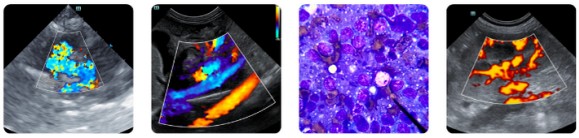

SonoPath FOSTERING THE ART OF VETERINARY MEDICINE™ www.animalsoundsnw.com info@animalsoundsnw.com 541.357.9423

PATIENT

Mystic Lange

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

11 years

WEIGHT

11.56 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

Willakenzie Animal Clinic

REFERRING VET

Dr. DeWall

INVOICE

11585

DATE

3/31/2026

PRESENTING CLINICAL SIGNS

- Clinical Exam Findings: Indoor only. Hx of asthma- used fluticasone inhaler.
- Friday at 5:00 PM, P began vomiting kibble within minutes of eating. P has been unable to keep food or water down, vomiting within 10 minutes of ingestion. P is persistently vocalizing (crying/yowling) and appears distressed. No known exposure to toxins or access to trash.O reports possible blood observed in the litter box however, there is another cat in the household that has IBD. Urination and bowel movement status are unknown. O also reports that P appears bloated per O. Cranial abdominal pain perceived. Temp normal at 100.5 Treated supportively with SC fluids, cerenia and buprenorphine 3/30; buprenex made her foam at mouth per O. P did vomit this morning, not eating but stares at the bowl.
- Today: wt gain 12.2 # from 11.56#, 100.8, still acting painful in cranial abdomen
- ABNORMAL Labwork Values: BUN: 50 (16-37). AST: 94 (16-37). CK: 13967 (64-440) Yes you are reading that correctly. Na: 146 (147-157). Cl: 113 (114-126). Pending fPL.
- Current Medications: Cerenia, buprenorphine and SC LRS.

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 occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also 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.

Kidneys are bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. Small chronic infarcts are present bilaterally but more significant visibly in the left kidney. Left is small in size, measuring 3.08 cm. Right is normal in size, measuring 3.83 cm.

Adrenal Glands

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

The left adrenal gland is normal in size (0.35 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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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 mildly to 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

Pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. No pancreatic duct dilation is noted.

Free Abdomen

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

Mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

ULTRASONOGRAPHIC FINDINGS

- Mild to 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 or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.
- Concurrent chronic low grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- Very mildly reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Mild to moderate chronic kidney disease changes including chronic infarcts, most significantly visibly in the left kidney.
- A moderate amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There's not a definitive ultrasonographically visible explanation for the severity of patient's reported clinical signs, especially when combined with the reported CK value. Having said that, based on ultrasound changes. If not recently evaluated, urinalysis and, if indicated based on urinalysis results,

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urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

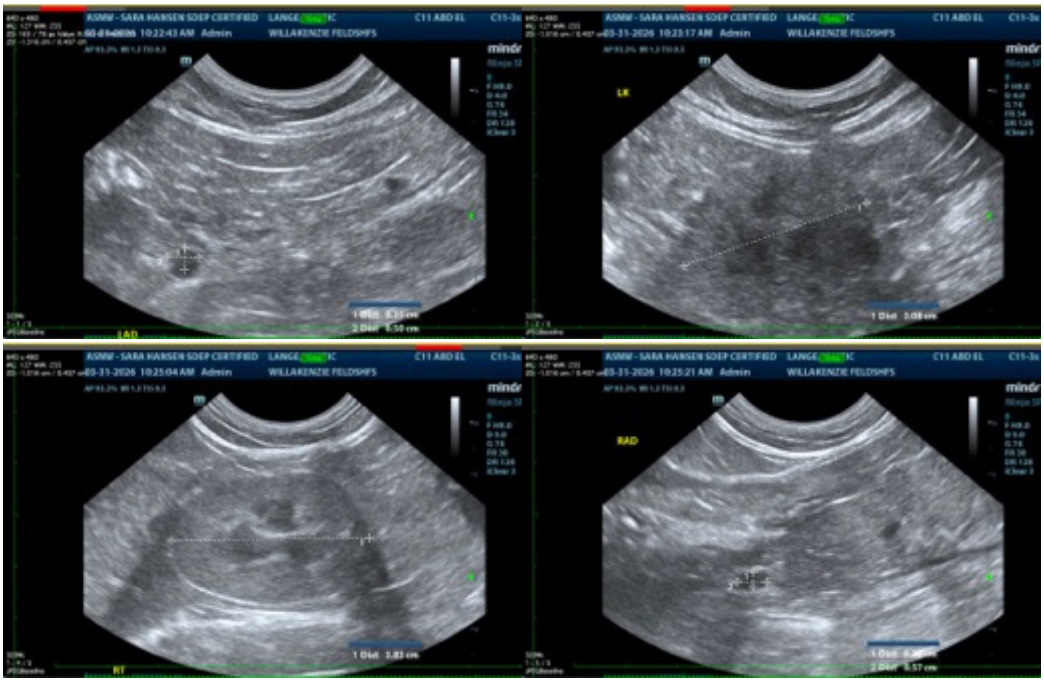
A blood pressure is also recommended.

A routine fecal/giardia exam is recommended if not recently evaluated.

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 fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

Having said that, while further urinary and gastrointestinal workup are indicated, given the CK additional evaluation of trauma or seizure history, and/or other infectious, inflammatory, neoplastic, etc., sources of myopathy are also recommended.

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



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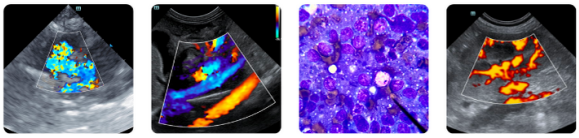

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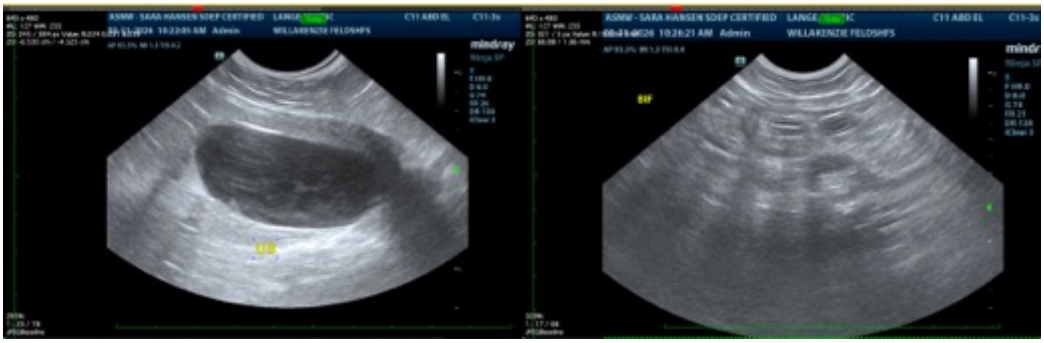

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
info@sonopath.com