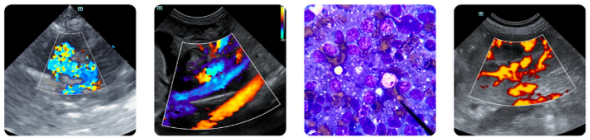


PATIENT

Charlie Albright

SPECIES

Feline

BREED

DSH

SEX

NM

AGE

9 years 6 months

WEIGHT

6.39 kgs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

Blue Pearl Wyomissing, ER

INVOICE

10896

DATE

12/9/2025

PRESENTING CLINICAL SIGNS

AUS to further evaluate acute-on-chronic vomiting (O reports cat normally vomits once every 3 weeks), elevated LES and mild azotemia (BUN). Presented to ER yesterday after vomiting food after eating, then was dry heaving bile, does eat but then vomits shortly after, acting fine, purring, not acting like he did when he had a foreign body 6 years ago, trouble breathing 2 weeks ago, dx pneumonia, finished 14 days of baytril on Friday, recheck bloodwork on Friday showed cbc wnl, slight elevated LES. PMH: FBO sx 6 years ago, backpain 2023, pneumonia 2 weeks ago Diet D/D dry other cat in house has food allergy Hospitalized on IVF, Cerenia, Ondansetron, buprenorphine, and pantoprazole.

Abnormal PE/Chem/CBC/UA Results: ER Diagnostics: PCV/TP: 34/7.0 CBC: Hct 36%, WBC 4.9k, neut 3k, lymph 1.73k, plt 173k Chem: alb 3.1, glob 3.5, ALT 318 (H), ALP 32, Na 151, Cl 104 (L), K 4.5, P 5.7, chol 204 (H), BG 113, creat 1, BUN 36.2 (H) AXR: concern for gastric material vs. mass vs. other; incidental renoliths.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a large amount of echogenic non-shadowing debris, most consistent with exfoliated cells, crystals, mucous and/or small blood clots likely combined with incidental suspended lipid. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal is size (4.1 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. Trace pyelectasia noted in the right kidney. There is no evidence of mineral or infarcts observed.

The left kidney is normal is size (4.5 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

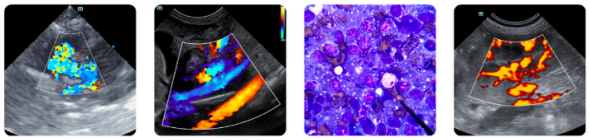
The right adrenal gland is normal in size (0.4 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.3 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively large in size, measuring just over 1.0 cm thick at the hilus, with a rounded, plump, mildly coarse, almost mass like appearance to the tail measuring 1.7 cm x 2.9 cm in size. Parenchyma is otherwise normal in echogenicity and echotecture with a largely normal shape to the cranial aspect of the spleen.

Liver



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Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestine demonstrates areas of moderately thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Splenomegaly– can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered, especially given the emerging mass like appearance of the tail of the spleen.
- Moderate inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.
- Hyperechoic hepatomegaly (feline) – This appearance is most consistent with benign hepatic lipidosis or endocrine/DM hepatopathy. Infiltrative disease such as amyloidosis or round cell neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.

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- Moderate amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, 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 ration is recommended.

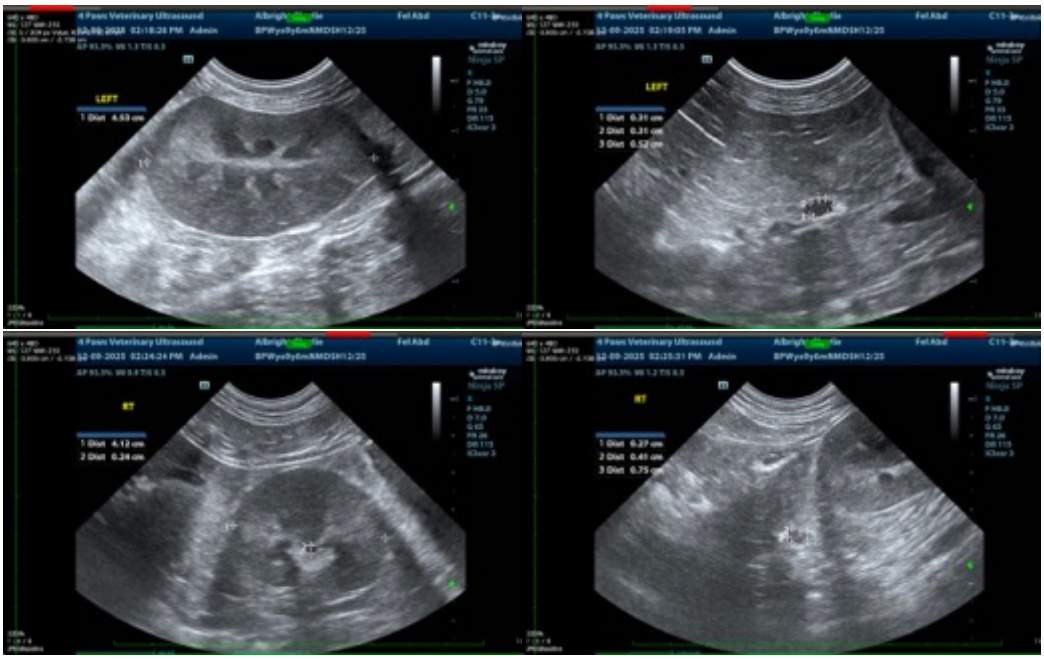
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

A T4 +/- Free T4 is recommended.

Fine needle aspirates of the spleen, and liver are recommended if patient's coagulation status is appropriate.

Ultimately, however, biopsies of the GI tract being sure to include ileum, if possible, may be necessary for a definitive diagnosis, if a cytologic diagnosis is not obtained.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.



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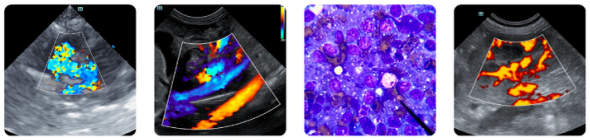

Clinical Sonography & Telecytology
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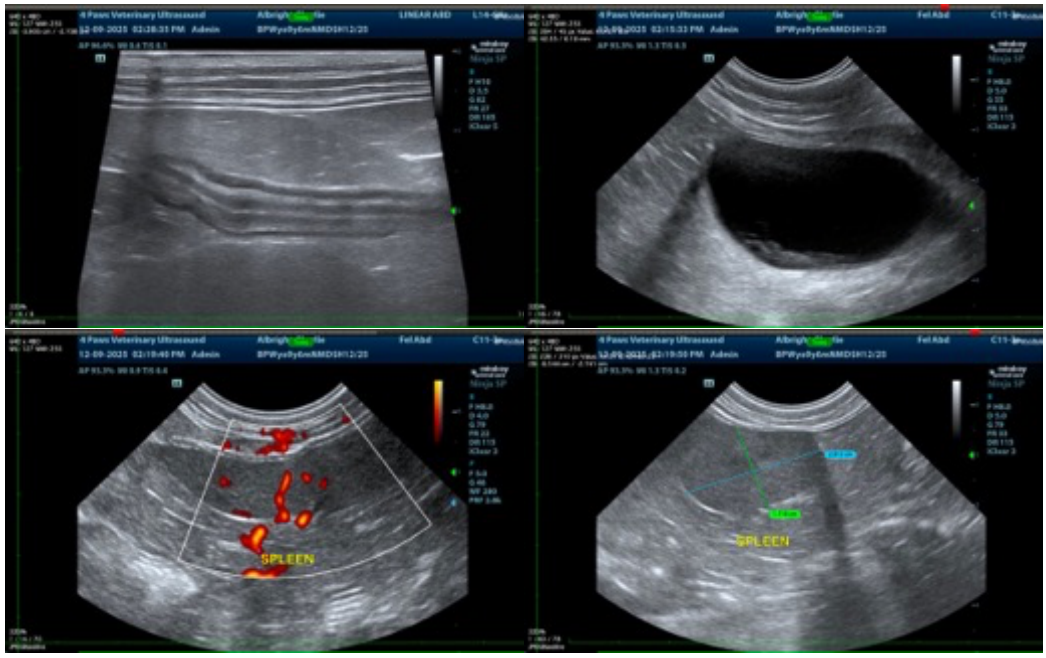

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
info@sonopath.com