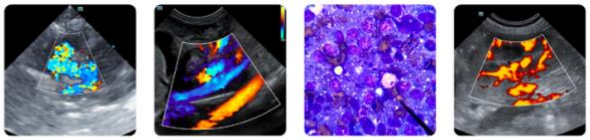

PATIENT

Malcolm Westman

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

14 Years

WEIGHT

10.36 pounds

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP

IMAGING PERFORMED BY

Dr. Kellie Pesola

HOSPITAL NAME

Stuga North Veterinary Care

REFERRING VET

Dr. Emily Angal

INVOICE

12404

DATE

11/21/25

PRESENTING CLINICAL SIGNS

Chronic diarrhea and weight loss over 9-12 months, no improvement with dietary changes. Suspected GI lymphoma.

Abnormal PE/Chem/CBC/UA Results: Thickened intestines palpated on exam, marked muscle wasting noted. BUN, Creat, Ca WNL

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 and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. 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 uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.36 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.47 cm width.

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.

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 mild biliary sludge. The common bile duct was not visualized.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained echogenic, mild nonshadowing to focally shadowing ingesta without signs of obstruction or foreign material.

The small intestine presented with primarily intact mild to variably thickened wall layering with intact to altered wall layer ratio owing to propensity for segmental mildly prominent muscularis layer. A

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segment of jejunum in the mid abdomen exhibited indistinct mural detail and thickened wall measuring 0.31 cm wall width. Overall small intestine wall measured 0.27 cm to 0.31 cm.

Normal visible colon wall layers were present with formed to semi formed fecal matter in lumen.

Pancreas

The left pancreas presented with normal size, capsule asymmetry and nonhomogenous possibly mildly cystic parenchyma with mildly prominent left limb pancreatic duct.

Free Abdomen

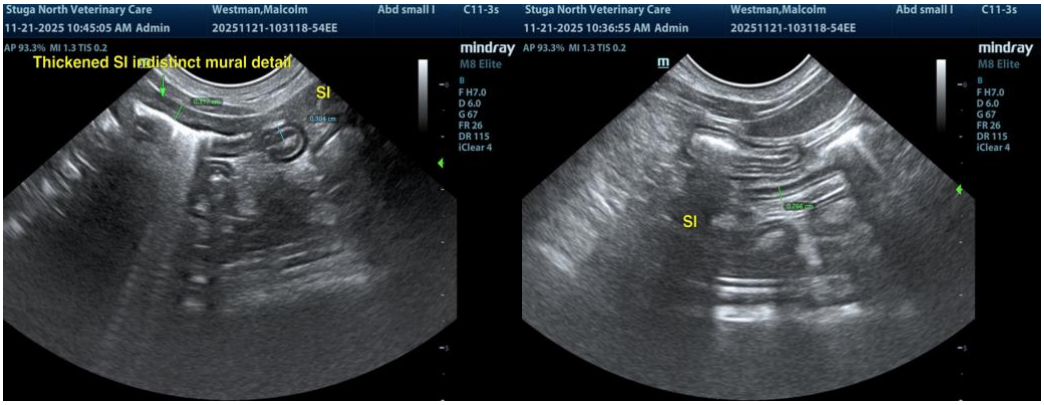
No visualized significant omental lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Mild to variably thickened small intestine wall exhibiting segmental indistinct jejunal mural detail.
- Normal stomach with focally shadowing ingesta.
- Probable chronic pancreatitis.
- Mild gallbladder debris.
- Semi formed fecal matter in colon.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Chronic IBD or other inflammatory enteropathy with potential for emerging neoplastic criteria or jejunal mural mass given segmental indistinct jejunal mural detail are primary considerations. Correlation with a GI panel to include PLI, TLI, cobalamin and folate and if not recently done, three view chest radiographs are recommended. A definitive diagnosis would required intestinal full thickness biopsies for histopathology. Dietary therapy, high colony count probiotics such as Proviable, empirical deworming if patient is outdoor, cobalamin supplementation pending assessment of cobalamin level +/- empirical IBD protocol with clinical and as needed sonographic monitoring if persistent gastrointestinal signs or weight loss would be a more conservative approach.



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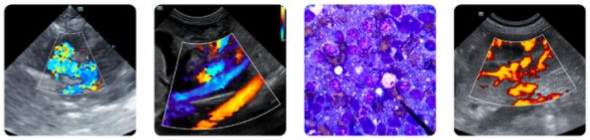

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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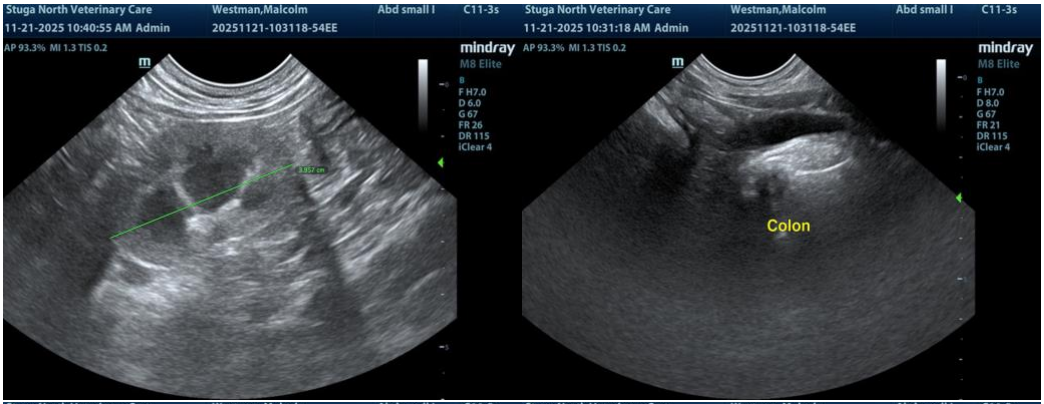

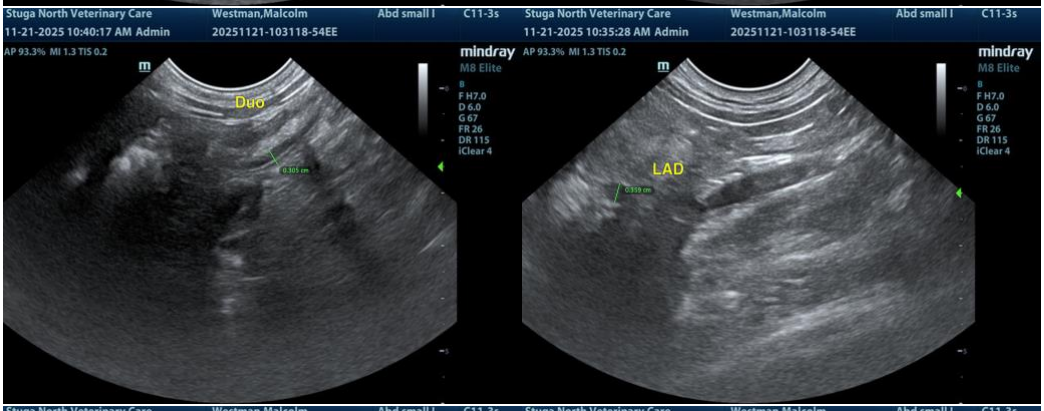

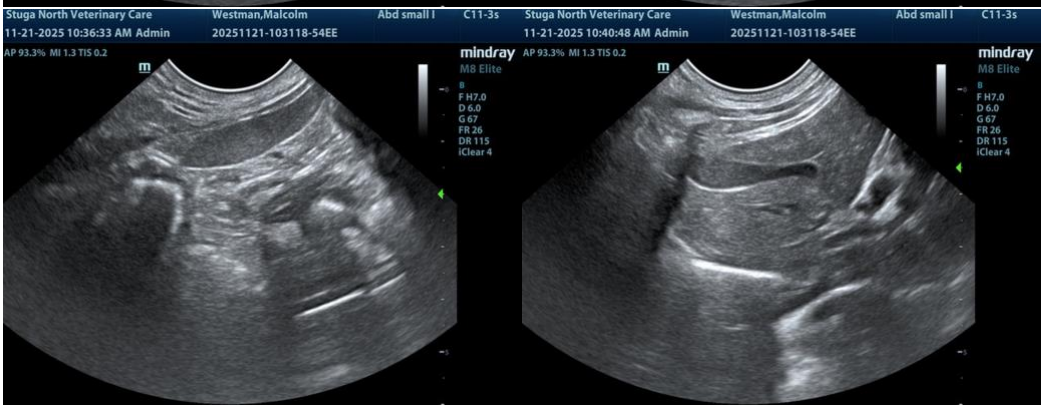

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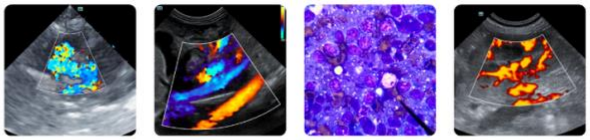

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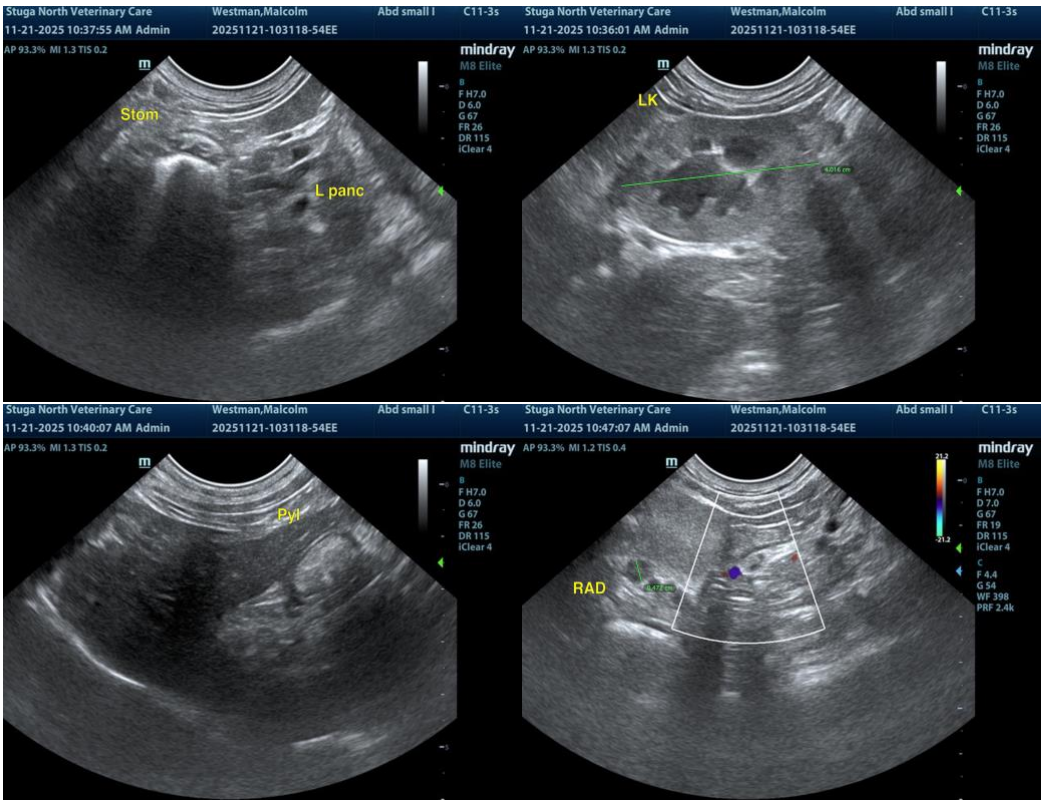

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@SonoPath.com