



PATIENT

Mikko Meyrovich

SPECIES

Feline

BREED

Domestic longhair

SEX

Male, neutered

AGE

11 Yrs.

WEIGHT

5.6 kg.

INTERPRETED BY

Andrea Nicastro, DVM,
Diplomate ACVIM
(Small Animal Internal
Medicine)

IMAGING PERFORMED BY

Dr. Jessica Meloche

HOSPITAL NAME

Viking VH

REFERRING VET

Dr. Jessica Meloche

INVOICE

13331

DATE

11/11/25

PRESENTING CLINICAL SIGNS

History: anorexia, gagging for a few days. Hx of hairballs Has congestion flare-ups - O unsure if FIV or FeLV | Doesn't believe P has been tested. Suspect diagnosis since 6wks old. Initial abd rads revealed distended bowel, repeat rads hours later on IVF -> distention improved but pt still anorexic. r/o FB, GI lymphoma/IBD, adrenal pathology, other endocrine pathology, other neoplasia, other Abnormal PE/Chem/CBC/UA Results: Brief AUS showed almost cyst-like structure/lesions near left kidney in area of suspect adrenal gland, small bowel possibly inflamed.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is distended. A small amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

In the visualized portion of the left kidney, it appears subjectively normal in size (3.92 cm in length) with a normal shape, architecture and smooth peripheral margins. There is minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal in size (3.99 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. Trace to mild pyelectasia is present (0.20 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.34 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The region of the right adrenal gland is evaluated. No obvious pathology is observed in this region.

Spleen

The spleen is normal in size (0.86 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

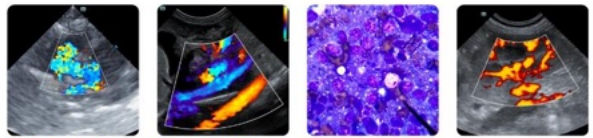
Liver

The liver is normal to prominent in size with smooth peripheral contours. The parenchyma is hyperechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1:1.

The gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is mildly to moderately fluid distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal to mildly thickened (up to 0.27 cm). There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.



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Pancreas

The left limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph nodes

At least 3 prominent hypoechoic mesenteric lymph nodes are observed, the largest node measuring 1.22 x 0.71 cm. Surrounding mesentery is hyperechoic.

Free Abdomen

There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The small intestinal wall changes could be consistent with inflammatory bowel disease or emerging small cell lymphoma. The prominent mesenteric lymph nodes could be consistent with lymphoid hyperplasia, lymphadenitis or emerging neoplasia (i.e., lymphoma). Mild adjacent peritonitis is present.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The diffuse hepatic parenchymal changes could be consistent with hepatic lipidosis, an inflammatory hepatopathy (i.e., bacterial cholangiohepatitis, lymphoplasmacytic hepatitis, feline infectious peritonitis), infiltrative neoplasia (i.e., lymphoma) and/or other hepatopathy.

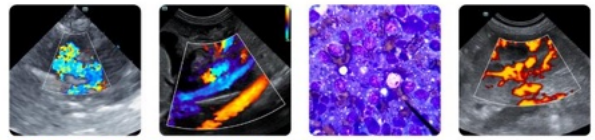
Secondary Findings:

- Minor bilateral nonspecific age-related renal changes with trace to mild right pyelectasia

*Given the sonographic changes, "triaditis" is a consideration in this patient.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. A minimum database including a CBC chemistry panel, urinalysis and T4 is recommended (if not already performed). Feline leukemia and FIV testing is also recommended.
2. Consider a sedated oral examination to assess for oropharyngeal disease as a cause for gagging.
3. Three-view thoracic radiographs are recommended to assess for occult esophageal disease and other pathology.
4. Consider a GI panel including serum cobalamin, folate, TLI and PLI as well as a fecal evaluation for ova and Giardia.
5. Consider fine needle aspiration of the prominent mesenteric lymph nodes (assuming normal clotting status). A 25-gauge needle should be used.
6. Depending on results of the above diagnostics, further workup (i.e., endoscopic or surgical GI biopsies) may be indicated.



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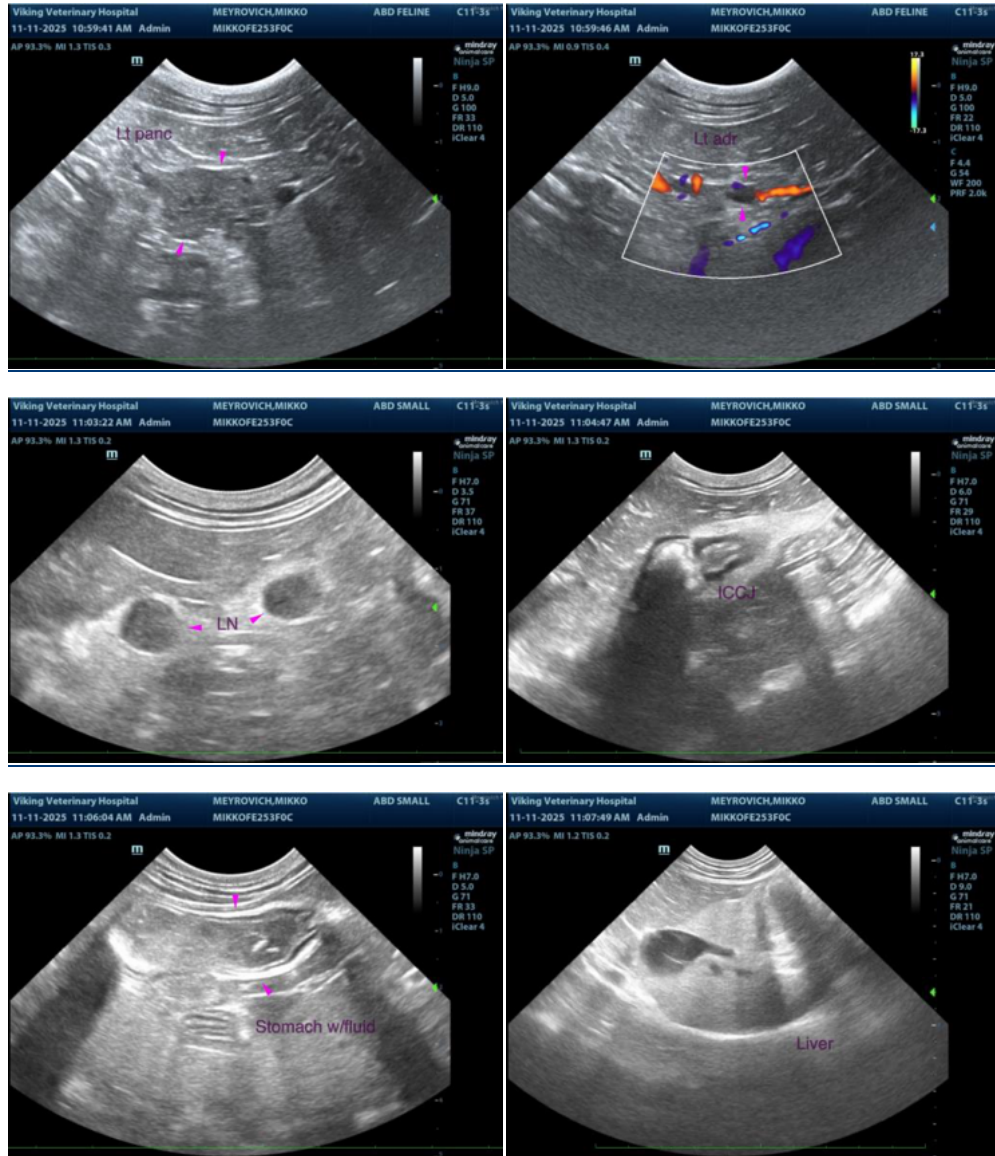
Dr. Jessica Meloche

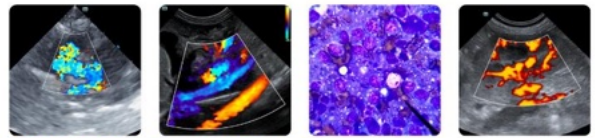
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com