



DATE PRESENTING CLINICAL SIGNS

5-22-26

Patient History: Vomiting x 5d

PATIENT

Current Medications: Phenobarbital 16.2mg 1/4 PO BID

Simba Patrick

Labwork Results: Labwork not attached, reported as: FPLI- strong abnormal, LIPA 3841, TBIL 0.2, mall else WNL

Radiograph findings- Kidney stones, Hair ball, Possible bladder stones

Date of Previous IntraPet Ultrasound: No previous.

SPECIES

Sedation: Not required to complete full diagnostic ultrasound.

Feline

Stat Report: Requested.

Imaging Performed by: Stephanie Warga RDCS, RVT.

BREED

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

DLH

Urinary System

The urinary bladder is moderately distended. The wall is normal in thickness with a smooth mucosal surface. A small- to moderate amount of gravity-dependent mineralized sand and suspected tiny calculi are observed within the lumen. The region of the trigone and visible portion of the proximal urethra are normal.

SEX

Neutered Male

The left kidney is small in size (2.97 cm in length) with an irregular shape. The cortex is variably thickened with moderate loss of of corticomedullary distinction. Trace pyelectasia is present. Several, small, nonobstructive nephroliths are visualized. There is no evidence of hydroureter. Renal vasculature is normal.

AGE

4/19/2016

The right kidney is enlarged (4.80 cm in length) with smooth peripheral contours. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. Several, small, nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

WEIGHT

20 lbs

Adrenal Glands

INTERPRETED BY

The left adrenal gland is normal size (0.46 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

The right adrenal gland is normal size (0.49 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

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Spleen

The spleen is prominent in size (1.05 cm in width at the level of the hilus) with smooth peripheral contours. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

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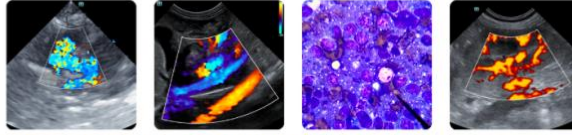
Liver

The liver is subjectively normal- to prominent-in-size, with smooth peripheral contours. The parenchyma is isoechoic relative to the spleen. Several, small, hyperechoic nodules are observed throughout the organ. The parenchyma is otherwise homogenous. Hepatic vasculature and intrahepatic 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. A small amount of echogenic debris is observed within the lumen. The cystic and common bile ducts are normal. The duodenal papilla is normal-in-size (0.29 cm in width).



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Gastrointestinal

The gastric lumen is mildly distended with ingesta and soft, shadowing material. The gastric wall is mildly thickened (up to 0.41 cm) and hyperechoic- to heterogenous in appearance. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal. 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 prominent-in-size, with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and mottled in appearance, with several small, ill-defined cystic areas. The pancreatic duct is not overtly dilated. The mesentery effacing the serosal surface of the pancreas is hyperechoic.

Lymph Nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

Trace free fluid is observed.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The pancreatic changes are most consistent with moderate pancreatitis with parenchymal cysts and adjacent peritonitis.
- The small intestinal wall changes could be consistent with inflammatory bowel disease, emerging lymphoma, or may be a normal variant for this older feline patient. Correlation with the patient's long term clinical history is recommended.
- The gastric wall changes are suggestive of gastritis with a lower possibility of emerging neoplasia. Retained gastric ingesta. The soft, shadowing material within the gastric lumen may represent normal ingesta and/or foreign material (i.e., hair). It appears nonobstructive at the time of this study.
- Trace ascites

Secondary Findings

- Bilateral nonspecific age-related renal changes with nephrolithiasis and left renal atrophy. The right renomegaly is likely secondary to compensatory hypertrophy, with a lower possibility of interstitial nephritis, pyelonephritis, emerging neoplasia, other.
- The hyperechoic hepatic nodules likely represent lipogranulomas or myelolipomas with a lower possibility of more insidious hepatic pathology.
- Urinary bladder sand +/- tiny calculi
- The mild splenomegaly may be a normal variant for this large feline patient. Other considerations include lymphoid hyperplasia, extramedullary hematopoiesis, splenitis, antigenic stimulation, or less likely, emerging neoplasia (i.e., round cell tumor).

Imaging performed by



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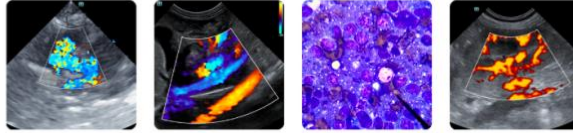
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Supportive care for pancreatitis is recommended including IV fluid therapy, gastric protectants, antiemetics, pain medication as needed, +/- fresh frozen plasma.
- Given the bowel changes, consider a GI panel including serum cobalamin and folate, TLI and PLI.
- Regarding the urinary bladder changes, a cystotomy with sand/stone removal, analysis and culture can be considered when the patient's current clinical condition has stabilized. Alternatively, consider an attempt at medical dissolution.



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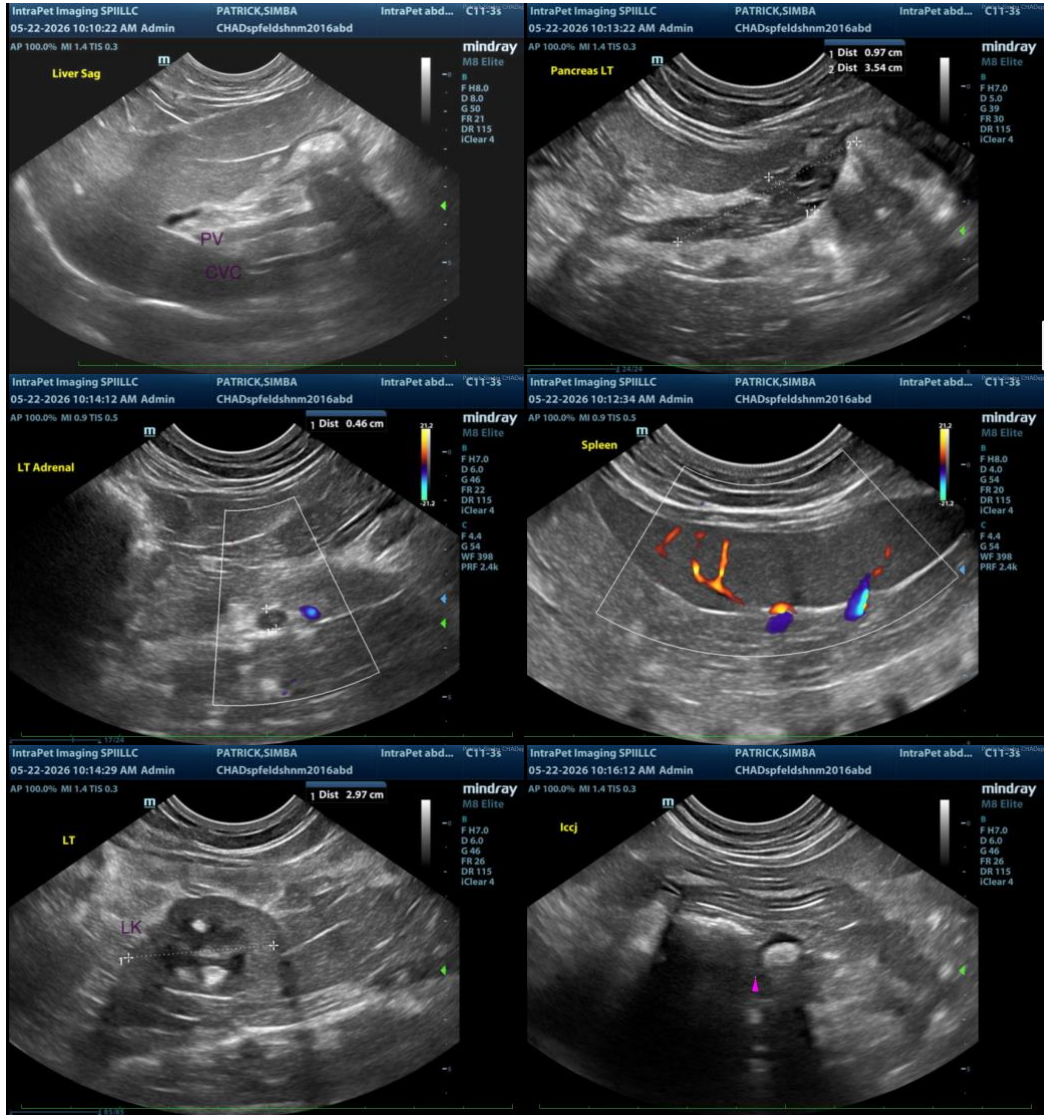
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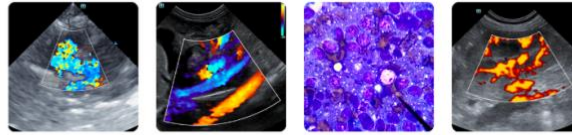
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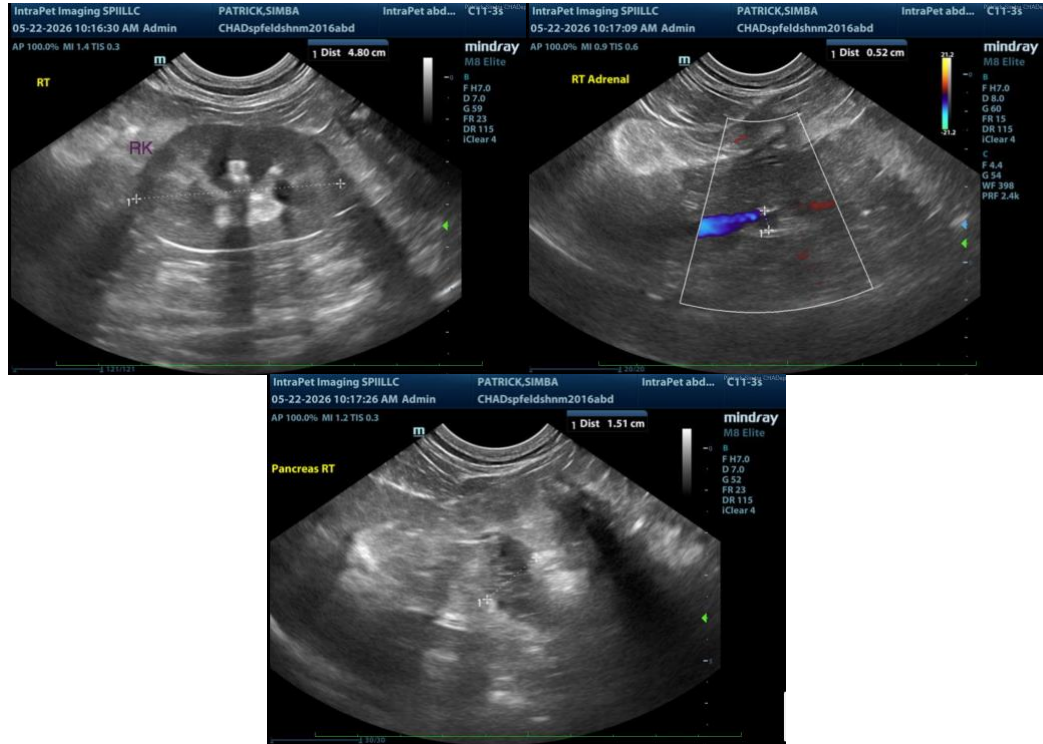
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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