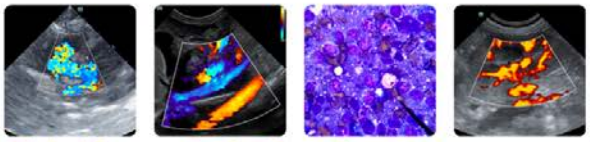


PATIENT

Max Harpainter

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

12 Years

WEIGHT

3.2 kg

INTERPRETED BY

Tam Mengine, DVM, DABVP (canine/feline practice)

IMAGING PERFORMED BY

Michael Schacher

HOSPITAL NAME

Emergency Veterinarians of Idaho

REFERRING VET

Arnold Vet

INVOICE

72108

DATE

1/10/26

PRESENTING CLINICAL SIGNS

Lethargic and not eating at home Full bloodwork and x-ray performed at rDVM - referred for ultrasound Abnormal PE/Chem/CBC/UA Results: Markedly cachexic, nauseous, uncomfortable on cranial abdominal palpation Bloodwork: Anemia of chronic disease, slight leukopenia with slight neutropenia, spec FPL severely elevated X-rays: Largely unremarkable per radiologist

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. A small amount of echogenic luminal sediment is present, which is freely movable. The ureteral papillae, trigone and pelvic urethra (visible to 3.0 cm) are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted.

The kidneys are of normal size and shape and exhibit appropriate corticomedullary differentiation with a normal 1:3 cortex to medulla ratio. There is no evidence of nephrolithiasis, mineralization, pyelectasia, cystic change or hydronephrosis. The proximal ureter is not visible (normal). Left measures 3.8 cm. Right measures 4.0 cm.

Adrenal Glands

The adrenal glands are both identified in their normal locations. They are normal in size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. Left measures 4.6 mm. Right measures 4.1 mm.

Spleen

The spleen is diffusely thickened, measuring 1.3 cm at the hilus. The capsular margins are scalloped and the parenchyma is normal. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal.

Liver

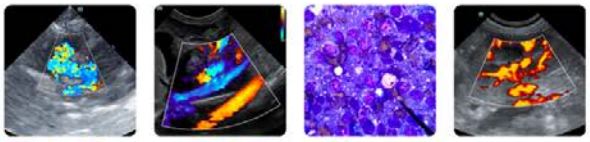
The liver is of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents and a small amount of freely-moveable echogenic sludge. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

Gastrointestinal

The stomach is mildly distended with gas. The gastric wall is 2.1 mm with normal deviations due to rugal folds, and exhibits appropriate wall layering. The pylorus is of normal appearance.

The small bowel has diffuse changes to the normal 1:3 muscularis to mucosa ratio. Wall measurements are increased up to 2.2 mm for duodenum and 3.0 mm for jejunum. Overall wall layering is preserved. Intestinal motility appears normal.



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The visible portions of the colon are of normal thickness (1.6 mm) with intact wall layering. The ileocecal junction is normal.

Pancreas

The left limb of the pancreas is swollen and hypoechoic, surrounded by hyperechoic mesenteric fat. The pancreatic ducts appear normal.

Free Abdomen

There is focal free fluid present with the abdomen in the region of the liver and pancreas. The associated omentum and intra-abdominal fat are hyperechoic. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

PRIMARY FINDINGS

- Diffusely thickened spleen with scalloped margins
- Diffuse small bowel changes typical of infiltrative bowel disease
- Hypoechoic left pancreas with steatitis, consistent with pancreatitis
- Scant free fluid in the region of the liver

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The splenic changes could represent a benign reactive splenitis, secondary to other pathology in the abdomen, however the possibility of infiltrative neoplasia such as lymphoma or splenic mastocytosis, as well as FIP, cannot be excluded without sampling. The changes in the gastrointestinal tract are suggestive of infiltrative bowel disease, including both inflammatory bowel etiologies (food allergy, lymphoplasmacytic enteritis, eosinophilic enteritis) or low-grade gastrointestinal lymphoma). There is evidence of concurrent pancreatitis, which commonly accompanies infiltrative bowel disease in cats.

Next steps of Max might include:

- Ultrasound-guided fine needle aspiration with a 25G needle, after pre-medicating with diphenhydramine.
- FeLV / FIV testing is recommended if not already performed
- Supportive care including fluid therapy, antiemetics, analgesics, appetite stimulants (if needed) and cobalamin supplementation are warranted. Trials with a novel protein or hydrolyzed diet
- A complete GI panel, or empiric cobalamin supplementation
- Empiric therapy with prednisolone at 2-4mg / kg daily could be considered if a diet trial is unsuccessful.
- Definitive diagnosis would require intestinal biopsies.

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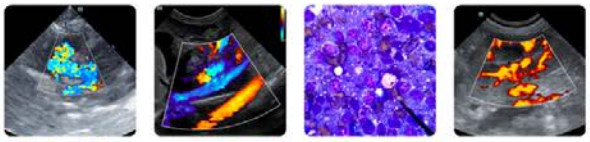

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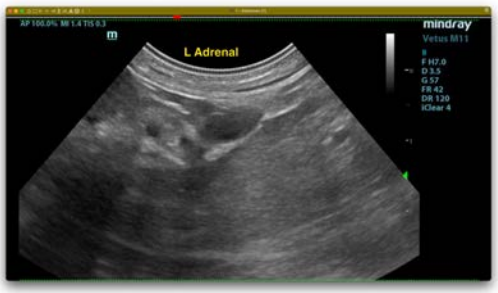

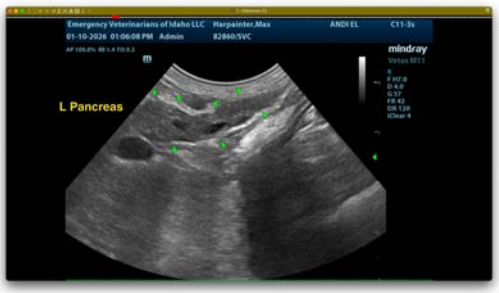

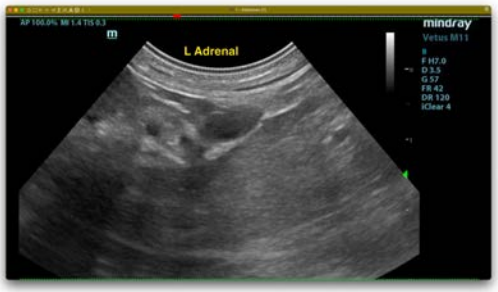

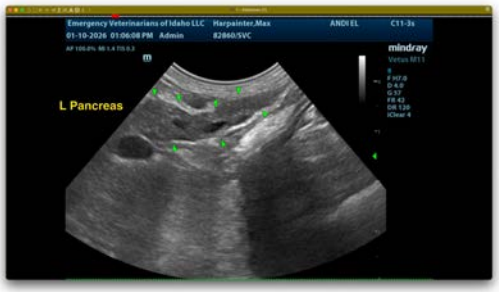

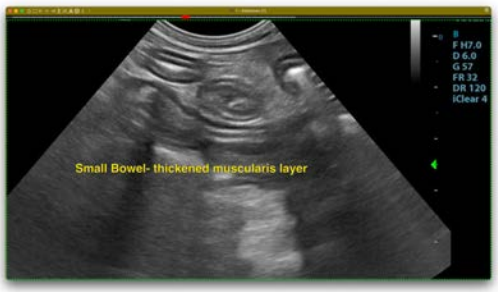

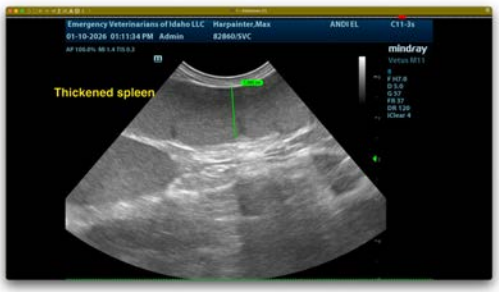

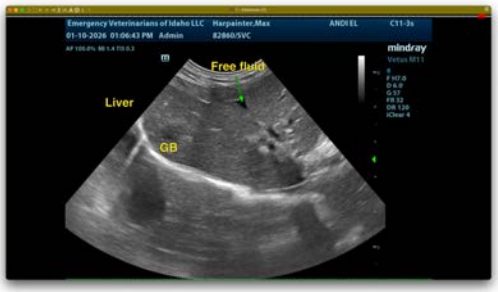

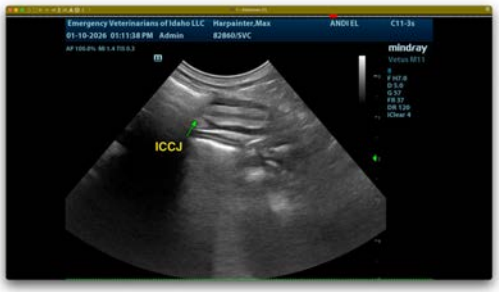

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Tam Mengine, DVM, DABVP (canine/feline practice)

info@SonoPath.com