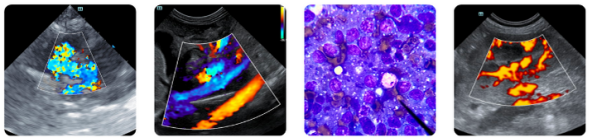

PATIENT

Fig Davis

SPECIES

Feline

BREED

Persian

SEX

Male Neutered

AGE

13y

WEIGHT

6.94 lbs

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Dr. Ashley Gambon

HOSPITAL NAME

Lanier AH

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PRESENTING CLINICAL SIGNS

History: Fig is a 13.5-year-old male feline presenting for lethargy and decreased appetite. The patient normally eats dry food well but has only picked at it today. He did consume some sardines. He has historically been picky with wet food. The owner reports the patient is not acting like himself and seems more lethargic, though it can be difficult to assess. His weight loss began approximately six months ago when his diet was switched to a prescription kidney food, which is significantly less calorie dense. The decreased appetite was also noted during a recent boarding stay but was not observed by the owner prior to that. There has been no vomiting, diarrhea, coughing, or sneezing. Urination habits appear to be normal, and he has been observed drinking water. He currently receives amlodipine for hypertension and eye drops. Amlodipine is administered in his wet food, which he does not always consume. He is current on NexGard Combo for parasite prevention. Recent bloodwork revealed slightly elevated kidney values and elevated calcium. He lost a little over 2 pounds since June 2025.

Abnormal PE/Chem/CBC/UA Results: BW 12/31/25 CBC: mild eosinophilia (2k) with normal total WBCs - likely not significant Chem: mild azotemia (SDMA = 14, creat = 2.6, BUN = 34) - slightly increased from previous; mild hyperphosphatemia (6.2 - target <4.6 for CKD) - increased from prev; mild hypercalcemia (11.3) - increased from prev UA: low USG (1.015) - decreased from prev; otherwise NSF T4: WNL (2.9) - decreased from prev so likely not significant even though "gray zone"

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 changes were noted.

The area of the aortic trifurcation was free of pathology.

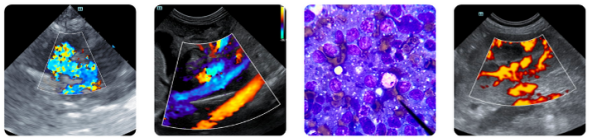
Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. Mild medullary mineral was present. The left kidney measured 3.3 cm in length. The right kidney exhibited a cortical cyst. The right kidney measured 3.8 cm in length.

Adrenal Glands

The left adrenal gland was not definitively visualized with no obvious pathology present. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.37 cm.

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



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thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted. The spleen measured 0.87 cm width level of the mid spleen.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. Torturous proximal to mid common bile duct dilation without evidence of obstruction. The common bile duct measured 0.25 cm diameter.

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 small intestine presented intact segmental borderline thickened wall layering. The lumen of the small intestine was generalized empty without mechanical/metabolic ileus to the level of the colon. Small intestine wall measured up to 0.26 cm.

Normal visible colon wall layers were present with apparent semi-formed to possible soft feces 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. No overt evidence of neoplasia.

Free Abdomen

No visualized significant omental lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Bilateral chronic nephropathy
- Intact borderline thickened small intestinal wall
- Active to chronic active pancreatitis
- Non-obstructive proximal to mid common bile duct dilation

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although nonspecific with potential for patient variant, the small intestine exhibited borderline mural changes which may suggest underlying enteropathy such as IBD or other. Emerging to occult intestinal neoplasia thought less likely. In conjunction with evidence of mild pancreatitis and common bile duct dilation which may suggest mild cholangitis. Emerging triaditis is a potential. No definitive evidence of intraabdominal neoplastic criteria. A GI panel to include PLI/TLI/Cobalamin/Folate given weight loss as well as, if not done, 3-view chest radiographs in light of hypercalcemia is recommended. Current gastrointetsinal and renal support with monitoring of renal parameters and gastrointetsinal signs would be reasonable. Sonographic reassessment if progressive azotemia, weight loss or gastrointestinal signs.

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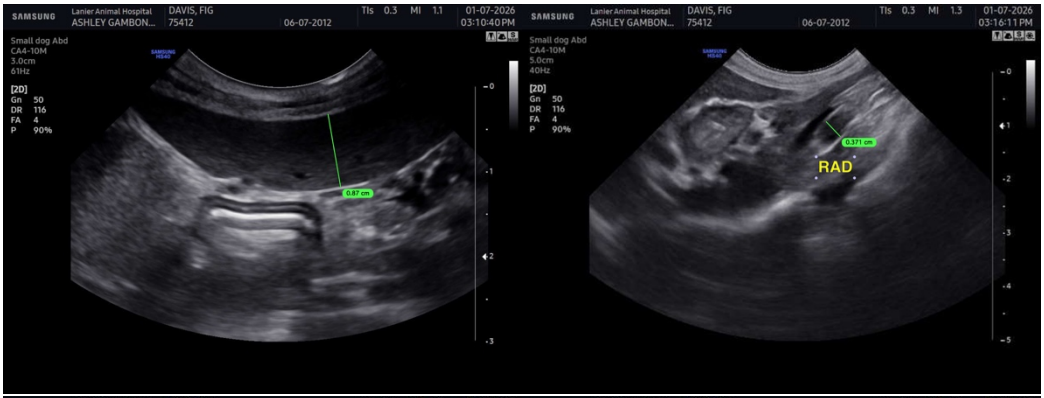

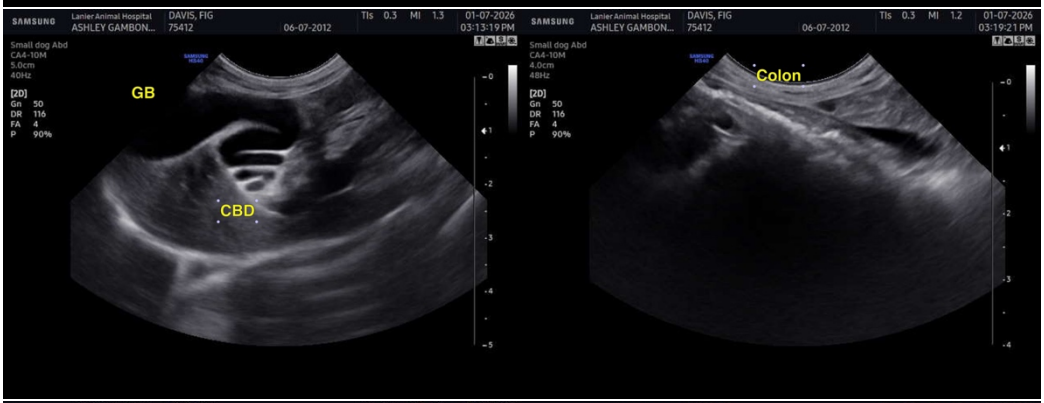

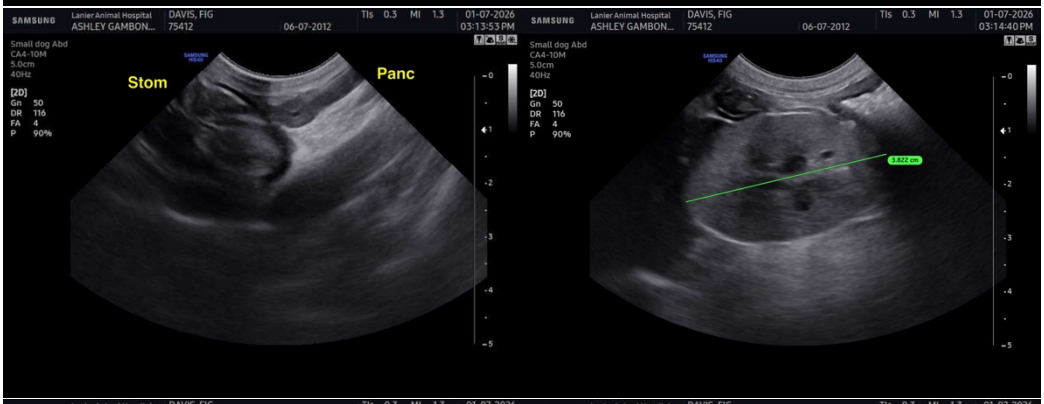

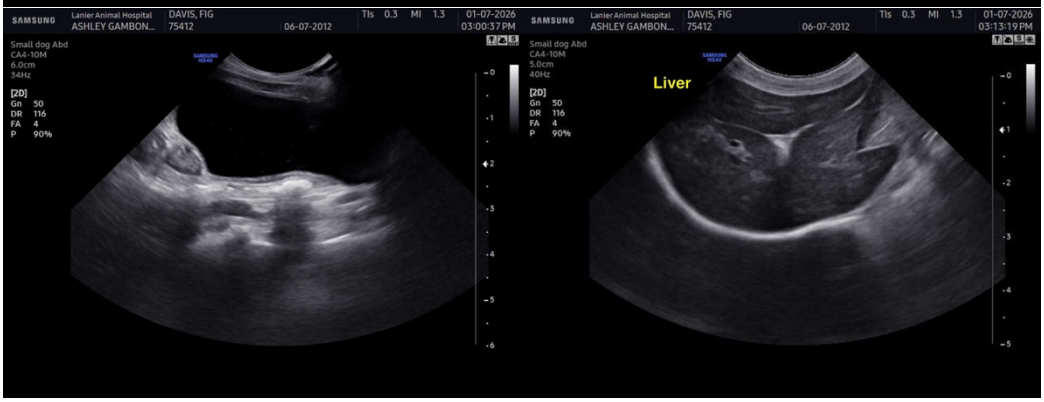

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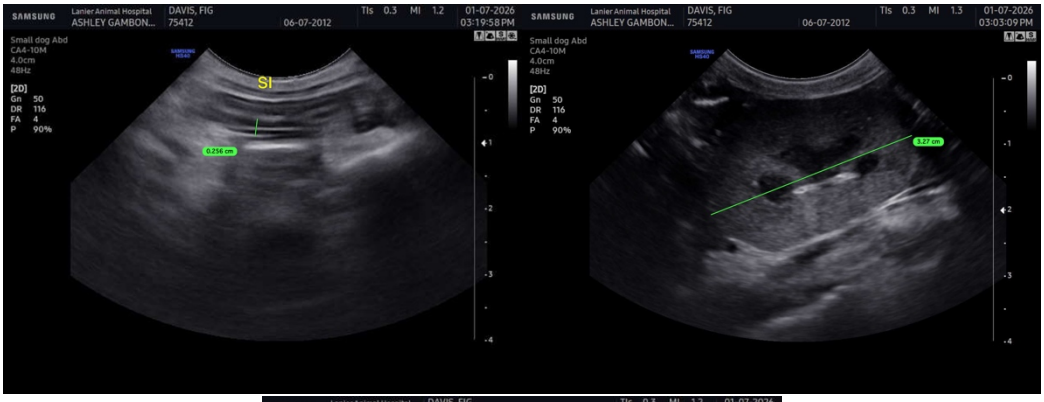

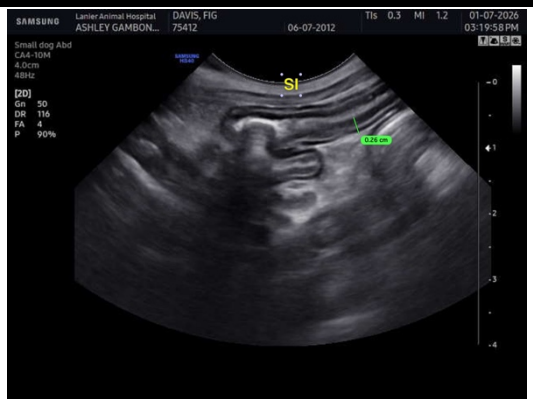

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@sonopath.com