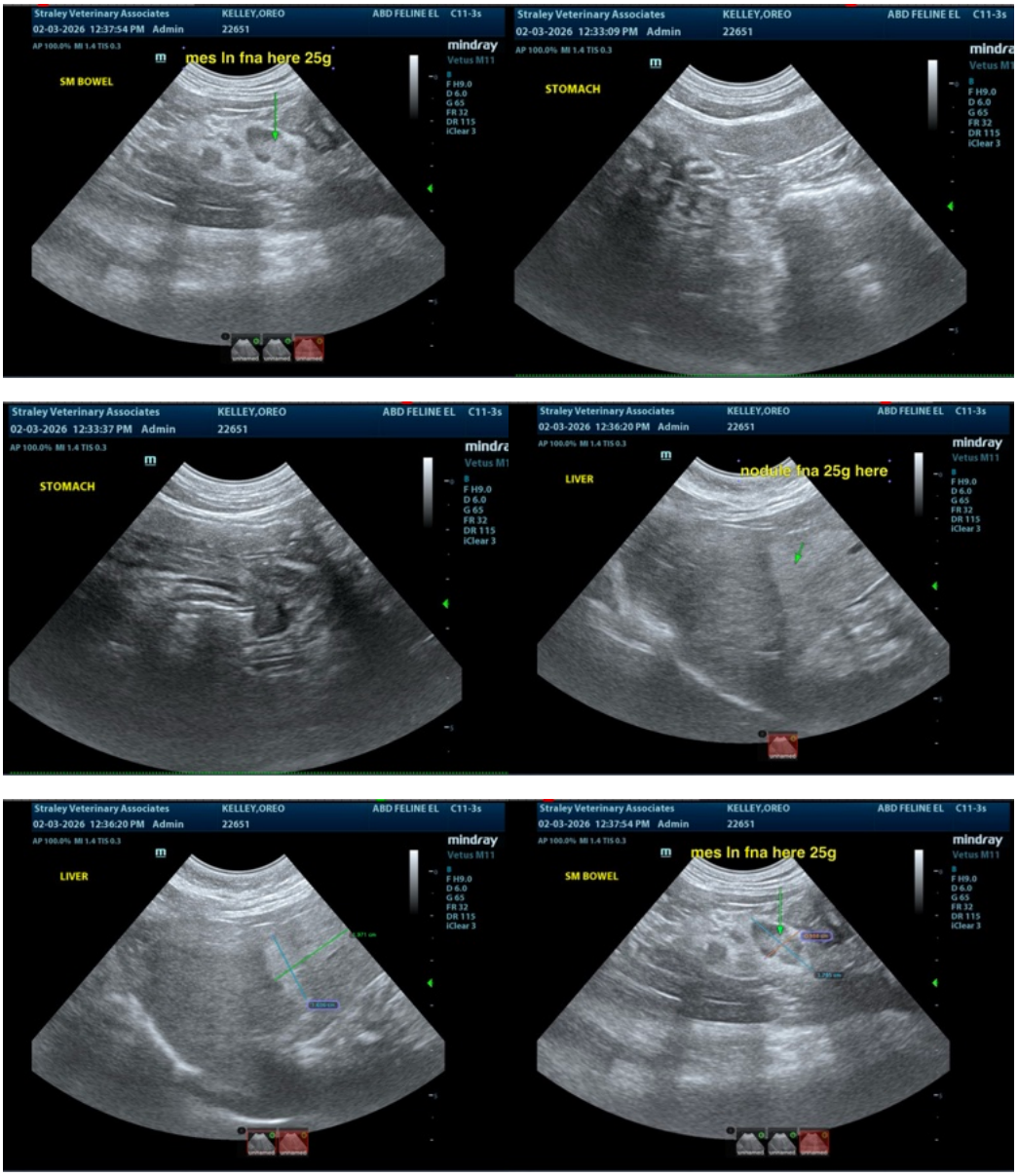

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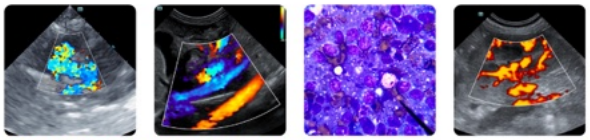

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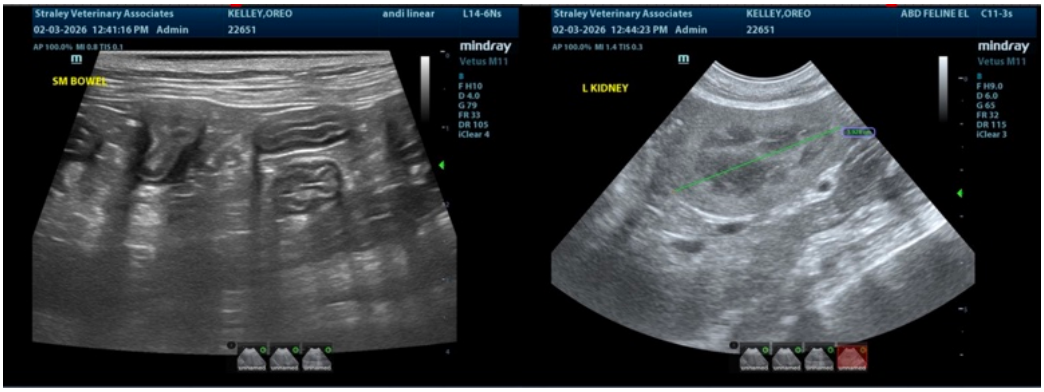

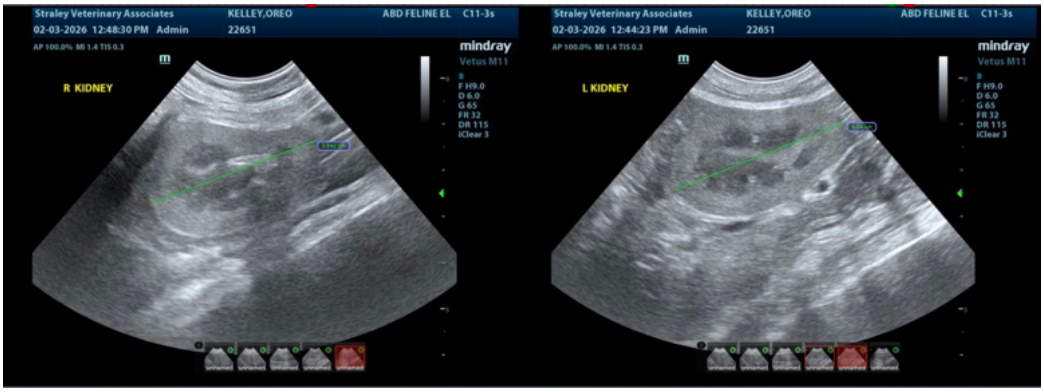

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP (CFM), Cert. IVUSS, CEO of SonoPath.com

info@SonoPath.com