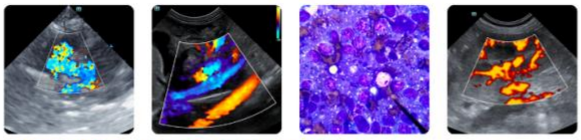


DATE

04/10/26

PATIENT

Blynken Long

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

11/05/18

WEIGHT

14.75 pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Cat Sense Feline Hospital

REFERRING VET

Dr. Sinclair

INVOICE

14982

PRESENTING CLINICAL SIGNS

Patient History: Blynken presented yesterday for being ADR. He didn't want to eat yesterday and his face "didn't look right," seemed tired and not feeling well. He was hiding. He had done the same thing on Monday and one of the cats had vomited on Monday but she doesn't know if it was him. He seemed fine Tuesday and Wednesday. Bloodwork and an x-ray were taken. The in-house FPL was normal but the rest of the bloodwork sent to the lab is still pending. The X-ray showed some food/material in the stomach but he hadn't eaten that morning and there was also a lot of gas in the colon. He was treated with sq fluids, ondansetron and cerenia
injections and he did eat some yesterday afternoon and at 10pm last night. The owner said he vomited sometime overnight and was hiding, not wanting to eat this morning. She does not keep food out overnight. A radiograph this morning shows improvement with the gas in the colon but there is still some food/other material in the stomach.

Current Medications: 100ml LRS sq and 1.4mg ondansetron and 7mg cerenia given sq at 1pm on 4/9/26
Labwork Results: Attached, reported as: Radiographs show some material in the stomach when he hasn't eaten in 10 hours and had vomited overnight
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Requested.
Imaging Performed by: Stephanie Warga RDCS, RVT.

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.

Left kidney is normal in 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.

Right kidney is normal in size (4.4 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

Left adrenal gland is normal in size (0.45 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.46 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

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

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.

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 stomach is mildly distended and contains an echogenic interface with distal progressively shadowing material consistent with hairball density (or similar fluid absorbing material) noted. Normal ingesta and gas cannot be definitively ruled out and should be considered especially without adequate fasting prior to the ultrasound.

The visible small intestine demonstrates areas of moderate to severely 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 mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted.

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

A very scant/trace pocket of free fluid is noted in the cranial abdomen.

Mesenteric lymphadenopathy appeared 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

- Moderate inflammatory bowel disease 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 cannot be ruled out and should be suspected in the face of appropriate ongoing clinical signs.

- Scant/trace amount of free fluid- Free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.
- Mesenteric lymphadenopathy- infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- A moderate amount of echogenic urinary bladder debris.
- In my very subjective opinion, the appearance of the gastrointestinal contents are consistent with normal ingesta and gas, potentially some delayed gastric emptying secondary to other underlying emerging bowel disease. Having said that, given the shadowing pattern, non-fully obstructive gastric foreign material, including hairball versus other, cannot be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recheck imaging of the stomach following an additional 12 to 24 hours of fasting could be considered to more definitively investigate/rule out foreign material.

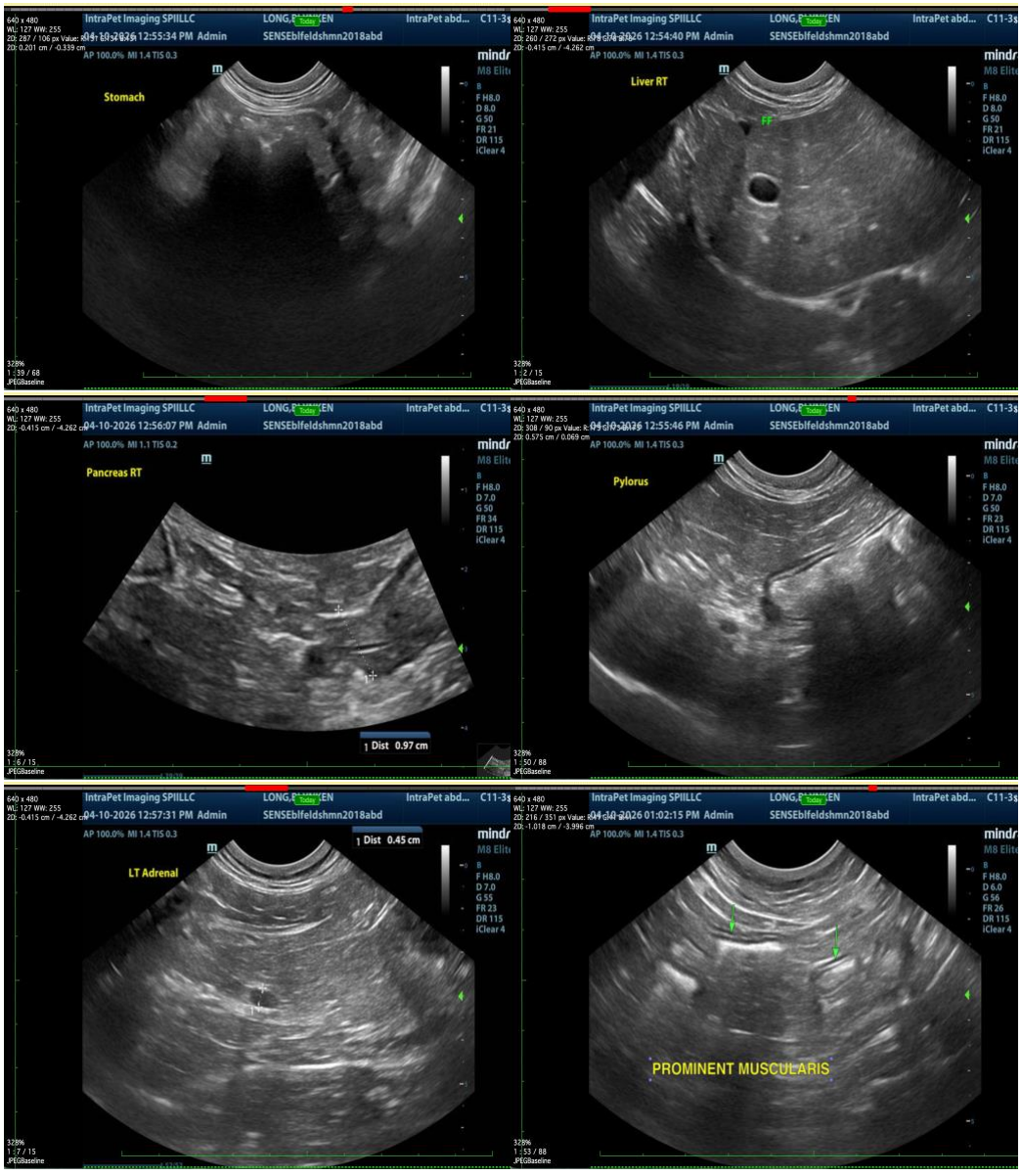
Alternatively, gastroscopy could be considered for further visual evaluation of the stomach as well as biopsies of the proximal small bowel.

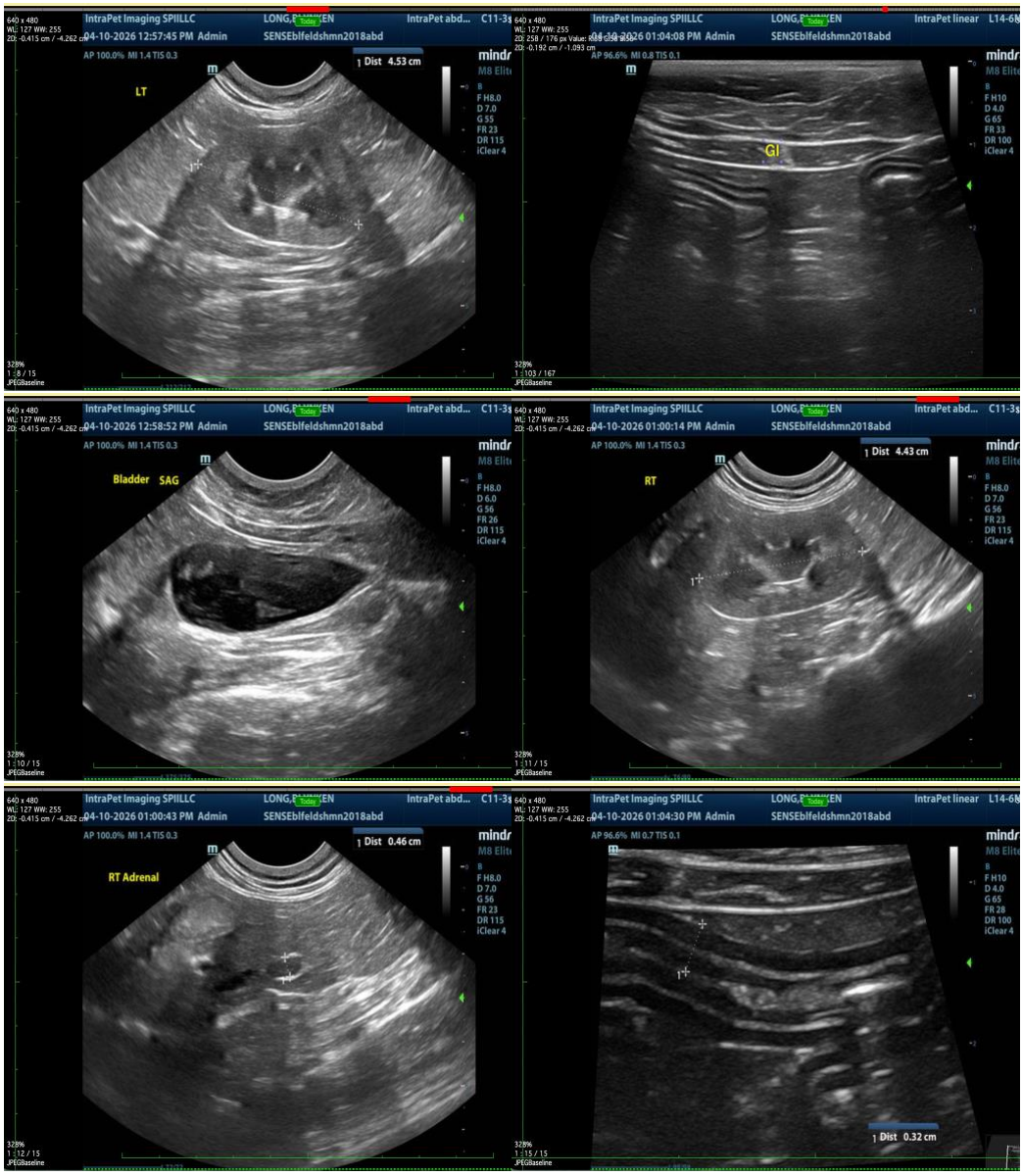
- Ultimately, however, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

- 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.).


Stomach
Liver RT
Pancreas RT
Dist 0.97 cm
Pylorus
LT Adrenal
Dist 0.45 cm
PROMINENT MUSCULARIS



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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