



**PATIENT**

Duke Smith

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

04/26/2023

**WEIGHT**

9.04kg

**INTERPRETED BY**

Andrea Nicastro DVM  
Diplomate ACVIM  
(Sm Animal Internal Med)

**IMAGING PERFORMED BY**

Andrea Nicastro DVM  
Diplomate ACVIM  
(Sm Animal Internal Med)

**HOSPITAL NAME**

Blue Pearl MP ER

**REFERRING VET**

Rachel Fuller, DVM

**PRESENTING CLINICAL SIGNS**

History: Duke is a 3y/o MN DSH presenting for vomiting. O says she has been out of town for a couple days, but her husband and daughter say that they found 3-4 piles of vomit this morning that contained undigested food. O says they originally thought it was the other cat in the home as the other cat IBD. But O's said they witness P vomit 2 times within the past hour which contained red, clear fluid and yellow foam. O says P had a diet change about 6 months ago. P is now on pea and rabbit Royal Canin wet food and Royal Canin hydrolyzed protein. O says these diets are for the other cat in the home that has IBD and O has both the cats on the same food. O says P has done well with these foods. O says P does not usually get into things he's not supposed to. O mentions she has flowers in the home which the cats can't get into. O notes there are no lilies present in the home. UTD on vx and preventions, e/d decreased - since vomiting started today, no d/c/s, no prior medical hx, no daily medications. Febrile, Temp 104.

Abnormal lab-work values:

- CBC - HCT 47% ; WBC 10 k; PLT 26k (L)

Manual PLT estimate: 210 PLT with adequate clumping

-Chem - K 3.3 (L); BG 169 (H); ALT 172 (H)

-Triple SNAP - negative x 3

-UA complete in house (via cystocentesis) - USG >1.050; pH 6.5; Glucose 300; 10 Ery/uL blood; no crystals/bacterial are noted

Current Medications: No current daily oral medications given at home. Administered Cerenia, Famotidine, Ondansetron, Buprenorphine, and Pt is on a KCL CRI.

Radiographic Assessment

This imaging study does not conclusively determine an underlying cause for the gastrointestinal clinical signs. A functional condition, such as gastroenteritis (due to infection, inflammation, toxin, parasitic causes, or dietary discretion), chronic enteropathy, or extra-gastrointestinal causes (such as pancreatitis, endocrine-related disorders, hepatopathy, among others), is considered most likely. Mechanical obstruction is not identified. Gastrointestinal distention, gastrointestinal foreign material and small intestinal plication are not identified. The findings involving the colon may indicate retention of contents.

Delayed voiding is a possible cause for the distended urinary bladder. Clinical correlation is warranted as other functional or mechanical conditions, including lower urinary tract obstruction, can lead to a distended urinary bladder. Urolithiasis is not identified.

Mildly enlarged inguinal lymph nodes and ventral abdominal subcutaneous edema or inflammation (possible incidental findings).

Degenerative changes to the left coxofemoral joint.

No thoracic abnormalities are identified.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

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4-27-26

**Urinary System**

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney mildly enlarged (5.08 cm in length) with a normal shape, architecture and smooth peripheral contours. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.



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The right kidney is mildly enlarged (5.23 cm in length) with a normal shape, architecture and smooth peripheral contours. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

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**Adrenal Glands**

The left adrenal gland is normal size (0.39 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

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The right adrenal gland is normal size (0.48 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

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**Spleen**

The spleen is normal in size (0.72 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.

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**Liver**

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative pathology is evident. 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.

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The gallbladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal.

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**Gastrointestinal**

The gastric lumen is mildly fluid-distended and hypomotile. The gastric wall is diffusely thickened (up to 0.53 cm) and hyperechoic, with retention of the normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecolic junction and colonic wall are normal. The lumen of the descending colon contains shadowing fecal material. There is no obvious evidence of an obstructive pattern.

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**Pancreas**

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

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**Lymph Nodes**

The abdominal lymph nodes are normal/not visible.

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**Free Abdomen**

The peritoneal cavity is normal. There is no evidence of inflammation or effusion.

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**Other**

A brief echocardiogram reveals no obvious evidence of pericardial or pleural effusion in the visible window.

**ULTRASONOGRAPHIC FINDINGS**

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**Primary Findings**

- The gastric wall changes are most consistent with gastritis. Mild gastric ileus is also present.



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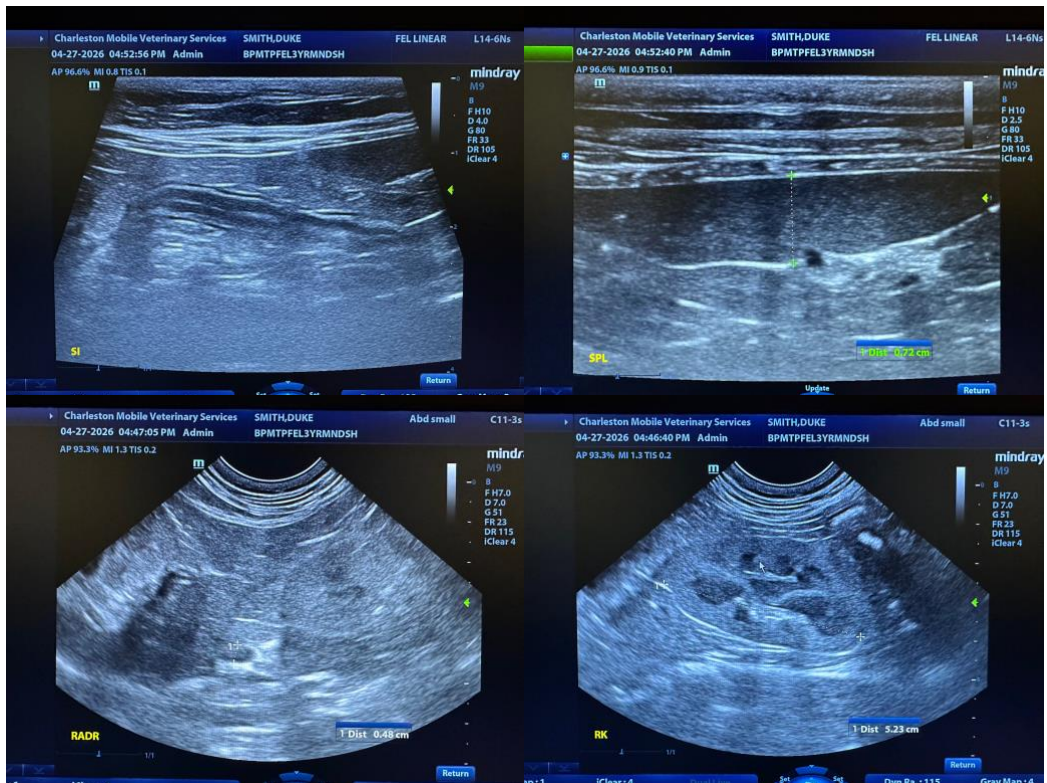
**Secondary Findings**

- The mild bilateral renomegaly likely represents a normal variant for this larger feline patient. Other considerations include interstitial nephritis, pyelonephritis, other. Correlation with the patient's renal values is recommended.

\*There is no obvious evidence of a gastrointestinal foreign body/obstruction.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

- A fecal evaluation for ova and Giardia is recommended.
- Supportive care for gastritis/gastroenteritis is recommended. If clinical signs persist despite medical management further GI work-up (i.e., GI panel, limited antigen diet +/- GI biopsies) may be indicated.
- Regarding the fever, consider further workup (i.e., feline infectious disease panel +/- urine culture, fPLI, thoracic radiographs, echocardiogram).





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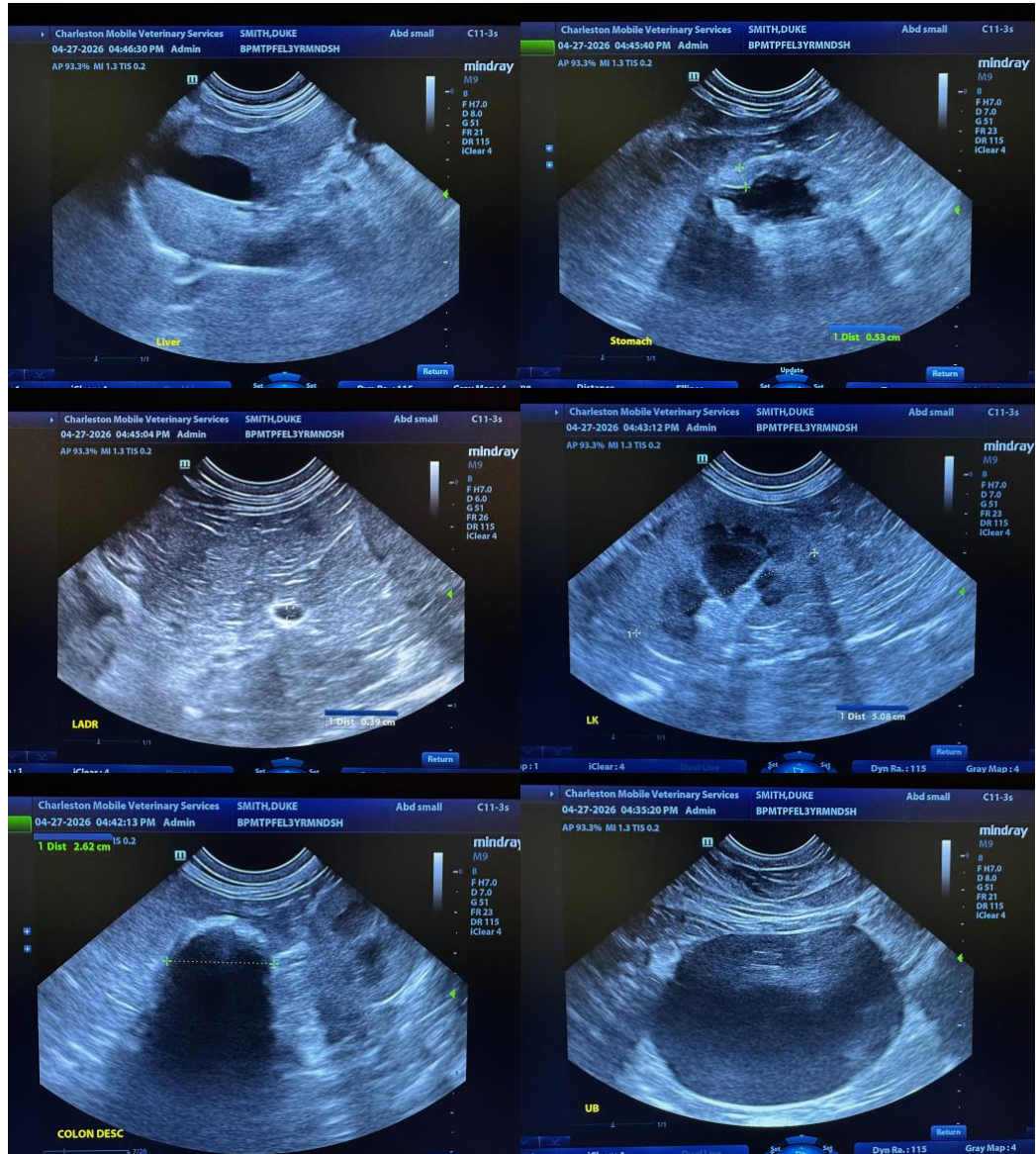
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)**  
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