

DATE

5-18-26

PATIENT

Leliana Domagala

SPECIES

Feline

BREED

Ragdoll

SEX

Female Spayed

AGE

2/11/2012

WEIGHT

10lbs

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Animal EH

REFERRING VET

Dr Shannahan

INVOICE

23039

PRESENTING CLINICAL SIGNS

Patient History: Eating and drinking enthusiastically - No prior history of constipation - Client reports abdominal distension - Observed repeatedly posturing to defecate without producing stool, including outside litter box - Still urinating normally - Occasionally regurgitates water after drinking too quickly (not new behavior) - One episode of water regurgitation this week - Weight stable between 8-10 pounds - History of pyometra and upper respiratory infection. Eosinophilia. SDMA 20. T4 normal.

Current Medications: Cerenia, Ondansetron, Methadone.

Labwork Results: Labwork attached. Xray Abdomen 2 view- thickened intestines, some stool in colon.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Hydro/Midaz/Alfax.

Stat Report: Requested.

Imaging Performed by: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

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 visible portion of the proximal urethra are normal.

The left kidney is normal in size (3.91 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild- to moderate loss of corticomedullary distinction. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.11 cm in length) with a normal shape, architecture and smooth peripheral margins. 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.

Adrenal Glands

The left adrenal gland is normal size (0.44 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.40 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

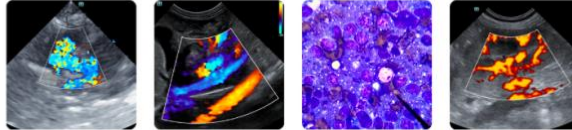
Spleen

The spleen is normal in size (0.83 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. (See also "Other" category).

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is isoechoic 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 lumen is moderately distended. The wall is thin and smooth. A small- to moderate amount of echogenic debris is observed within the lumen. The cystic and common bile ducts are normal. The duodenal papilla is normal-in-size (0.52 cm in width).



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Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not 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 0.26 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.

Pancreas

The pancreas is diffusely visible. The parenchyma is slightly hypoechoic relative to surrounding omental fat and subtly mottled in appearance. The pancreatic duct is visible but not overtly dilated. (See also "Other" category).

Lymph Nodes

A few prominent mesenteric lymph nodes are visualized (one measuring 0.73 x 0.35 cm). Surrounding mesentery is hyperechoic. (See also "Other" category).

Free Abdomen

There is no obvious evidence of free fluid.

Other

In the left cranial- to mid-abdomen, just medial to the spleen, a 5.3 x 1.8 cm ill-defined heterogenous, multiseptated cystic structure is visualized. Echogenic debris is observed in some of the cystic regions.

In the caudodorsal abdomen, just dorsal to the cystourethral junction, a 0.52 x 0.38 cm anechoic structure is visualized.

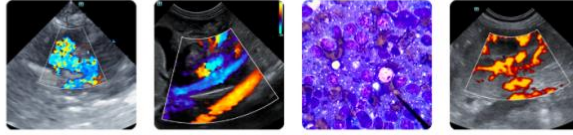
ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The origin of the heterogenous cystic structure in the left cranial to mid-abdomen is unclear. It may be arising from spleen, the left limb of the pancreas, mesentery, other. Considerations include a benign cystic focus, inflammatory lesion, neoplasia, other.
- The small intestinal wall changes could be consistent with inflammatory bowel disease or emerging lymphoma.

Secondary Findings

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Bilateral nonspecific age-related renal changes with trace pyelectasia
- The origin of the structure just dorsal to the cystourethral junction is unclear. It may represent a cystic sublumbar lymph node, cyst within the mesentery, other. Its significance is unclear.



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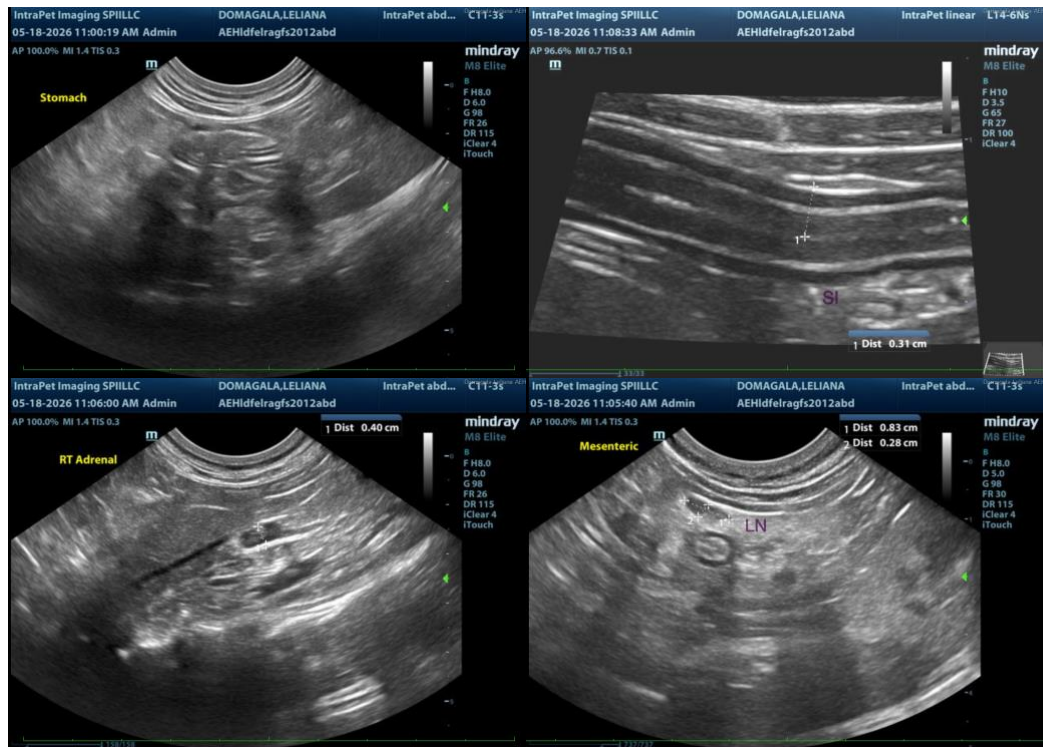
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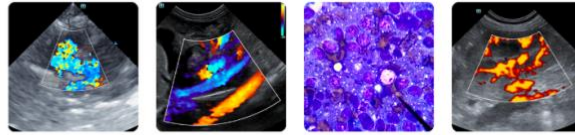
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the heterogenous cystic structure in the left cranial- to mid-abdomen, consider the following:
 - Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
 - Fine-needle aspiration of the lesion can be considered. However, given its origin is unknown, there is a risk of iatrogenic leakage of the cystic material into the abdominal cavity with aspiration. Alternatively, excisional biopsy and submission for histopathology can be considered. If pursued, GI biopsies should also be obtained at the time of surgery.
- Regarding the patient's clinical signs, consider the following:
 - Fecal evaluation for ova and Giardia
 - GI panel including serum cobalamin and folate, TLI and PLI
 - Limited antigen or hydrolyzed protein diet trial
 - Depending on the results of the above diagnostics, further work-up (i.e., GI biopsies) may be indicated.



Imaging performed by



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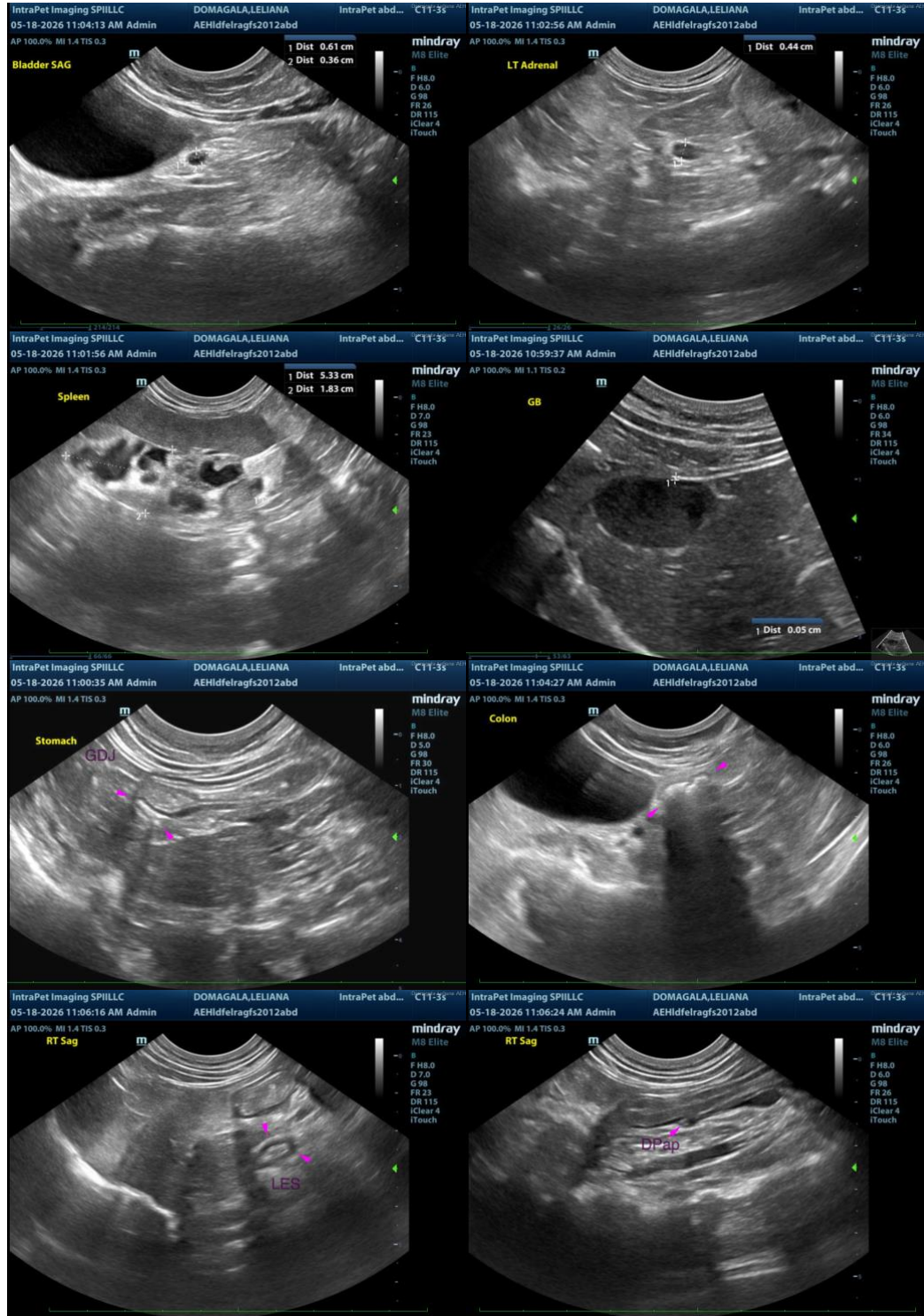
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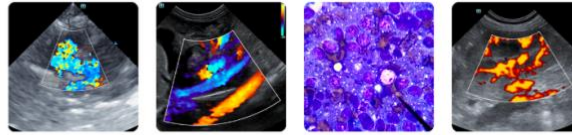
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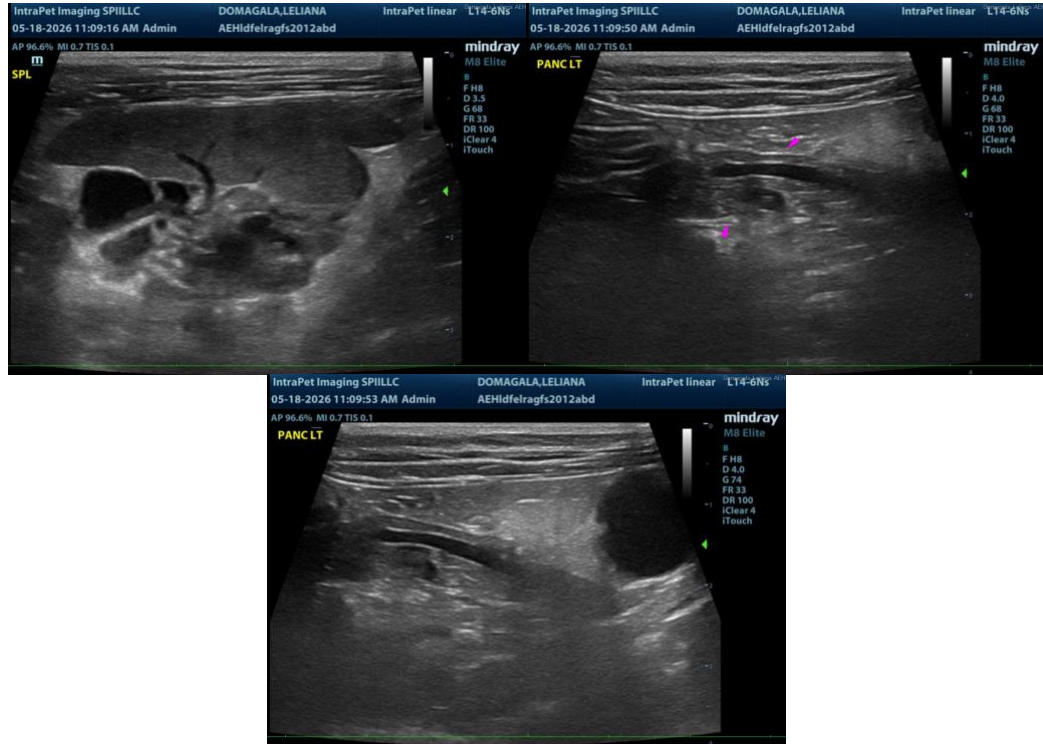
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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