

PATIENT

Meghan Scott

SPECIES

Feline

BREED

Domestic longhair

SEX

Female, spayed

AGE

6 Yrs. 8 months

WEIGHT

7.8 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Fidelis

REFERRING VET

Dr. Johnston

INVOICE

13412

DATE

12/3/25

PRESENTING CLINICAL SIGNS

Pt has a history of presumptive inflammatory bowel disease diagnosed via ultrasound 2-3 years ago. Has been on Budesonide since then. Has had a recent increase in vomiting frequency and is currently on Budesonide at 1 mg daily. No special diet at this time. A CBC chemistry panel and T4 are unremarkable. Heartworm antibody negative.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are mostly 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 is normal in size (3.62 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.53 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of 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 (0.26 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

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

Spleen

The spleen is normal in size (0.76 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.

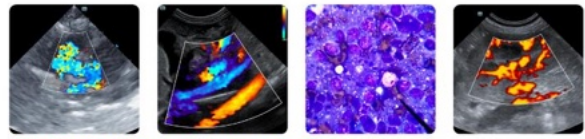
Liver

The liver is 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.

The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is minimally to mildly 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 in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileoceocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.



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Pancreas

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

Lymph nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

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

Other

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

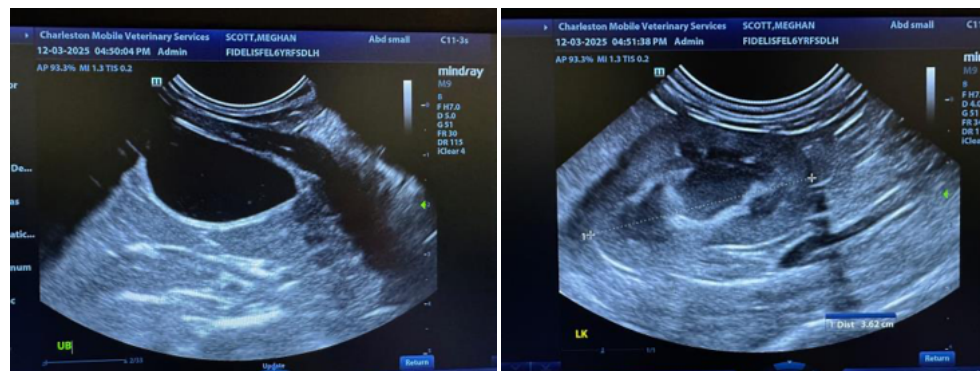
ULTRASONOGRAPHIC FINDINGS

- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.

*An obvious cause for the patient's increase in vomiting is not definitively identified in this study. Considerations include inflammatory bowel disease flare-up, low-grade pancreatitis, underlying metabolic issue, heartworm disease, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Fecal evaluation for ova and Giardia
- GI panel including serum cobalamin, folate, TLI and PLI
- Consider transitioning to a limited antigen or hydrolyzed protein diet
- If the above diagnostics are inconclusive and the patient continues to vomit despite a diet trial, endoscopic or surgical GI biopsies may be indicated. If biopsies are not pursued and vomiting persists, transition from Budesonide to Prednisolone may be warranted.





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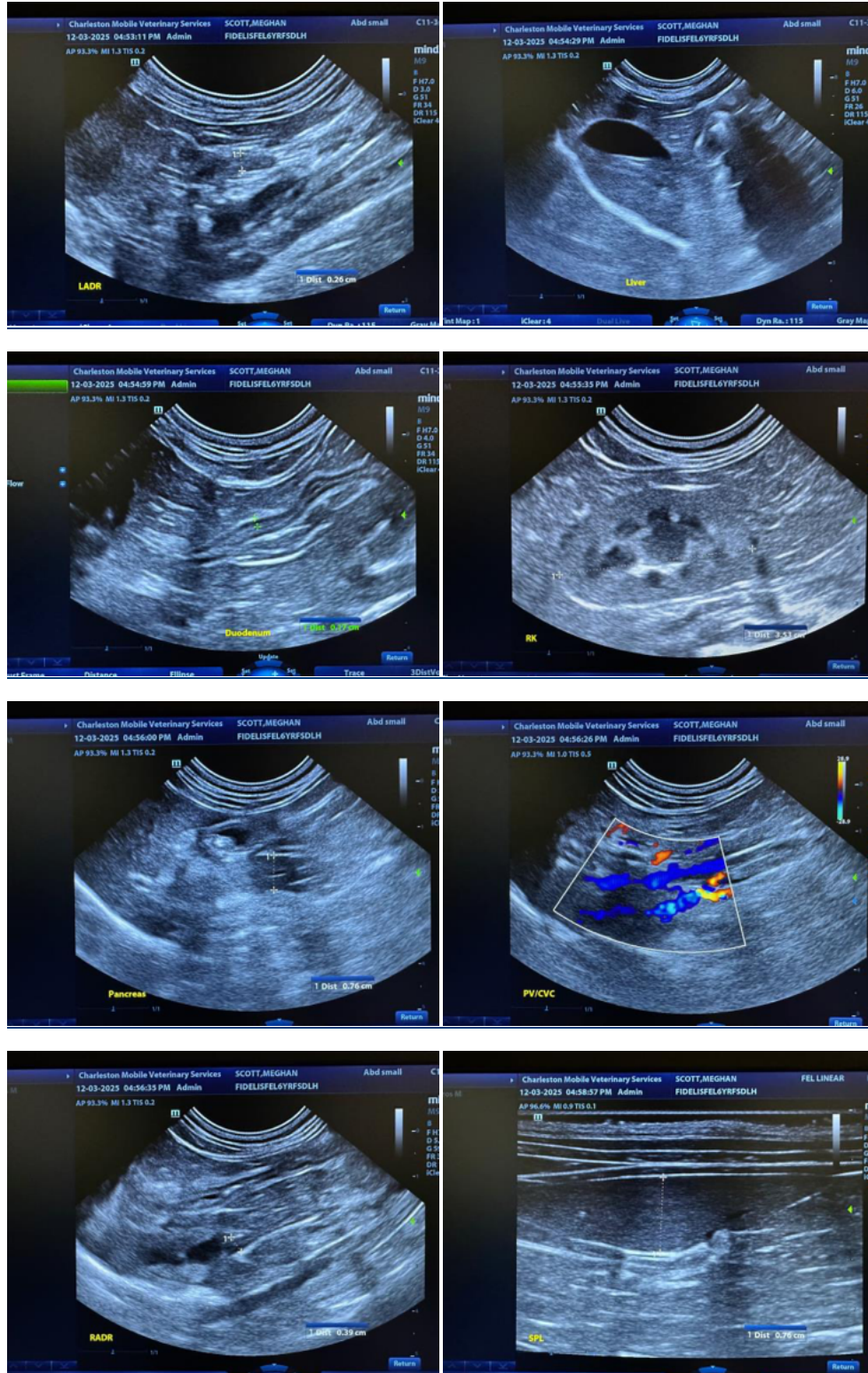
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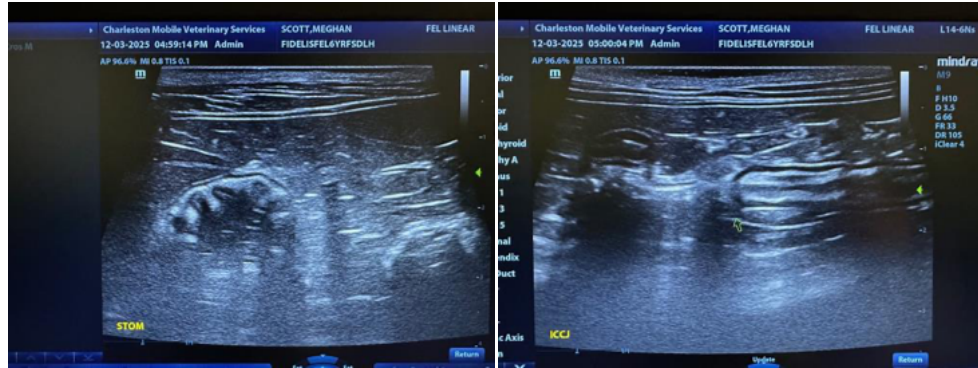
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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