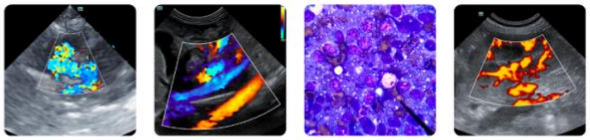


PATIENT

Nemo Malcolm

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

15 Years 8 Months

WEIGHT

10.5

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Heather

HOSPITAL NAME

Animal Care Clinic of Flanders

REFERRING VET

Dr. Hallihan

INVOICE

12917

DATE

01/02/26

PRESENTING CLINICAL SIGNS

Vomiting with some blood in it

Abnormal PE/Chem/CBC/UA Results: famotadine- 0.25ml sq given today

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is poorly distended. The bladder wall appears mildly thickened and irregular; however, this appearance may be attributable to under distension. Additionally, a small intraluminal mural structure measuring approximately 2.7×2.8 mm, compatible with a possible bladder polyp, is observed. The bladder neck and proximal urethra appear normal. No uroliths are identified, and there is no definitive ultrasonographic evidence of inflammatory or neoplastic disease.

The left kidney is normal in shape and size, measuring 4.19×2.73 cm, with a cortical thickness of 0.43 cm in the sagittal plane.

The right kidney is normal in shape and size, measuring 3.39 2.00 cm; cortical thickness is not recorded.

In both kidneys, the renal cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

Both adrenal glands have normal shape and echogenicity. The left adrenal gland measures 0.28 cm at the cranial pole and 0.31 cm at the caudal pole. The right adrenal gland was not clearly visualized.

Spleen

Splenic thickness measures 1.01 cm. The splenic parenchyma has normal echogenicity and a fine, homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

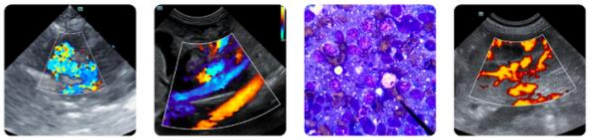
The liver is subjectively normal in size, with sharp margins and a regular contour. The hepatic parenchyma is uniform and isoechoic relative to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The gallbladder wall is thin, and the contents are primarily anechoic with a very small amount of biliary sludge. No dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty and mildly folded, with a mural thickness of 1.93 mm and preserved wall layering. The pylorus is not visualized. The duodenum is not visualized.

The jejunum measures 3.45 mm, with the following wall layer measurements: mucosa 1.98 mm, submucosa 0.87 mm, and muscularis propria 0.55 mm.



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The ileum measures 3.03 mm, with mucosa 0.94 mm, submucosa 1.00 mm, and muscularis propria 0.74 mm; wall layering is preserved.

The ileocecal junction measures 2.98 mm, with a muscularis thickness of 1.01 mm. No evidence of gastrointestinal obstruction, ileus, or foreign material is identified.

The colonic wall measures approximately 1.04 mm, with a small amount of formed fecal material in the descending colon.

Pancreas

The pancreas measures approximately 7.92 mm in thickness. The pancreatic parenchyma is hypoechoic relative to the adjacent omental fat. The pancreatic duct measures approximately 1.20 mm in diameter. No ultrasonographic evidence of peripancreatic fat inflammation is observed.

Free Abdomen

No abdominal effusion or evidence of peritonitis is observed. Cranial mesenteric and ileocecal lymph nodes are not visualized; the surrounding regions appear unremarkable. The iliac trifurcation appears normal.

PRIMARY FINDINGS

- Mild diffuse small intestinal wall thickening with preserved layering and mild muscularis prominence.
- Mild pancreatic thickening and parenchymal hypoechogenicity.

SECONDARY FINDINGS

- Poorly distended urinary bladder with suspected small intraluminal polyp.
- Mild biliary sludge.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The fundus and body of the stomach demonstrate normal wall thickness and preserved layering, without focal masses, ulcer craters, or transmural defects within the portions of the stomach that were visualized. The pyloric region was not visualized during this examination and therefore could not be adequately evaluated, and pathology localized to the pylorus cannot be excluded. It is also important to note that ultrasound has limited sensitivity for superficial gastric mucosal ulceration or erosive gastritis, and a normal gastric ultrasound does not exclude clinically significant gastric mucosal disease.

The small intestines show mild diffuse wall thickening with preserved layering, including mild muscularis prominence at the ileum and ileocecal junction. This pattern is most consistent with chronic inflammatory enteropathy, particularly lymphoplasmacytic-type disease, and does not support an acute infiltrative or obstructive process. (These changes are unlikely to be the primary cause of acute hematemesis).

The pancreas appears mildly hypoechoic with a mildly visible pancreatic duct but without enlargement, peripancreatic fat reaction, or free fluid. In the absence of supportive clinical or laboratory findings, this appearance is most consistent with age-related or chronic pancreatitis.

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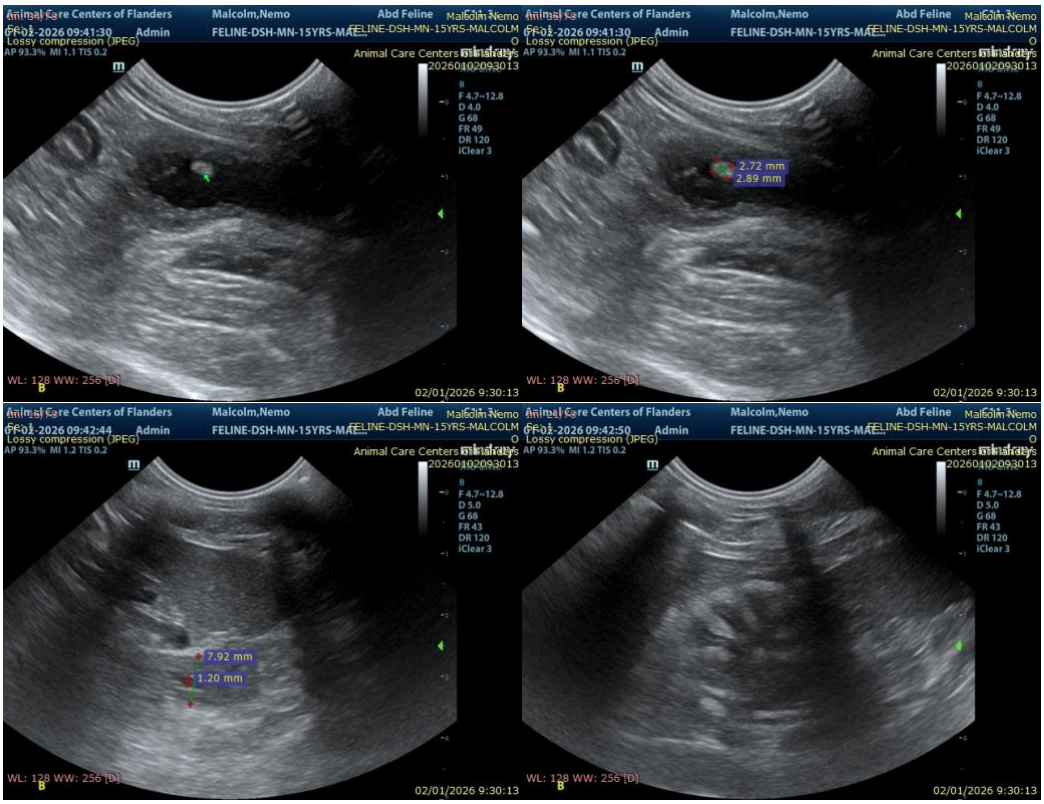
The urinary bladder is poorly distended, limiting wall assessment. Mild wall irregularity may be artifactual; however, a small, suspected bladder polyp is noted. This finding is incidental in the context of the presenting complaint and is unlikely to be clinically relevant at this time.

Recommendations

- Medical management of suspected gastric mucosal disease: Continue acid suppression and gastroprotective therapy as clinically indicated, recognizing that ultrasound cannot exclude erosive or ulcerative gastritis.
- Further evaluation if hematemesis persists or recurs: Consider upper gastrointestinal endoscopy to directly assess the gastric mucosa and obtain biopsies if clinically warranted.
- Given the presence of vomiting and the limited sensitivity of ultrasound for feline pancreatitis, measurement of a feline pancreatic lipase may be considered to further evaluate for concurrent pancreatic disease. A complete gastrointestinal panel is optional.
- Monitor intestinal findings.
- If lower urinary tract signs develop, repeat ultrasound with adequate bladder distension.



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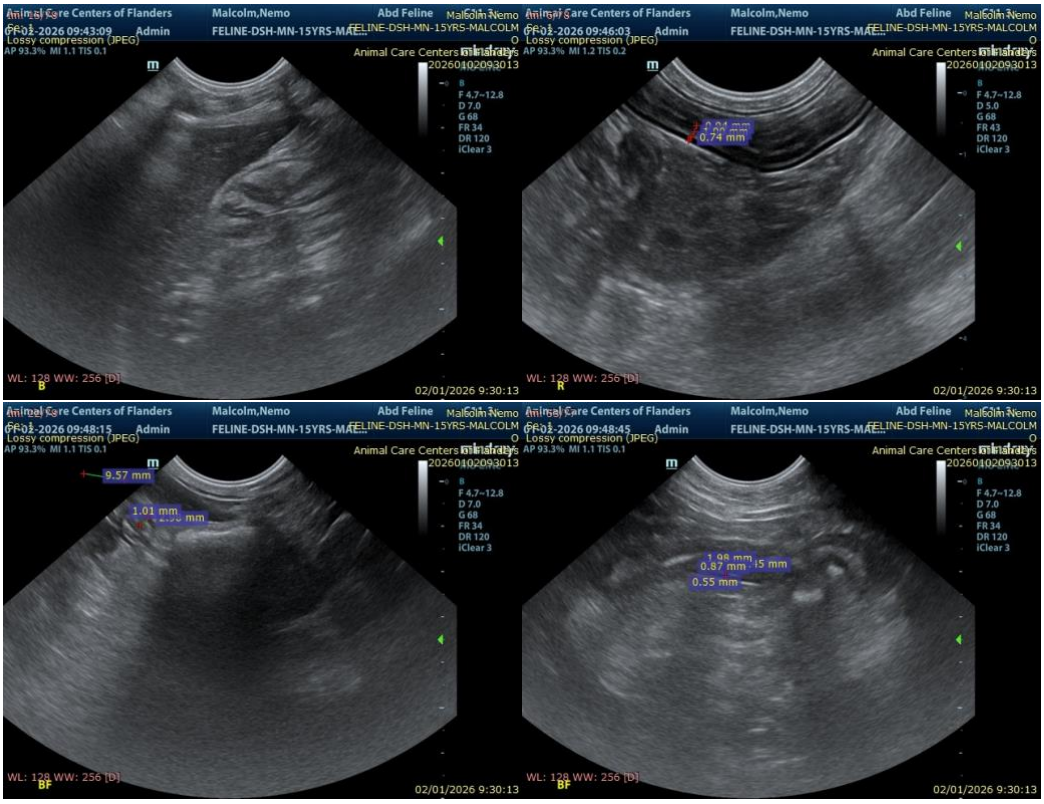

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

info@SonoPath.com