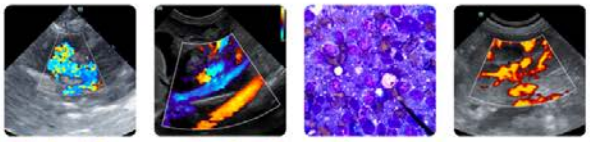


PATIENT

Tough Guy Hartman

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

8 Years 9 Months

WEIGHT

6.4 kg

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

New Holland Veterinary Hospital

INVOICE

74671

DATE

4/22/26

PRESENTING CLINICAL SIGNS

AUS to further evaluate anemia (normocytic, normochromic, mildly regenerative), mild hyperbilirubinemia, elev GGT with normal LES, mild hypoalbuminemia, and weight loss (5.3# in 5 mos). In Oct 2025- evaluated in the ER for hematuria and a thickened bladder wall. AUS done at that time and revealed suspected cystitis, IBD, chronic low-grade smoldering pancreatitis, scalloped spleen and changes to the kidneys (r/o fat deposition). Since that fall, has been steadily losing weight. Prednisolone was dispensed at last rDVM visit on 4/8/26. (O has not started yet)

Abnormal PE/Chem/CBC/UA Results: 4/9/26 - CBC: Hct 20.3%, Hgb 6.4 L, normocytic, normochromic, RBC 5.21 L, Retic-Hgb 12.5 L, NRBC 2/100 WBC, Abs Retic 47 (wnl), Aniso- moderate, plts adequate, Rouleaux present, Saline agglutination neg, No feline hemotropic mycoplasmas - Chem: Alb 2.4 L, normal LES, normal BUN & Cr, Gluc 176 H, T.Bili 0.4 H (I. Bili 0.2 high-norm, D. Bili 0.2 high-norm), GGT 7 H-mild - T4: 2.3-n Prev AUS 10/15/25: Moderate(IBD) pattern. No loss of layering. • Chronic low-grade smoldering pancreatitis suspected. • Scalloped spleen. • Chronic cystitis can't be r/o, but reassessment of a more fluid distended urinary bladder is recommended, if possible. • The appearance of the kidneys is most consistent with fat deposition, with infiltrative disease being a less likely differential.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder contains minimal urine. In the luminal margin of the apical aspect of the urinary bladder there are several hyperechoic areas of material that appears to be adhered to the luminal bladder wall, which are most likely small uroliths adhered to the urinary bladder wall. In the mid ventral bladder wall there appears to be a polyp present measuring 3.3 mm in width and 2.2 mm in height.

The right kidney cortex is diffusely hyperechoic, consistent with fat deposition. It otherwise appears normal and measures 4.7 cm.

The left kidney cortex is diffusely hyperechoic, consistent with fat deposition. It otherwise appears normal and measures 4.7 cm.

Adrenal Glands

The right adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The right adrenal gland measures up to 4.3 mm in width.

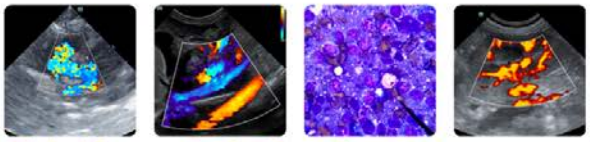
The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The left adrenal gland measures up to 4.5 mm in width.

Spleen

The spleen is diffusely hypoechoic and mildly enlarged, measuring 1.1 cm in width. Mildly scalloped margins noted.

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



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lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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

Gastrointestinal

The stomach has normal wall layering and thickness. The jejunum wall measures at the upper end of normal limits for thickness at 2.8 mm in width, with a mildly to moderately thickened muscularis layer. Colon contains normal contents with normal wall thickness.

Pancreas

The visible pancreas is diffusely markedly hypoechoic with no surrounding steatitis. The pancreas has a nodular echotexture to it diffusely.

Free Abdomen

A markedly enlarged abdominal lymph node is present, measuring 13.9 mm x 25.3 mm. It is rounded and hypoechoic.

A scant pocket of free fluid is present.

ULTRASONOGRAPHIC FINDINGS

- Hyperechoic renal cortices – Consistent with fat deposition. Unlikely to be due to an infiltrative neoplasia or infectious disease.
- Mildly enlarged, hypoechoic spleen with scalloped margins - Most likely a normal variation, less likely due to infiltrative neoplasia such as lymphoma or mast cell disease. Less likely due to infectious disease such as FIP or bartonellosis.
- Markedly enlarged, rounded, hypoechoic lymph node – Consistent with neoplastic disease such as lymphoma or mast cell disease, less likely metastatic neoplasia, or possibly due to infectious disease.
- Likely small uroliths adhered to urinary bladder wall.
- Urinary bladder polyp – Most likely present due to chronic inflammatory response due to presence of uroliths, possibly due to chronic bacterial cystitis. Unlikely to be neoplasia.
- Hypoechoic, nodular pancreas – Suggestive of chronic secondary pancreatitis.
- Hyperechoic hepatomegaly – Most likely due to hepatic lipidosis, assuming that the patient may have been in a negative energy balance for some time. Less likely the appearance of the liver could be due to infiltrative neoplasia such as lymphoma.
- Upper end of normal limits jejunal wall thickness – Consistent with either inflammatory bowel disease, small cell lymphoma, or mast cell disease. Less likely an infectious etiology such as histoplasmosis.

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- Scant pocket of free fluid.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

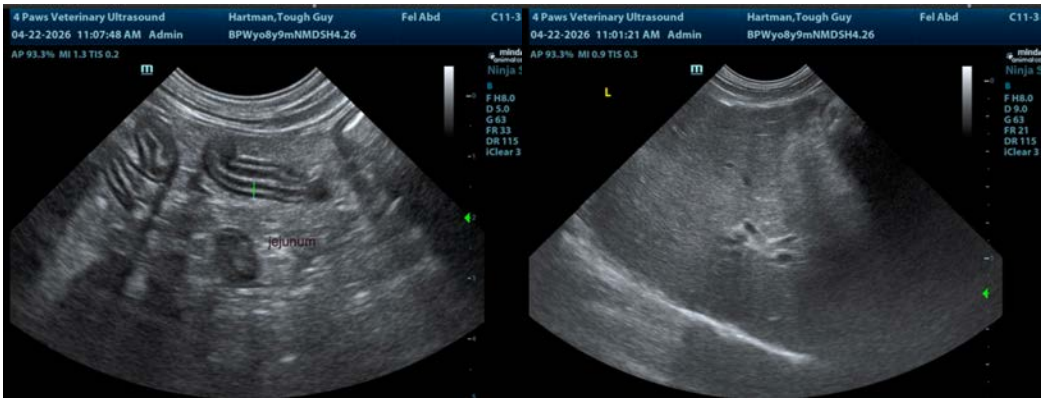
Recommend ultrasound guided fine needle aspirate of the enlarged lymph node with submission for cytology. Consider submitting to Colorado State University and adding on PCR for antigen receptor rearrangement, if clinically warranted.

Recommend submitting a urine culture and starting the patient on a urinary diet if not already done. If urinary tract infection is confirmed, recommend treating for at least 30 days with an appropriate antibiotic, rechecking culture 3-5 days after completion of antibiotics. If a urinary tract infection is not identified on culture, then recommend switching to a strict urinary dissolution diet and rechecking in one month to determine if the uroliths seen on this exam have decreased in size or have resolved. If not, consider cystotomy at that time and submit stones for analysis.

Consider a fine needle aspirate of the liver with submission for cytology to help determine the cause of the appearance of the liver.

Recommend sampling the free fluid via ultrasound guidance and submitting for fluid analysis and cytology.

Recommend Texas A&M GI panel to screen for chronic enteropathy. If confirmed, recommend GI biopsies either surgically or endoscopically. However, start the diagnostic process by aspirating the enlarged lymph node and submitting for cytology, as diagnosis may be confirmed through that procedure.



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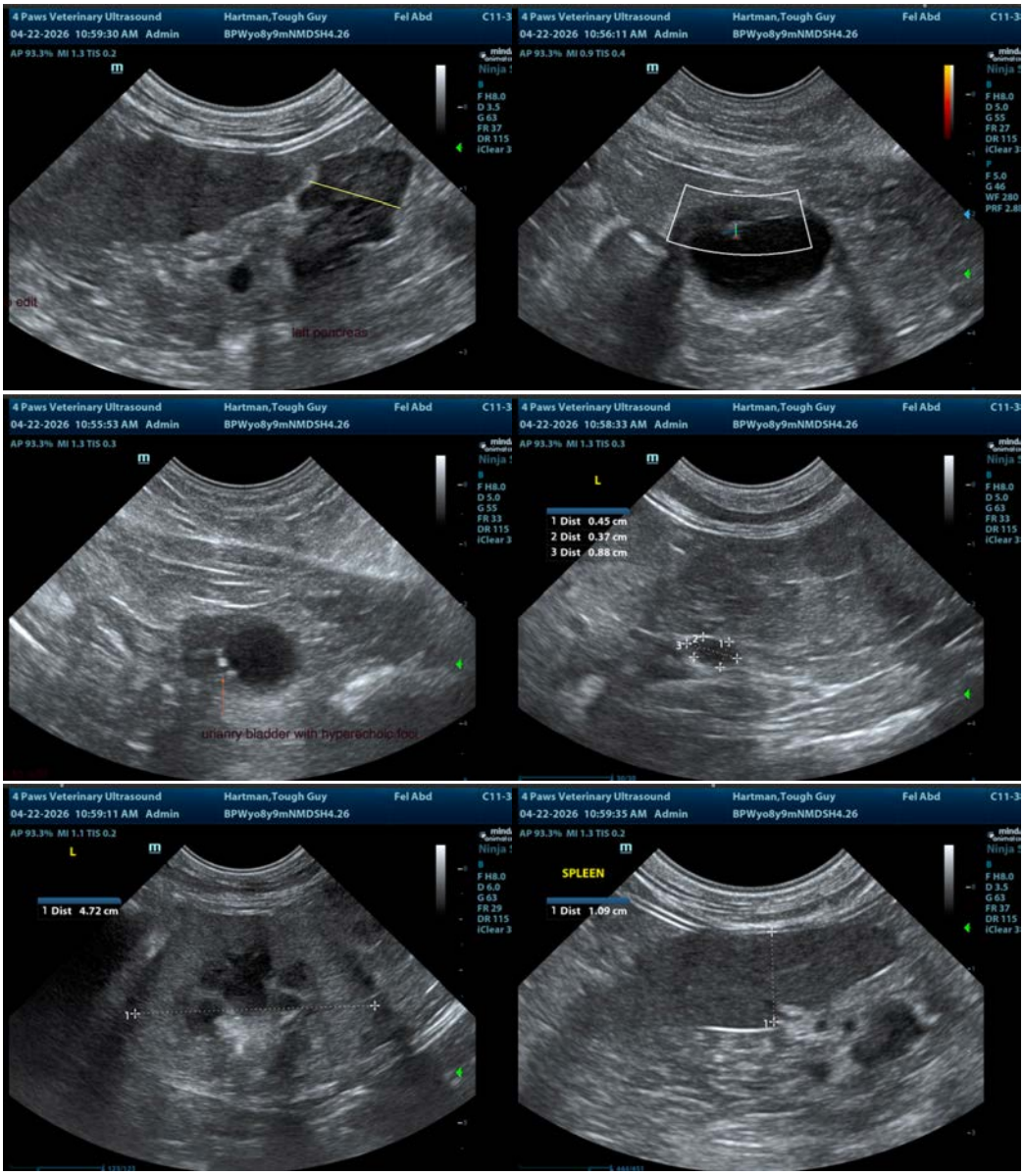

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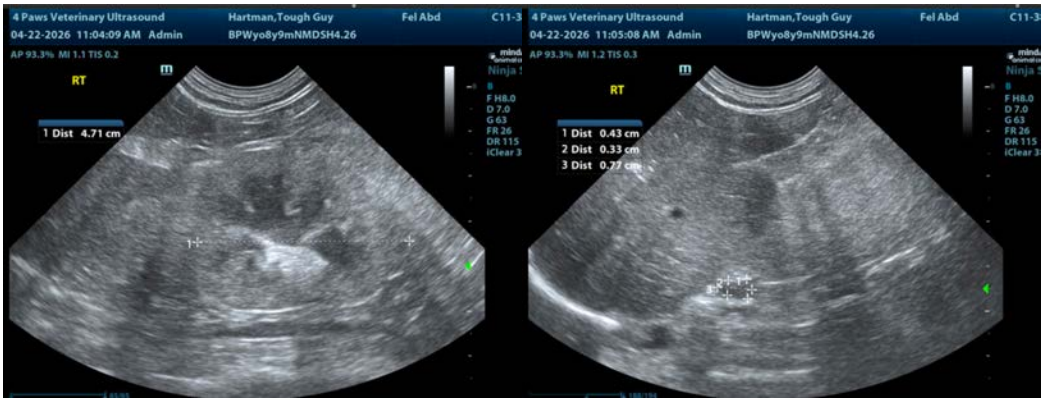

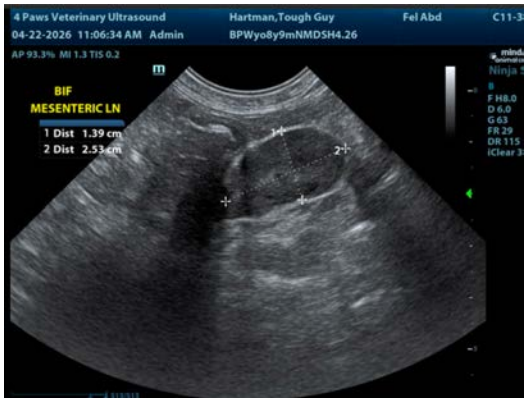

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Greg Kuhlman, DVM, DACVIM (SAIM)

Veterinary Internal Medicine Specialist
info@SonoPath.com