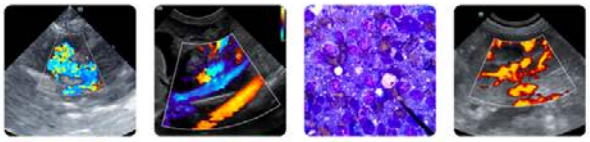


PATIENT

Isis Wedlund

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

13 Years

WEIGHT

6.3 lbs

INTERPRETED BY

Brad Harris, DVM, DACVECC, DACVIM (cardiology)

IMAGING PERFORMED BY

Dr. Saum Hadi

HOSPITAL NAME

Nimbus Pet Hospital

REFERRING VET

Dr. Saum Hadi

INVOICE

72803

DATE

2/7/26

PRESENTING CLINICAL SIGNS

P presented for weight loss. A grade 3/6 sternal systolic heart murmur was auscultated. Labs showed a moderate eosinophilia (2.9 K/uL), mild ALT increase (171 U/L), mild BNP increase (347 pmol/L), Mild BUN increase (31 mg/dL)... USG 1.038

Abnormal PE/Chem/CBC/UA Results: Moderate eosinophilia (2.9 K/uL), mild ALT increase (171 U/L), mild BNP increase (347 pmol/L), Mild BUN increase (31 mg/dL)... USG 1.038

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 moderately distended with anechoic urine and contains a moderate amount of suspended echogenic mobile 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 loss of corticomedullary distinction. The cortex to medulla ratio is appropriate, with no significant pyelectasis or pelvic dilation. The renal capsules are mildly irregular bilaterally. Left kidney measures 3.1 cm. Right kidney measures 3.5 cm.

Adrenal Glands

The right adrenal gland is visualized and has 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. The right adrenal gland measures 0.30 cm.

The left adrenal gland is not discretely visualized.

Spleen

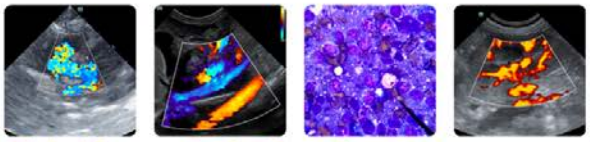
The spleen measures 0.56 cm at the hilus. It is smooth with homogeneous parenchyma and hyperechoic to liver and renal cortical parenchyma. The capsule is without noticeable irregularity or deformation. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis. 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-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 echogenic, minimally shadowing ingesta. The pylorus and pyloroduodenal junction are not discretely visualized, and a pyloric outflow obstruction cannot be completely excluded. The small intestine is minimally distended with echogenic ingesta and a mild to-fro motion, most consistent with ileus. There is no shadowing foreign material or significant small intestinal



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dilation that would be consistent with a mechanical small intestinal obstruction. The gastrointestinal walls are normal in thickness with maintenance of normal wall layering. The Ileocecocolic junction is patent and the colon contains normal shadowing feces.

Pancreas

The pancreas is prominent and irregular with a hypoechoic parenchyma and mixed hyper- and hypoechoic nodular changes. There is regional hyperechoic mesentery or omental fat and no significant regional free peritoneal effusion noted. There are prominent mesenteric and Ileocecocolic lymph nodes with normal length to width ratio and isoechoic parenchyma.

Other

The abbreviated cardiac scan reveals appropriate chamber dimensions and adequate contractility. No pericardial effusion or heart base mass effects are 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, 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 slightly prominent mesenteric and ileocecocolic lymph nodes display no loss of parenchymal detail or change in echogenicity. This is most consistent with reactive lymphadenitis or lymphatic hyperplasia.
- The gastrointestinal contents are most consistent with normal ingesta. However, an occult pyloric outflow obstruction can't be definitively excluded. Given the clinical signs and lack of significant gastric fluid accumulation, this is considered less likely based on this study.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

A gastrointestinal panel (TLI, PLI, B12, folate) via Texas A&M gastrointestinal laboratory is indicated to further evaluate for potential chronic enteropathy. Ultimately, gastrointestinal biopsies may be required for a definitive diagnosis.

Consider an fPLI to further evaluate the pancreas for active inflammation or pancreatitis.

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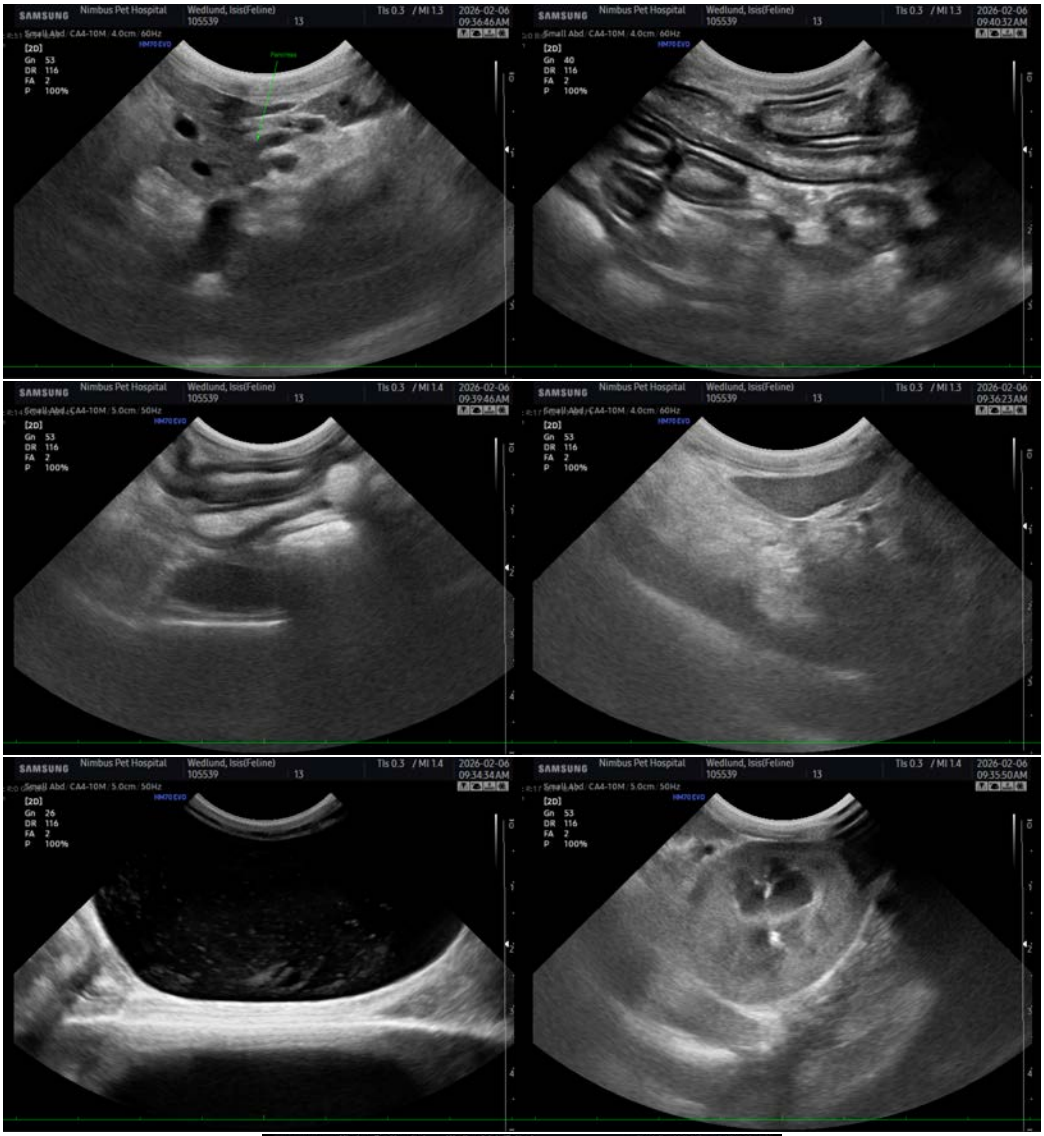

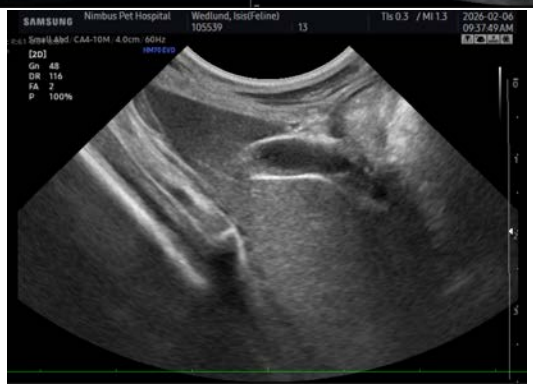

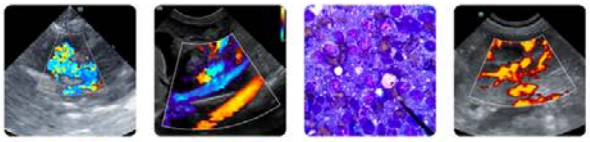

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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