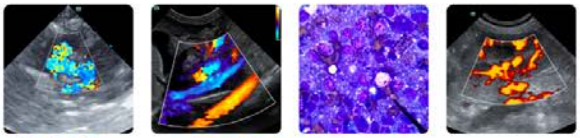

SonoPath www.carolinavetmobile.com info@carolinavetmobile.com 800.808.5948

PATIENT

Remy Wade

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

7 Years

WEIGHT

9 lbs

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Vine Veterinary Hospital

REFERRING VET

Dr. Beeson

INVOICE

73605

DATE

3/12/26

PRESENTING CLINICAL SIGNS

P presented for significant weight loss in 1 month, ADR,

Abnormal PE/Chem/CBC/UA Results: Glob 5.2, ALT 205, ALP 543, GGT 11, Tbili 4.8

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder is moderately distended with anechoic urine. There is a mild amount of suspended echogenic debris within the urine. No uroliths are seen. The bladder wall is normal in appearance and thickness. No masses are seen. No papillae seen.

The right kidney presents normal size (4.1 cm) with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis.

The left kidney presents normal size (3.6 cm) with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis.

Adrenal Glands

The right adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The left adrenal gland measures 2.7 mm in width.

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The left adrenal gland measures 2.8 mm in width.

Spleen

The spleen is normal in size, shape, margination and echogenicity. No masses are seen.

Liver

The liver is diffusely enlarged with a mild hyperechoic echogenicity and normal echotexture. No liver lesions seen. There is a scant pocket of free fluid present between liver lobes. A mildly enlarged perihepatic lymph node is noted measuring 7.4 cm x 4.1 cm.

The gallbladder presents normal size with anechoic contents. Normal gallbladder wall. No evidence of bile duct distention or obstruction.

Gastrointestinal

In the body of the gastric wall there is a hypoechoic intramural lesion measuring 1.2 cm x 1.2 cm. The pylorus is open. No pyloric outflow tract obstruction seen. Pyloric wall measures 2.3 mm in width and appears normal. The proximal duodenum has normal wall thickness but has mild loss of layering and is mildly hyperechoic. Colon contains normal contents with normal wall thickness.

Pancreas

The right limb of the pancreas appears normal, measuring 6.6 mm in width. The left limb is not seen.

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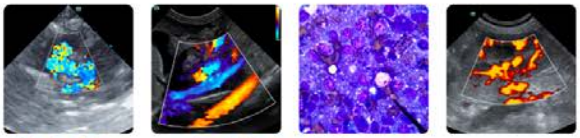

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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ULTRASONOGRAPHIC FINDINGS

- Hypoechoic intramural gastric wall lesion and loss of layering within the proximal duodenum – The gastric lesion may represent neoplasia such as lymphoma, adenocarcinoma, leiomyosarcoma, or may represent an inflammatory lesion such as gastric ulceration and associated hematoma. The loss of layering in the duodenum may represent associated inflammation from the gastric mass or may represent mild duodenal inflammation.
- Enlarged, hyperechoic liver – Possibly vacuolar hepatopathy due to hepatic lipidosis. Other differentials include infiltrative neoplasia such as lymphoma.
- Mildly enlarged perihepatic lymph node – Most likely reactive, less likely neoplastic.
- Scant pocket of free fluid between liver lobes – No cause seen on this exam.
- Mild suspended echogenic debris in the urinary bladder.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Doppler exam of the gastric lesion may help differentiate between hematoma and mass lesion. If possible, attempt ultrasound guided aspirate and submission for cytology. If inconclusive as to diagnosis, recommend either surgical or endoscopic biopsies of this lesion for histopathology. If biopsies of the gastric lesion are obtained, also recommend obtaining duodenal biopsy. It would be preferred to obtain endoscopic biopsies, as it is less invasive. The GI lesions are likely the cause for the patient's weight loss and suspected associated hepatic lipidosis.

Rule out primary hepatic disease as cause of weight loss. The appearance of the liver is most likely due to hepatic lipidosis. Recommend fine needle aspirate of the liver and submission for cytology to rule out infiltrative neoplasia. If hepatic lipidosis is confirmed based off fine needle aspirate, recommend placement of esophageal feeding tube to provide enteral nutrition to the patient while further workup is performed. Ultimately, if no cause can be found and fine needle aspirate is not helpful, liver biopsy ultimately may be necessary.

The scant pocket of free fluid appears to be too small to obtain an ultrasound guided sample.

If not already performed, recommend urinalysis. If active urine sediment, recommend urine culture and antibiotic sensitivity.

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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.

Greg Kuhlman, DVM, DACVIM (SAIM)

Veterinary Internal Medicine Specialist
info@SonoPath.com