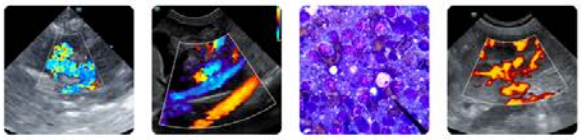


DATE

4/28/26

PATIENT

Jack Jenkins

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

6/15/10

WEIGHT

10 lbs 5 oz

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Cat Sense Feline Hospital

REFERRING VET

Dr. Sinclair

INVOICE

74794

PRESENTING CLINICAL SIGNS

Patient History: Jack presented as a new patient in February. He has had weight loss over the past few years in spite of a good appetite. Jack also can't eat a lot of hard food or treats as he throws up/regurgitates them back up. The previous veterinarian had started him on B12. Jack has ckd stage 2 and he had a grade 2/6 murmur
heard by the previous veterinarian in 12/2024 although I did not hear one at his visit. His BP was 170mmHg but he was also a bit jumpy and nervous. His small intestines felt a little more prominent to me. He has had 2 episodes in the past 10 days where a dry treat that he was regurgitating appears to have gotten lodged in his esophagus. He went to Homeward Bound Urgent Care for the first episode and he had radiographs and was scoped to push the treat back down into the stomach. The radiologist noted mild pneumomediastinum on those rads. He recovered fine and then he had another milder episode on 4/23 that he resolved.

Current Medications: B12 daily, MIralax, fortiflora every now and then
Labwork Results: Diagnostics attached, reported as: BUN=37, creat=1.7, radiographs from ER show pneumomediastinum
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Torbugesic.
Stat Report: Not 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 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.

The right kidney is normal is size (3.4 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.

The left kidney is normal is size (3.4 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

The right adrenal gland is normal in size (X cm at cranial pole and X cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.38 cm at cranial pole and 0.28 cm at caudal pole), 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, except for a discrete homogeneous hypoechoic nodular measuring 0.80 cm in size in the left liver. 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. The cystic and common bile duct are subjectively prominent in appearance, measuring 0.43 cm dilated with a mildly tortuous appearance. This is likely normal age related change in a senior cat.

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 observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. 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.

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.

Images of the esophageal inlet are provided and very subjectively look mildly prominent, potentially even mildly thick. There is no visible evidence of inflammation or free fluid noted in the images in that area.

ULTRASONOGRAPHIC FINDINGS

- 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.

- Pancreatic age-related remodeling/Chronic pancreatitis – Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.

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

- The liver nodule could represent a benign change, inflammatory lesion, etc., although infiltrative neoplasia such as round cell neoplasia or even a metastatic nodule, while thought less likely can't be definitively ruled out.

- The subjectively mildly prominent lower esophageal sphincter area is likely normal patient variant or potentially residual inflammatory change from the previously described foreign body and procedure. Infiltrative disease in that area can't be ruled out but is considered much less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given patient's reported regurgitation history, radiographs findings, etc., further workup/evaluation of the esophagus, pneumomediastinum, etc. via endoscopy, advanced imaging such as contrast CT scan, etc. may be indicated.

In the meantime, fine needle aspirates of the enlarged mesenteric lymph nodes +/- the liver nodule could be considered if patient's coagulation status is appropriate.

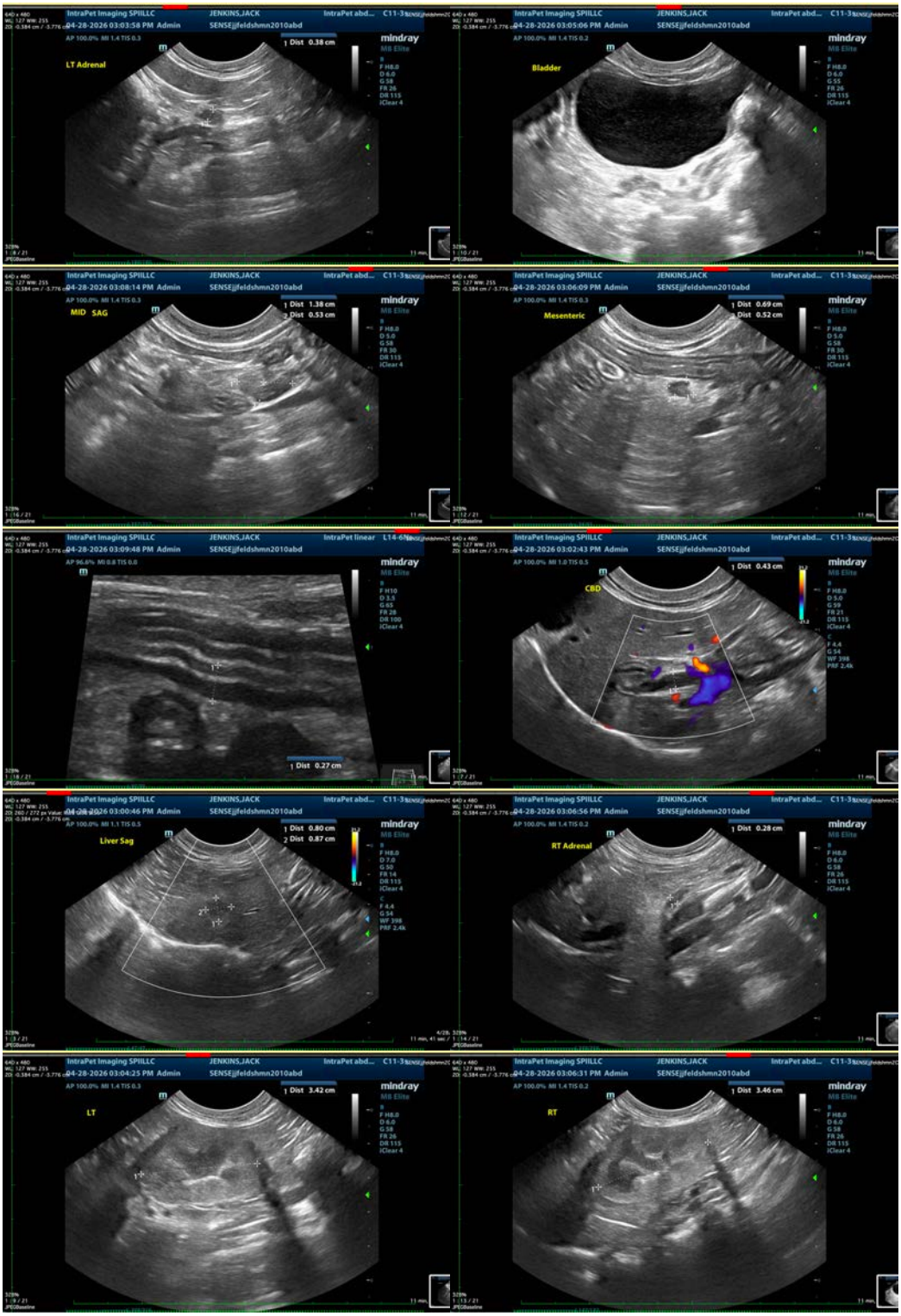
Ultimately, however, if a diagnosis is unable to be obtained, and the regurgitation is residual from the previous foreign body and unrelated, with vomiting and weight loss being a primary concern:

- 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.).


IntraPet Imaging SPIILLC
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SENSE@feldshmn2010abd
LT Adrenal
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Bladder
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MID SAG
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2 Dist 0.53 cm
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Mesenteric
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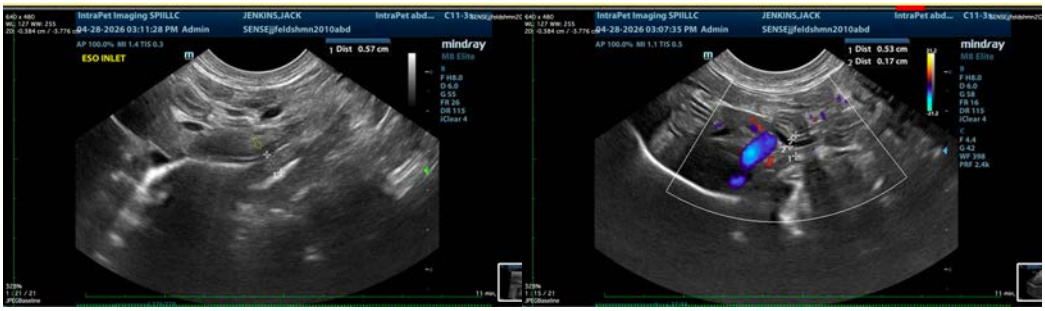

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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