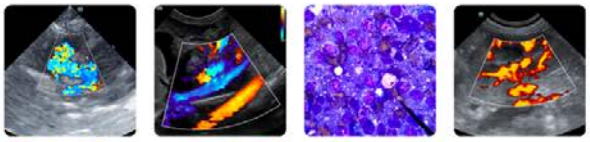


PATIENT

Sugar Cardwell

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

10 Years

WEIGHT

3.96 kg

INTERPRETED BY

Brad Harris, DVM, DACVECC, DACVIM (cardiology)

IMAGING PERFORMED BY

Dr. Bennett

HOSPITAL NAME

Wilvet South

REFERRING VET

Dr. Bennett

INVOICE

72551

DATE

12/14/25

PRESENTING CLINICAL SIGNS

History: O reports about 4d ago pt stopped E, started V+ for about 2d. Went to Banfield yest. and pt received appetite stimulant, cerenia and fluids, no V+ since cerenia started. Pt cont. to be inappetant. Symptoms: Not E, V+. Duration (Date & Time): x4d E/D/U/D: Not E x4d, not dr water, normal ur, no BM x4d. V/D/C/S: V+ x2 days but stopped yesterday. No D+/C/S Indoor/Outdoor/both: Indoor only Previous Medical Conditions: Uroliths, hx cystotomy abt. 3 yr ago. Current Medications: (dosage, how often, last time/dose given, why is the pt on this medication?): 1/4 tsp miralax last given 12:25p (via syringe w/ water), 1/2 tab 16mg Cerenia last given 9:00am, Elura 0.38ml last given 1:00pm. Anorexia x 4 days Vomited first 2 days, no vomiting since getting Cerenia.

Abnormal PE/Chem/CBC/UA Results: PE was unremarkable Diagnostics at rDVM (12/12/25): • CBC: Hct 43%, normal leukogram & PLT. • Chem: All WNL • SDMA: 9 (WNL) • Lytes: all neg. K 3.8 • fPL: Abnormal • FeLV/FIV/HWT: All negative • UA: USG 1.050, pH 6.5, quiet sediment. • Abdominal rads-radiology report: The gastrointestinal tract is within normal limits. There is no evidence of a mechanical small intestinal obstruction. Differentials include gastroenteritis and pancreatitis. The remainder of the abdomen is within normal limits. • Fecal pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

The kidneys are normal in size and structure, with appropriate corticomedullary definition and cortex to medulla ratio. The cortices are uniform in texture with normal echogenic relationship to liver and spleen. The medullary structure differed distinctly from the cortex and no evidence of pyelectasis is present. The capsules are uniform without significant irregularities noted. Left kidney measures 4.23 cm. Right kidney measures 3.67 cm.

Adrenal Glands

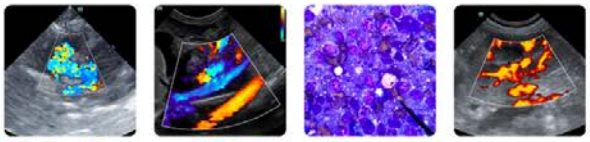
Both adrenal glands are visualized and have normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. Left measures 0.42 cm. Right measures 0.51 cm.

Spleen

The spleen measures 0.85 cm. It is smooth with homogeneous parenchyma and hyperechoic to liver and renal cortical parenchyma. The capsule is without noticeable irregularity or deformation. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis. No evidence of acute or chronic inflammatory, neoplastic, or infarct are documented.

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. The gallbladder has thin walls which contain anechoic bile. There is no evidence of intra- or extra-



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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 stomach is moderately distended with a combination of anechoic fluid as well as echogenic, minimally shadowing contents. The pylorus and pyloroduodenal junction appear patent, and there is no overt indication of pyloric outflow obstruction noted. The small intestine is non-distended with no shadowing foreign material or evidence for mechanical small intestinal obstruction. The gastrointestinal walls are normal in thickness with maintenance of normal wall layering. The colon contains normal shadowing feces.

Pancreas

The pancreas is hypoechoic and prominent with irregular margins. There is a mild degree of regional hyperechoic mesentery or omental fat, and mixed hypo- and hyperechoic nodular changes throughout the parenchyma. The pancreatic duct appears normal.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

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 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.
- The gastric dilation with echogenic contents is likely mild gastroparesis secondary to underlying pancreatitis. An occult pyloric outflow obstruction cannot be definitively excluded yet is not highly suspected at this time.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Supportive care for suspected pancreatitis as clinically indicated is recommended.

Urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended.

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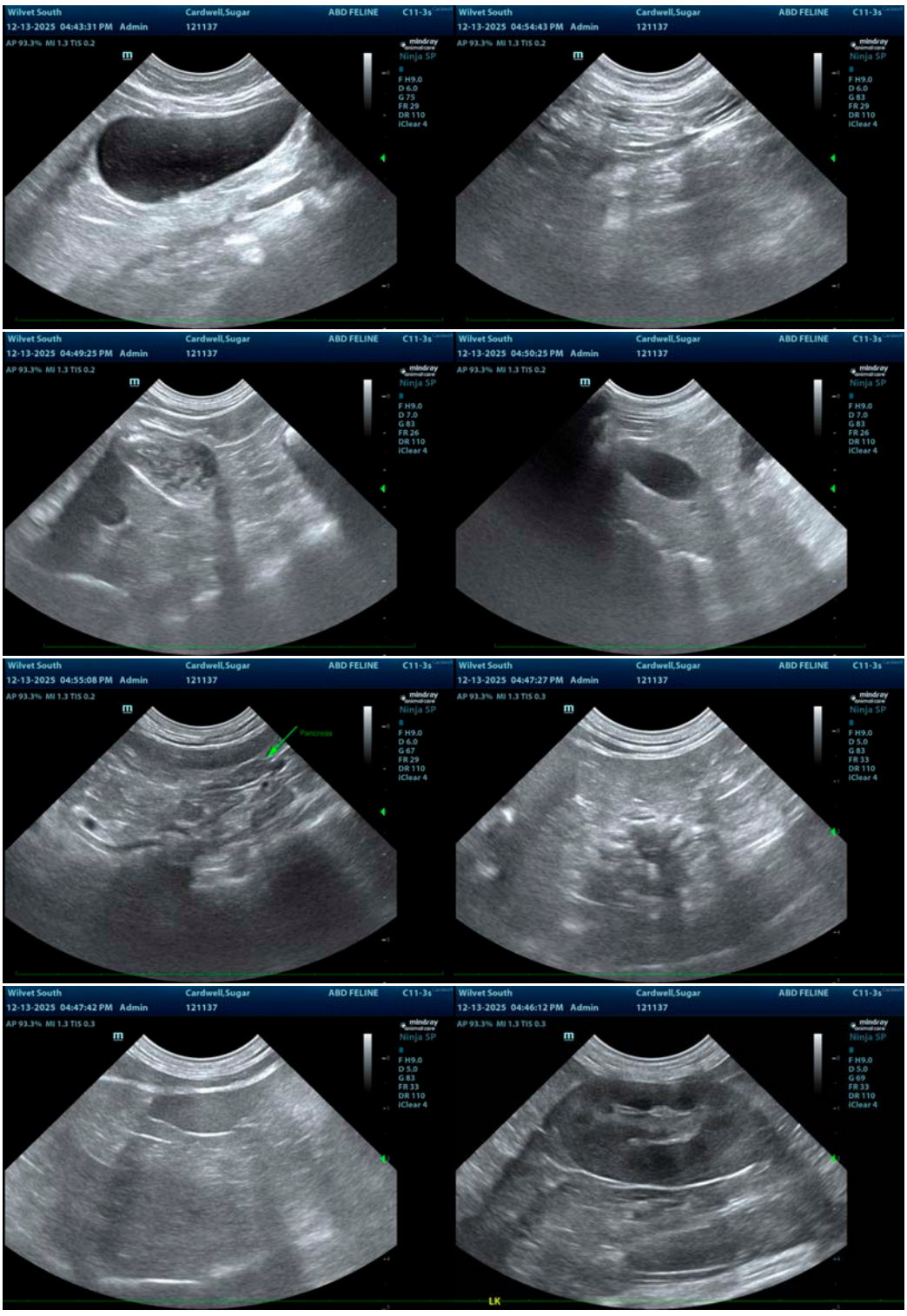

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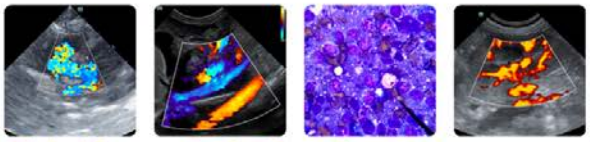

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Brad Harris, DVM, DACVECC, DACVIM (cardiology)

info@SonoPath.com