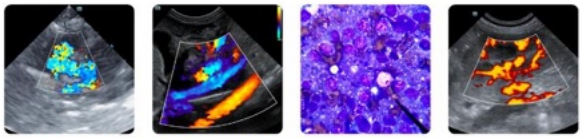

PATIENT

CC Gadsby

SPECIES

Feline

BREED

Domestic shorthair

SEX

Female, spayed

AGE

6/10/11

WEIGHT

8.51 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

Cats Meow

REFERRING VET

Dr. Levy

INVOICE

13587

DATE

5/27/26

PRESENTING CLINICAL SIGNS

Hx of pancreatitis, occasional vomiting, Pancreatic Lipase 5.8

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 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 small in size (2.14 cm in length) with an irregular shape. The cortex is variably thickened with moderate to severe loss of corticomedullary distinction. There are questionable cortical infracts. Pinpoint hyperechoic to mineralized foci are visualized. There is no evidence of pyelectasia or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.73 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. Trace pyelectasia is present. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.41 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.32 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is prominent in size (1.02 cm in width at the level of the hilus) with smooth peripheral 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 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 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. The duodenal papilla is normal in size (0.21 cm in width).

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 thickness is normal. There is disruption in the normal 1:3 muscularis: mucosal ratio in several segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

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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
A few prominent irregular mildly hypoechoic mesenteric lymph nodes are visualized, one of the nodes measuring 2.06 x 0.84 cm. Surrounding mesentery is mildly hyperechoic.

Free Abdomen
Three is no obvious evidence of free fluid.

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The small intestinal wall changes could be consistent with inflammatory bowel disease or emerging lymphoma.
- The mesenteric lymphadenopathy could be consistent with lymphoid hyperplasia, lymphadenitis or emerging neoplasia (i.e., lymphoma).
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

Secondary Findings:

- Bilateral nonspecific, age-related renal changes with dystrophic mineralization, suspected left cortical infarcts and trace right pyelectasia. The left kidney appears atrophied.
- The mild splenomegaly may be a normal variant for this patient or may be secondary to lymphoid hyperplasia, extramedullary hematopoiesis, splenitis, antigenic stimulation or less likely, emerging neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Fine needle aspiration of the mesenteric lymph nodes can be considered (assuming normal clotting status). A 25-gauge needle should be used.
- Other considerations include the following:

1. Serum cobalamin, folate, PLI and TLI
2. A fecal evaluation for ova/Giardia
3. 3-4-week limited antigen or hydrolyzed protein diet trial to assess for food allergies
4. Initiation with a probiotic may also prove beneficial.
5. Also consider heartworm antigen and antibody testing as heartworm disease can be a cause of chronic vomiting in cats.
6. If the above diagnostics/therapeutics are inconclusive, endoscopic or surgical gastrointestinal biopsies may be warranted. Thoracic radiographs are recommended prior to anesthesia.

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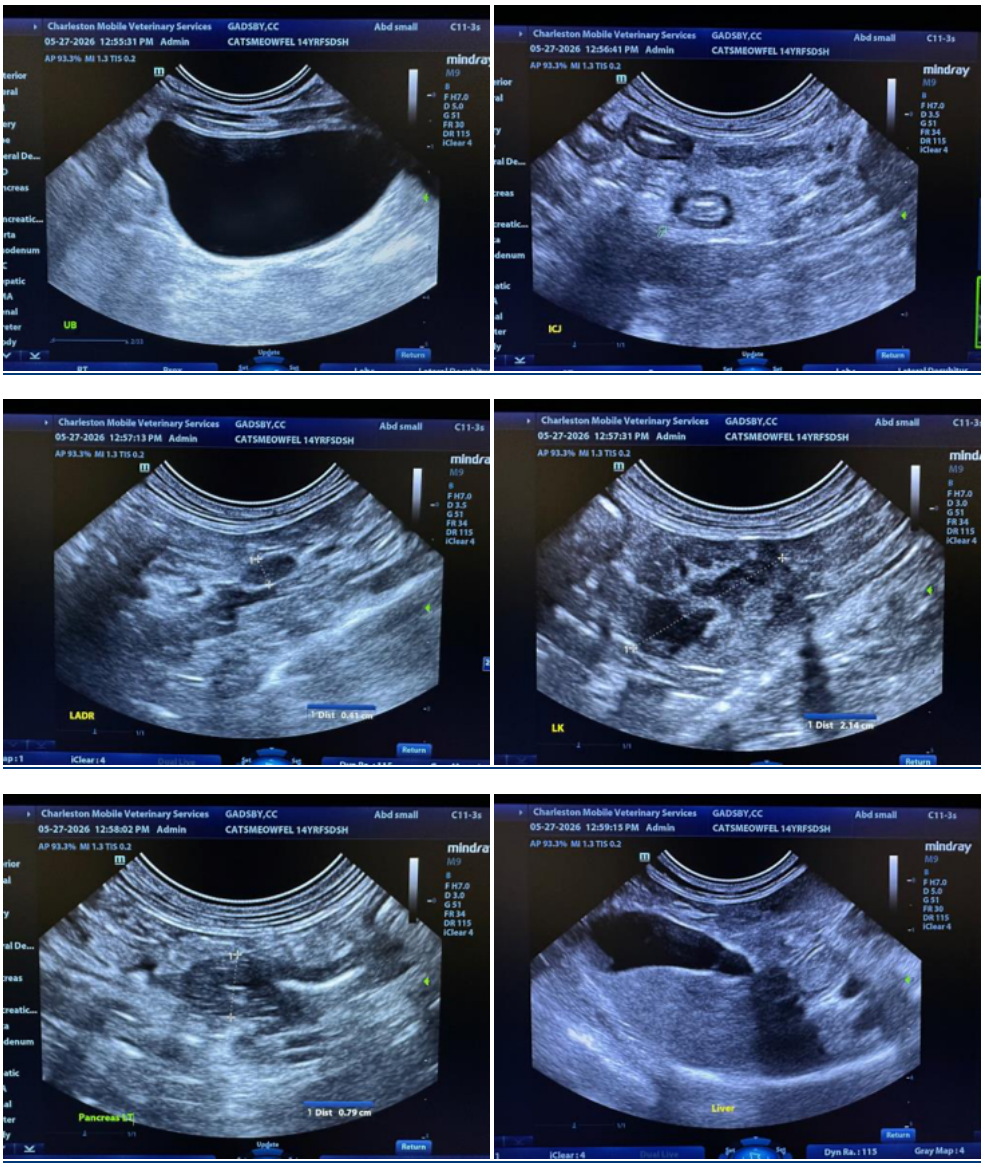
7. For patients where chronic vomiting is present but additional diagnostics are not to be performed, consider empirical treatment for Helicobacter gastritis, which includes a 14–21-day course of amoxicillin, metronidazole, clarithromycin and an acid blocker (i.e., omeprazole or famotidine).



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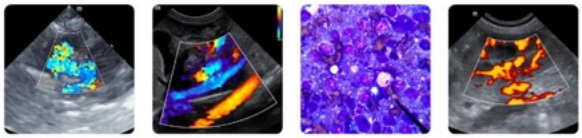

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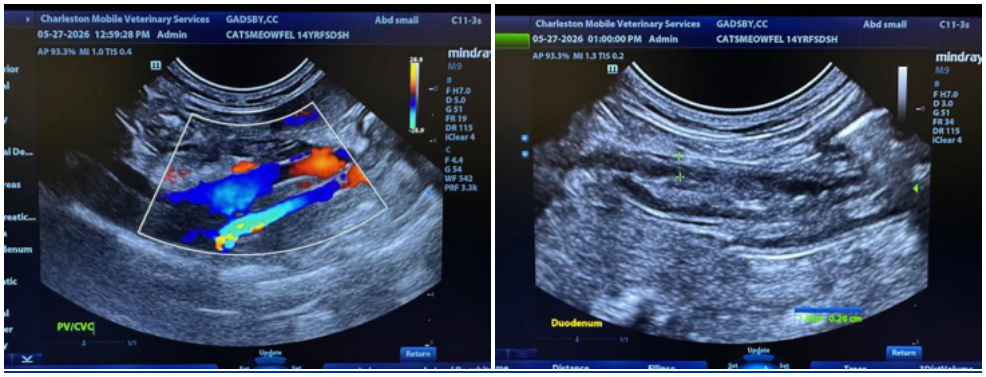

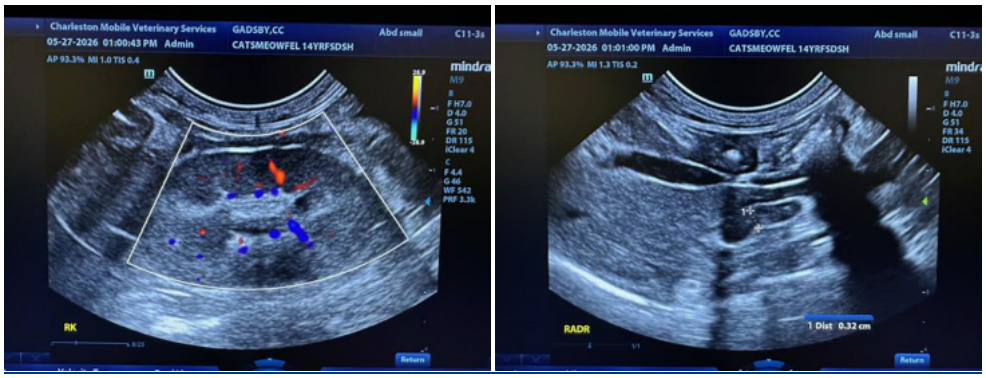

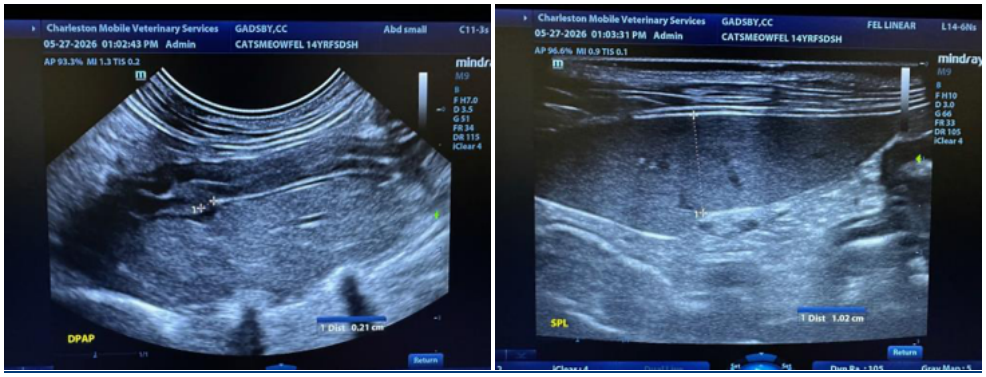

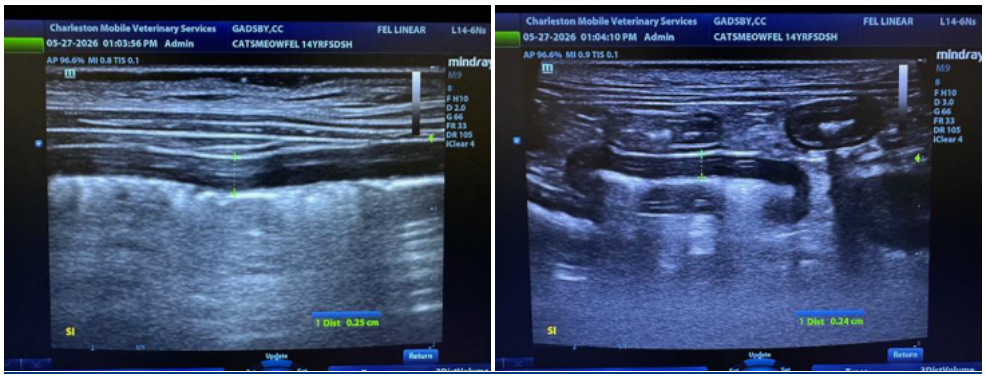

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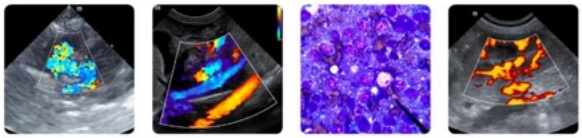

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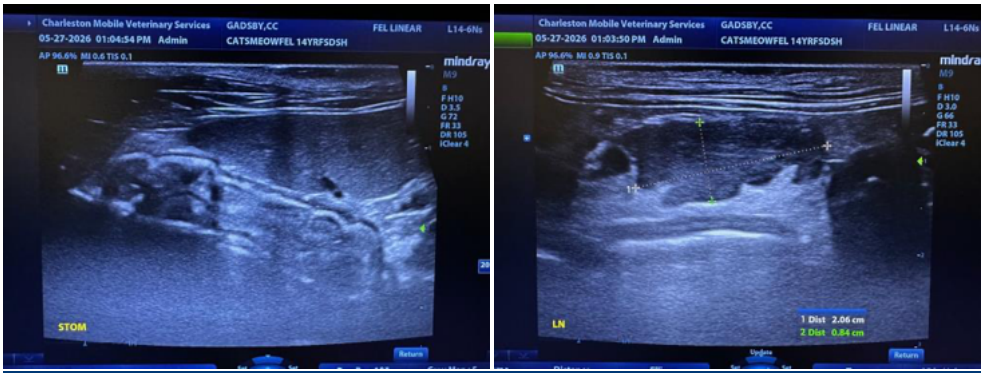

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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