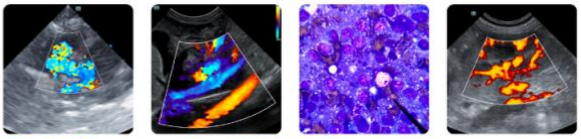


PATIENT

Dexter Barrilleaux

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

11 Years

WEIGHT

6.5

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

IMAGING PERFORMED BY

Dr. Ashley Gambon

HOSPITAL NAME

Lanier Animal Hospital

REFERRING VET

Dr. Ashley Gambon

INVOICE

13495

DATE

01/30/26

PRESENTING CLINICAL SIGNS

- The patient is a 12-year-old neutered male domestic shorthair feline presenting for chronic, slow weight loss and intermittent diarrhea over the last 4-6 weeks. His peak weight was approximately 9.5-10 lbs, and he weighed around 7.5 lbs in October. The diarrhea occurs in cycles, lasting for about a day with multiple small, loose stools, followed by a return to normal feces. He has had approximately two such episodes in the past month. On days with diarrhea, he is more withdrawn and lethargic but continues to eat. Appetite is inconsistent but generally present, and water intake is reportedly normal. He has a history of decreased grooming and activity, no longer jumping onto high surfaces. He eats a diet of Blue Buffalo indoor chicken formula dry food. Past attempts to introduce wet food, boiled chicken, and a salmon-based dry food seemed to exacerbate his diarrhea. He receives Greenies dental treats. He is strictly indoors with no other pets in the household. He is not on any medications or heartworm/flea prevention. He sneezes occasionally without discharge and has some black discharge from his eyes that the owner cleans.

Abnormal PE/Chem/CBC/UA Results: BW from 1/24/26: cbc: wnl/nsf chem: significant mixed hepatopathy (ALT 657, AST 191, ALP 438, total bilirubin 9.9, unconjugated bilirubin 4.4, conjugated bilirubin 5.5) UA: USG 1.034, 2+ protein, 3+ bilirubin, occasional bilirubin crystals, 1+ ammonium mg phosphate UPC 0.2 T4 1.6

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic change were noted.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 4.0 cm in length. The right kidney measured 4.0 cm in length.

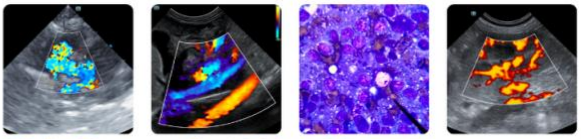
Adrenal Glands

The left adrenal gland was normal in size and contour. Pinpoint areas of mineralization were present without capsular distortion or overt tumors. This is an age-related finding and not pathological. The left adrenal gland measured 0.43 width.

The right adrenal gland was not definitively visualized.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.



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Liver & Gallbladder

The liver presented mild to moderately enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non-distended in size with mild thickened echogenic gallbladder wall. The gallbladder contained mild nonorganized debris. The proximal common bile duct was dilated and mildly tortuous without overt post hepatic obstruction.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The intestinal walls demonstrated intact wall layers with overall nonthickened walls and mild altered 1:3 muscularis / mucosa ratio owing to propensity for prominent jejunal muscularis layer and segmental increased mucosa echogenicity. Mild segmental nonobstructive intestinal ileus. The duodenum wall measured 0.32 cm wall width. The jejunum wall measured 0.20 cm wall width. The ileocolic wall measured 0.29 cm wall width.

Normal visible colon wall layers were present with soft fecal matter in lumen.

Pancreas

The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation.

Free Abdomen

Intermittent mildly enlarged mesenteric nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). Scant pockets of peritoneal effusion were present.

ULTRASONOGRAPHIC FINDINGS

- Chronic enteropathy pattern with soft fecal matter in colon.
- Chronic/chronic active pancreatitis.
- Suspect cholangiohepatitis.
- Intermittent primarily mild mesenteric lymphadenopathy.
- Mild chronic renal changes.
- Mild nonorganized gallbladder debris with proximal common bile duct dilation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Primary consideration for triaditis is warranted. Emerging to low-grade intestinal or multicentric round cell neoplasia, i.e. lymphoma may present in a similar manner and not definitively excluded yet thought less likely. Further assessment may include (assuming normal clotting status and using 25-gauge needle) hepatic FNA cytology to assess for inflammatory cell type or possible concurrent lipidosis. A GI

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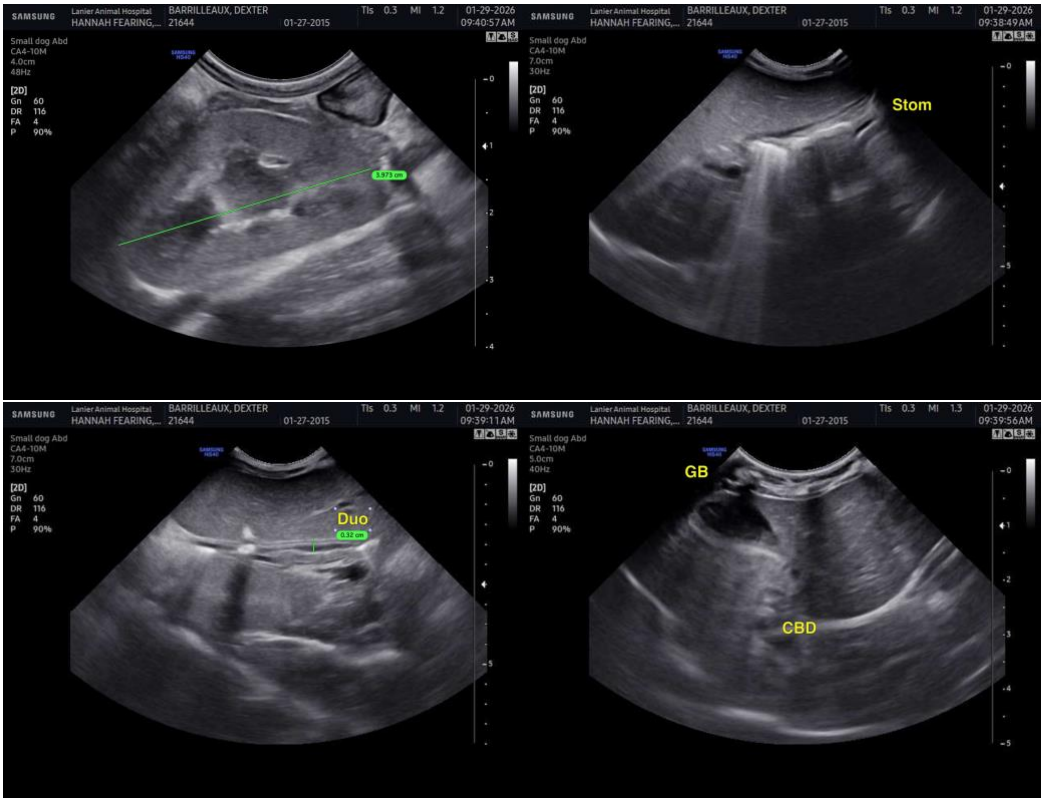
panel to include PLI, TLI, cobalamin and folate is recommended. A definitive diagnosis may require biopsies for histopathology.



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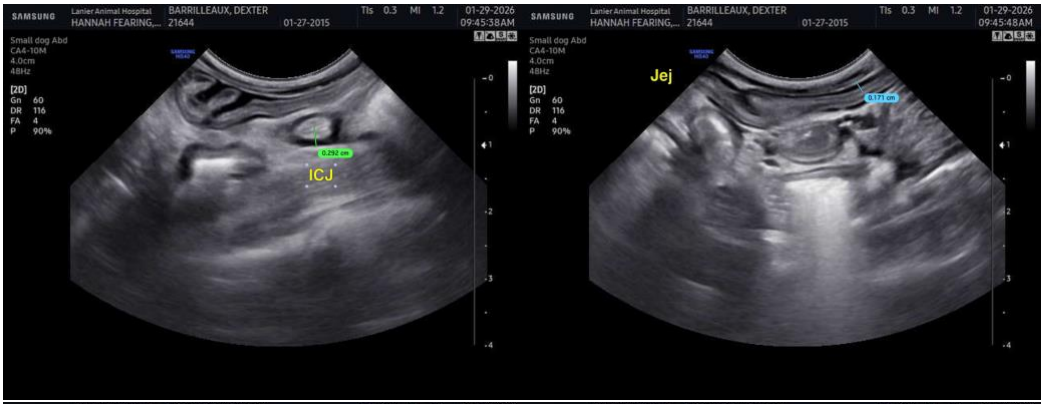

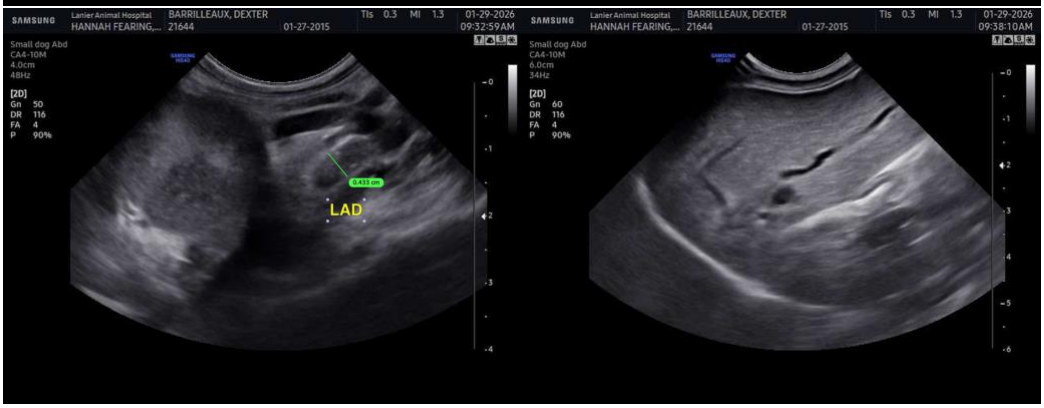

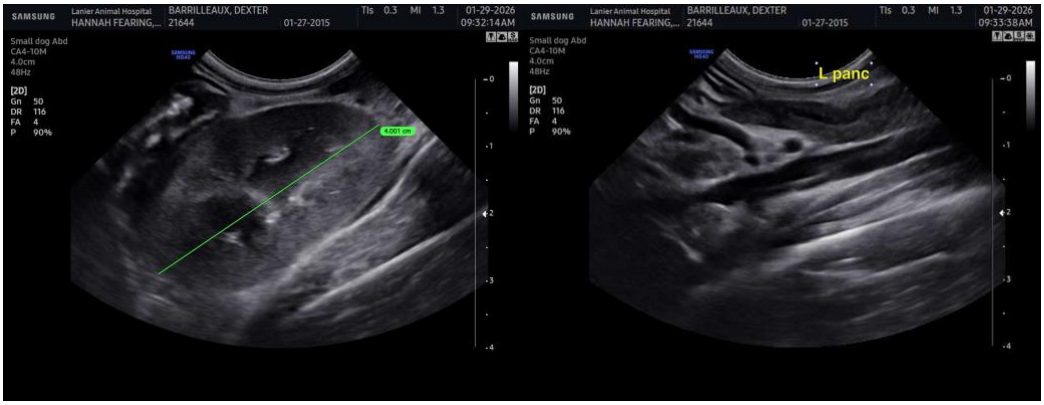

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

info@SonoPath.com