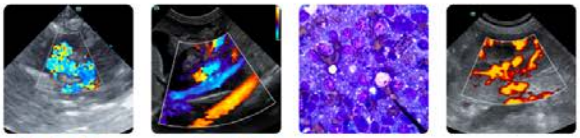

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info@carolinavetmobile.com 800.808.5948

PATIENT

Noodles Wright

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

6 Years

WEIGHT

3.6 kg

INTERPRETED BY

Brad Harris, DVM, DACVECC, Residency trained in cardiology

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Animal Emergency Clinic of the High Country

REFERRING VET

Dr. Phipps

INVOICE

71842

DATE

11/15/25

PRESENTING CLINICAL SIGNS

P presented for labored breathing, decreased appetite, vomiting, lethargy, weight loss. On exam P icteric

Abnormal PE/Chem/CBC/UA Results: FBNP abnormal HCT 27.7, Neu 13.3 ALT 187, Glob 5.5, GGT 50, T bili 3.3

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are unremarkable with normal wall thicknesses and normal tone. The ureters were not visualized, which is a normal finding. The bladder is adequately distended with anechoic urine and a mild amount of suspended echogenic debris. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size. The cortices are hyperechoic with a mild loss of corticomedullary definition. The cortex to medulla ratio is appropriate with no significant pyelectasis or pelvic dilation. The renal capsules are mildly irregular bilaterally. Left kidney measures 3.96 cm. Right kidney measured 4.52 cm.

Adrenal Glands

Both adrenal glands are visualized and have normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. Left measures 0.35 cm. Right measures 0.49 cm.

Spleen

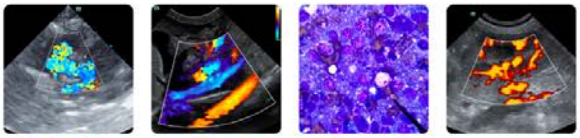
The spleen measures 1.11 cm at the hilus. It is prominent and slightly mottled with subtle diffuse hypoechoic odules throughout that do not distort the splenic capsule. The capsule is smooth without significant irregularity. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis.

Liver

The liver is subjectively normal liver size, contour, and structure. Parenchymal echogenicity is naturally coarse and hypoechoic to the spleen. Vasculature is within normal limits with no evidence of congestion. There is a mild amount of suspended echogenic debris and dependent sediment within the gallbladder. The gallbladder walls are appropriately thin. There is no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal. No hepatic lymphadenopathy is documented. There is no overt structural evidence of inflammatory, infiltrative or regenerative pathology evident.

Gastrointestinal

The gastrointestinal tract contains a mild amount of fluid and ingesta with a mild to-fro motion, most consistent with functional ileus. There is no shadowing foreign material or evidence for mechanical gastrointestinal obstruction. The gastrointestinal walls are normal in thickness with maintenance of normal wall layering.



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Pancreas

The pancreas is enlarged and hypoechoic with irregular margins. There are subtle hypo- and hyperechoic nodular changes throughout, and regional hyperechoic mesentery or omental fat consistent with steatitis.

Free Abdomen

There is a scant volume of free pleural effusion noted.

No significant lymphadenopathy identified.

ULTRASONOGRAPHIC FINDINGS

- The urinary bladder contains echogenic, suspended debris contrasted with anechoic urine. This is often related to urinary tract infection but may represent exfoliated debris or sterile inflammation.
- The kidneys are relatively normal in size and structure, and cortex:medulla ratio (cortex 1/3 of medulla) is essentially maintained. There is age-related loss of the normal smooth capsular contour and C/M junction definition. The cortices are largely uniform in texture with mild hyperechogenicity expected for this patient's age. There is no evidence of pelvic dilation present.
- The prominent and mottled spleen may represent reactive splenitis or lymphoid hyperplasia. However, infiltrative neoplastic disease cannot be definitively excluded at this time. The unorganized non-obstructive gallbladder debris is considered likely an incidental finding at this time.
- There are areas of minor gastrointestinal luminal fluid noted with echogenic contents and a to-fro motion consistent with ileus. There was no evidence of an obstructive pattern, and normal wall thickness and layering is retained throughout the gastrointestinal tract. This is a consistent response to irritation or inflammation. Gastroenteritis or pancreatitis should be considered.
- The prominent, hypoechoic pancreas with an irregular contour and mixed ill-defined hyper and hypoechoic changes is most consistent with pancreatic remodeling and nodular hyperplasia. This may be secondary to active or acute-on chronic inflammatory disease or pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The scant volume of free pleural effusion noted is suspected likely to be secondary to the concern for pancreatitis. However, other causes of pleural effusion should also be considered.

A urinalysis and urine culture via cystocentesis are recommended to evaluate the urinary tract changes for potential urinary tract infection.

Fine needle aspirates of the spleen with cytology are recommended. A coagulation profile and platelet estimate prior to sampling are indicated to ensure the absence of coagulopathy. Occasionally some tissues are poorly exfoliative, or cytology is non-specific, in which case biopsy with histopathology may be required for a definitive diagnosis.

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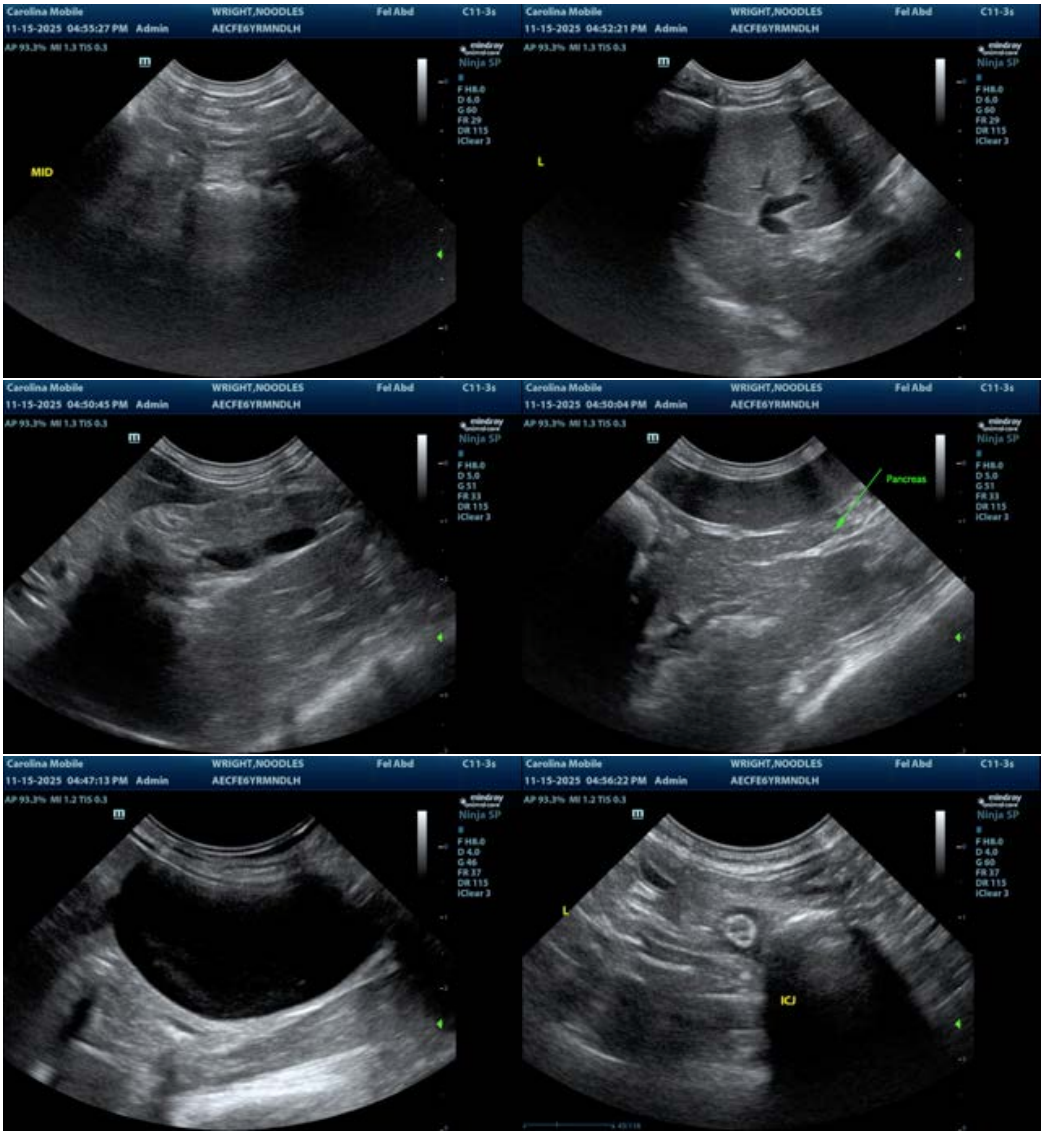
At this time, supportive care for pancreatitis is recommended, as clinically indicated, to include gastroprotectants, fluid therapy, antiemetics, appetite stimulants, etc.



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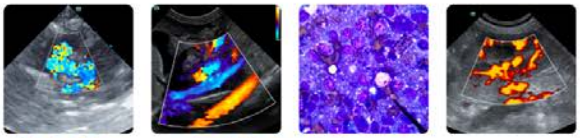

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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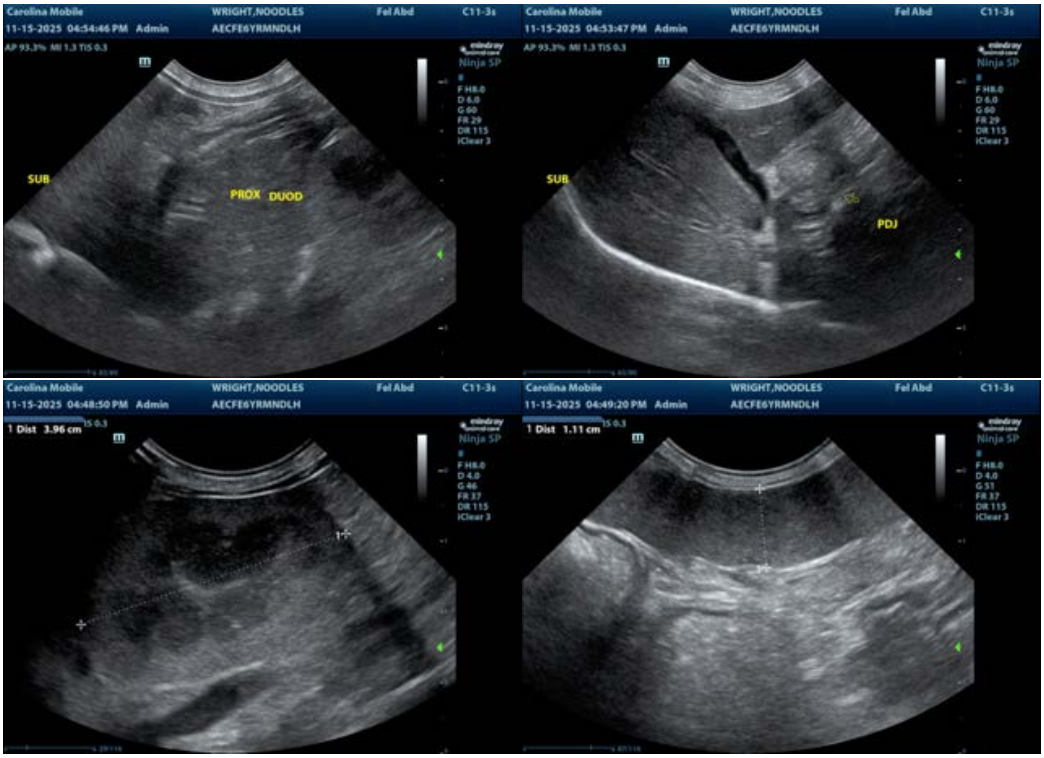

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Brad Harris, DVM, DACVECC, Residency trained in cardiology

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