

**PATIENT**

Bizzy Cook

**SPECIES**

Feline

**BREED**

Domestic shorthair

**SEX**

Female, spayed

**AGE**

3 Yrs. 4 months

**WEIGHT**

10.2 lbs.

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Kathleen Byrnes

**HOSPITAL NAME**

Stewart's  
 Mountainview AH

**REFERRING VET**

Dr. Stewart

**INVOICE**

13325

**DATE**

11/10/25

**PRESENTING CLINICAL SIGNS**

History: P presented on 10/27/25 for ADR, vomiting, lethargy. P has vomited several times per month. Still E/D good. Abd Rads- NSF rdvm concerned about elevated calcium, lymphoma, food allergies P presented today 11/10/25 for US. Owner reports P doing well, no concerns. e/d good/. No recent vomiting.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is mildly to moderately distended. A small amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The left 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 normal corticomedullary distinction. A hyperechoic medullary band is observed adjacent to the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.27 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. A hyperechoic medullary band is observed adjacent to the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is normal size (0.35 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 (0.78 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.

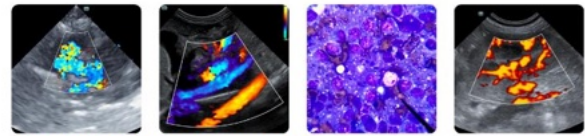
**Liver**

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. A bi-lobed confirmation is suspected. The wall is thin and smooth. A small amount of suspended echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

**Gastrointestinal**

The gastric lumen is moderately distended with ingesta. 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 segmentally dilated with chyme. The small intestinal wall is normal in thickness with a normal layering



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pattern and appropriate mural detail. Discreet masses are not identified. The ileoceocolic junction and colonic wall are normal. There is no obvious evidence of an obstructive pattern.

**Pancreas**

A portion of the pancreas is obscured by the gastric distention. In the visualized portion, no obvious abnormalities are seen.

**Lymph nodes**

2-3 prominent mesenteric lymph nodes are observed adjacent to the ileoceocolic junction, one of the nodes measuring 0.59 x 0.40 cm.

**Free Abdomen**

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

**ULTRASONOGRAPHIC FINDINGS**

- If the patient was fasted for this study, the presence of ingesta within the gastric lumen could suggest delayed gastric emptying.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The hyperechoic medullary band seen in both kidneys may be a normal variant for this patient or may represent subclinical renal disease.

\*An obvious cause for the patient's clinical signs is not identified in this study. Considerations include a microscopic enteropathy (i.e., food allergy/intolerance, inflammatory bowel disease, infectious/parasitic disease), underlying metabolic issue, other.

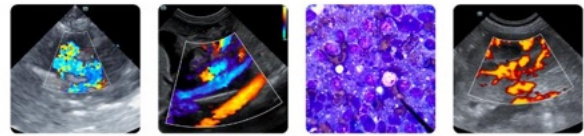
**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The following diagnostic/treatment recommendations can be considered:

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.
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).

Regarding the hypercalcemia, consider:

1. Ionized calcium +/- PTH/PTHrP.
2. Three-view thoracic radiographs would also be useful in evaluating for neoplasia in the chest.



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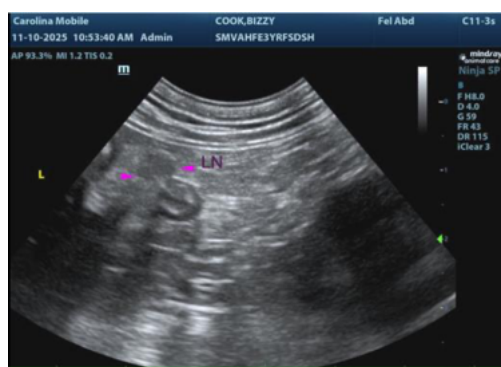
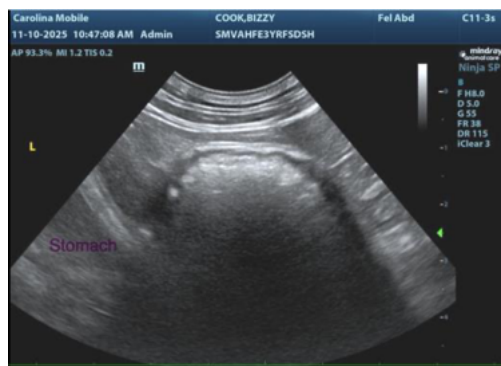
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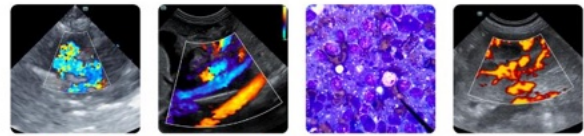
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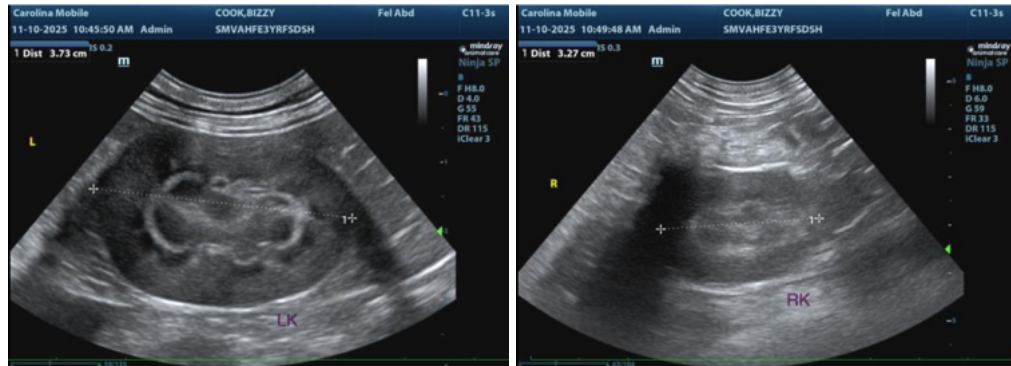
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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