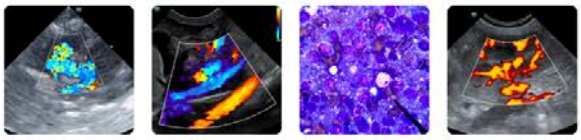


DATE

3/5/26

PATIENT

Fritzal Chamberlain

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

12/1/11

WEIGHT

8.52 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Everhart Veterinary Hospital

REFERRING VET

Dr. Notarangelo

INVOICE

73450

PRESENTING CLINICAL SIGNS

Patient History: Longstanding history of heart murmur, has been ~1 year since last echocardiogram, no current cardiac medications. Increased sternal contact of heart on recent x-rays. Chronic intermittent vomiting, does well on PR diet, transdermal maropitant, B12 and probiotics. Previous ultrasound showed chronic pancreatic remodeling, age-related kidney change, non-obstructive nephroliths, inflammatory bowel disease pattern and prominent mesenteric lymph nodes. Recent history of vomiting and hematuria and was seen at ER.
X-ray show nephrolith in R kidney. Mild progression of kidney disease on labs. Chronic low-grade hypercalcemia. Stress hyperglycemia in clinic, has normal BG at home. Murmur grade: 2-3/6.

Current Medications: Ondansetron (from HCl) Anhydrous AccuClick Transdermal Pen 60 clicks per pen (compounded) 2mg / click 1 dosing pen 2/27/2026, CONVENIA INJECTION 80MG/ML 2/27/2026 MIRATAZ (MIRTAZIPINE) TRANSDERMAL OINTMENT 2/27/2026, ONDANSETRON INJECTION 2MG/ML 2/27/2026, Royal Canin Selected Protein PR Dry for Cats 8.8lb bag 1 bag 2/3/2026, Maropitant Citrate - compounded 24mg/mL 8/2/2024, B12 inj every other week, Fortiflora daily.
Labwork Results: Labwork submitted. Reported as 2/27/26 radiographs increased sternal contact of heart with nephrolith in R kidney, no obvious masses. 2/27/26 Crea 2.7, BUN 39, PSL 37, Glu 238, neu 11.5 K, hematuria.
2/21/26 (VEG) Crea 2.2, BUN 40, neu 11.5, hematuria. 10/28/25: BUN 32, crea 2, PSL 62, neu 11.3.
Date of Previous IntraPet Ultrasound: 2022, 2024, 2025. See attached.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Andi Parkinson,BS, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, 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. The left kidney is small at 2.6 cm. The right kidney is compensatorily large at 4.96 cm. Non-obstructive nephroliths are noted bilaterally.

Adrenal Glands

The right adrenal gland is normal in size (0.57 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.41 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.

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 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 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.

- Mildly to moderately reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

- Chronic kidney disease changes with non-obstructive nephroliths noted bilaterally, most visibly significant in the left kidney.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a blood pressure is recommended.

In the meantime, beginning or continuing medical management for chronic kidney disease, including management of hypertension and proteinuria if indicated, supportive/symptomatic medical management of clinical signs i.e., antiemetics, gastroprotectants, etc., as well as potentially, if tolerated, dietary therapy, fluid therapy, etc. could all be considered.

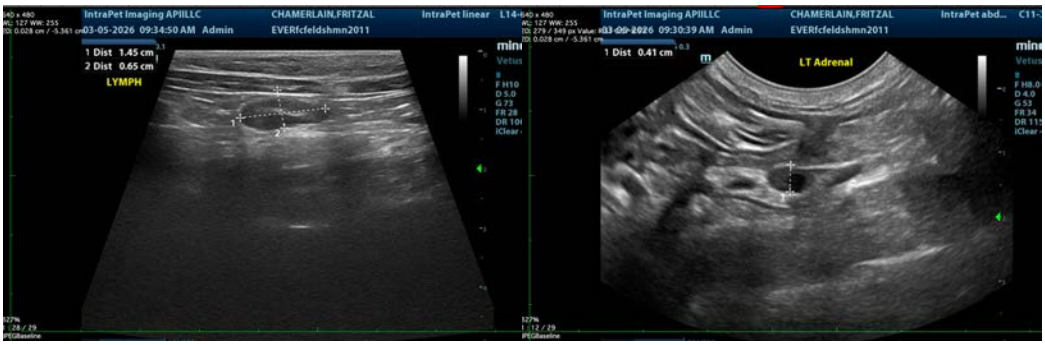
The significance of the mild bowel changes in terms of the vomiting is unknown, but given the changes:

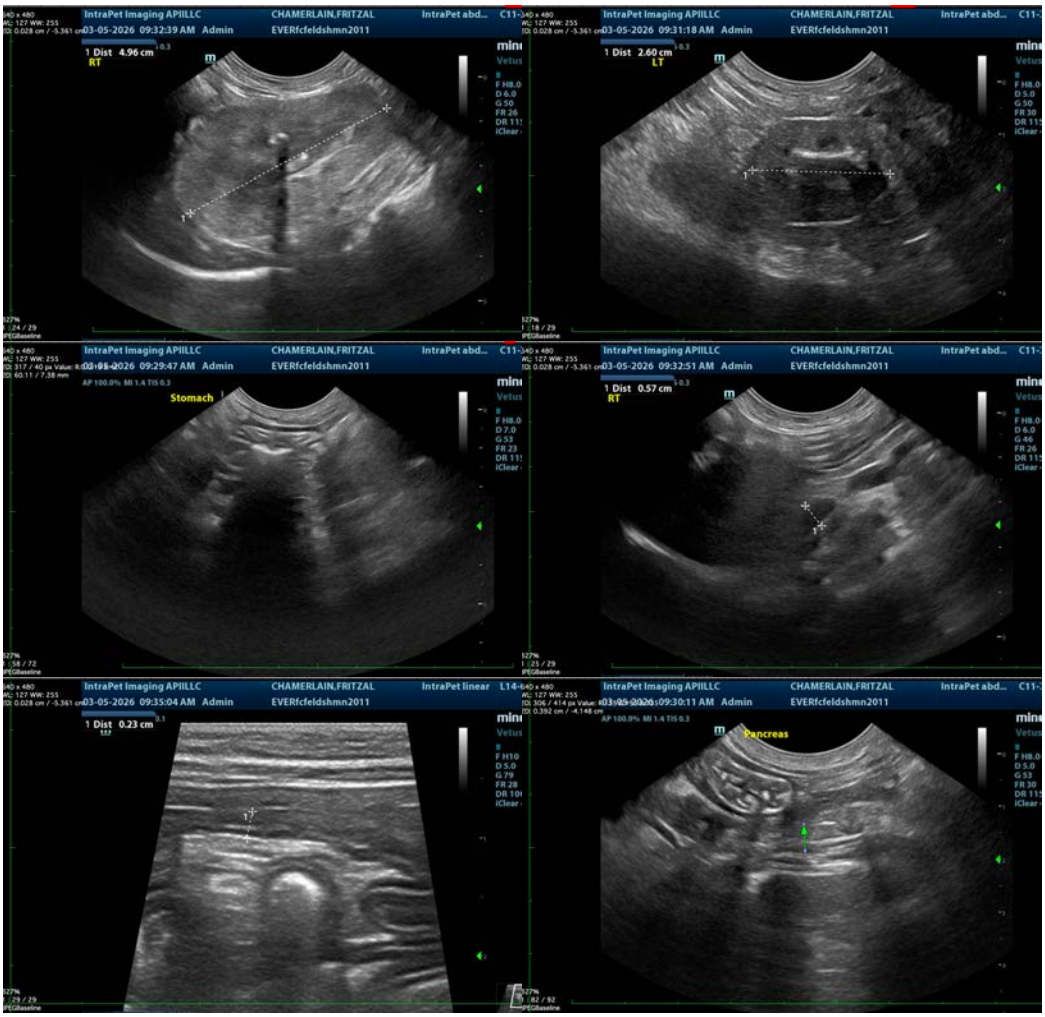
- A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

- Ideally, biopsies of the GI tract, being sure to include ileum if possible, are recommended to definitively diagnose and therefore manage the infiltrative bowel disease.

- If biopsies cannot be obtained, empirical therapies could include a probiotic (if diarrhea is present, such as visbiome or proviable), empirical deworming with a 5-day course of Panacur and, if tolerated, a transition in diet, based on trial-and-error response, beginning with a hydrolyzed protein diet. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several trials may be required.

- Additional considerations could include cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.).





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
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