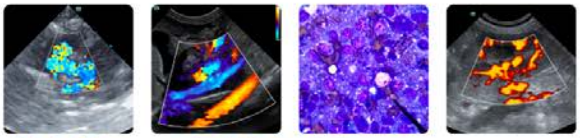


SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Maisie Rita McInnis

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

7 Years

WEIGHT

10.88 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Centerville Animal Hospital

REFERRING VET

Dr. Sandhu Jr

INVOICE

75116

DATE

5/13/26

PRESENTING CLINICAL SIGNS

A 7-year-old Domestic Shorthair is presenting for multiple episodes of vomiting which began Saturday. The patient received a maropitant injection at an emergency clinic Saturday and initially improved, but vomiting recurred this Monday morning (less then 24 hours after injection). Possible relevant history includes a left renal infarct and mild right ureteral dilation noted on a 2025 abdominal ultrasound (performed with focal zone), as well as a history of resolved idiopathic hypercalcemia. Concern regarding hairballs vs other foreign material. Radiographs were unremarkable. Patient is still not able eat and keep food down. TPR normal. Blood work normal as well. Sulcrate, Aventi Hair and Stool and Famotidine.

Abnormal PE/Chem/CBC/UA Results: Please see attached rads, rad report, previous Abdominal Ultrasound report and lab results.

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 (3.92 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 (3.69 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. A subtle small chronic infarct is noted in the left kidney. There is no evidence of pyelectasia or mineral observed.

Adrenal Glands

The right adrenal gland is normal in size (0.42 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

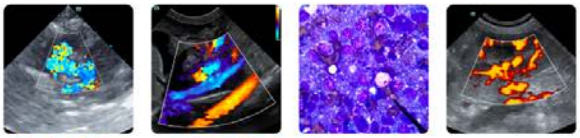
The left adrenal gland is normal in size (0.37 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is at the upper end of normal limits for thickness (measuring right at 1.0 cm thick at the hilus) with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. 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 intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

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.

PRIMARY FINDINGS

- Possible mild 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.

SECONDARY FINDINGS

- Small chronic infarct in the left kidney.
- Moderate to large amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is not a definitive ultrasonographically visible intraabdominal explanation for patient's reported vomiting. If not recently evaluated, a T4 +/- free T4 could be considered.

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.

The splenic changes are subtle/mild, but fine needle aspirates could be considered if patient's coagulations tatus is appropriate to rule out a pathologic infiltrative process.

If not recently evaluated, a 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 ratio is recommended.

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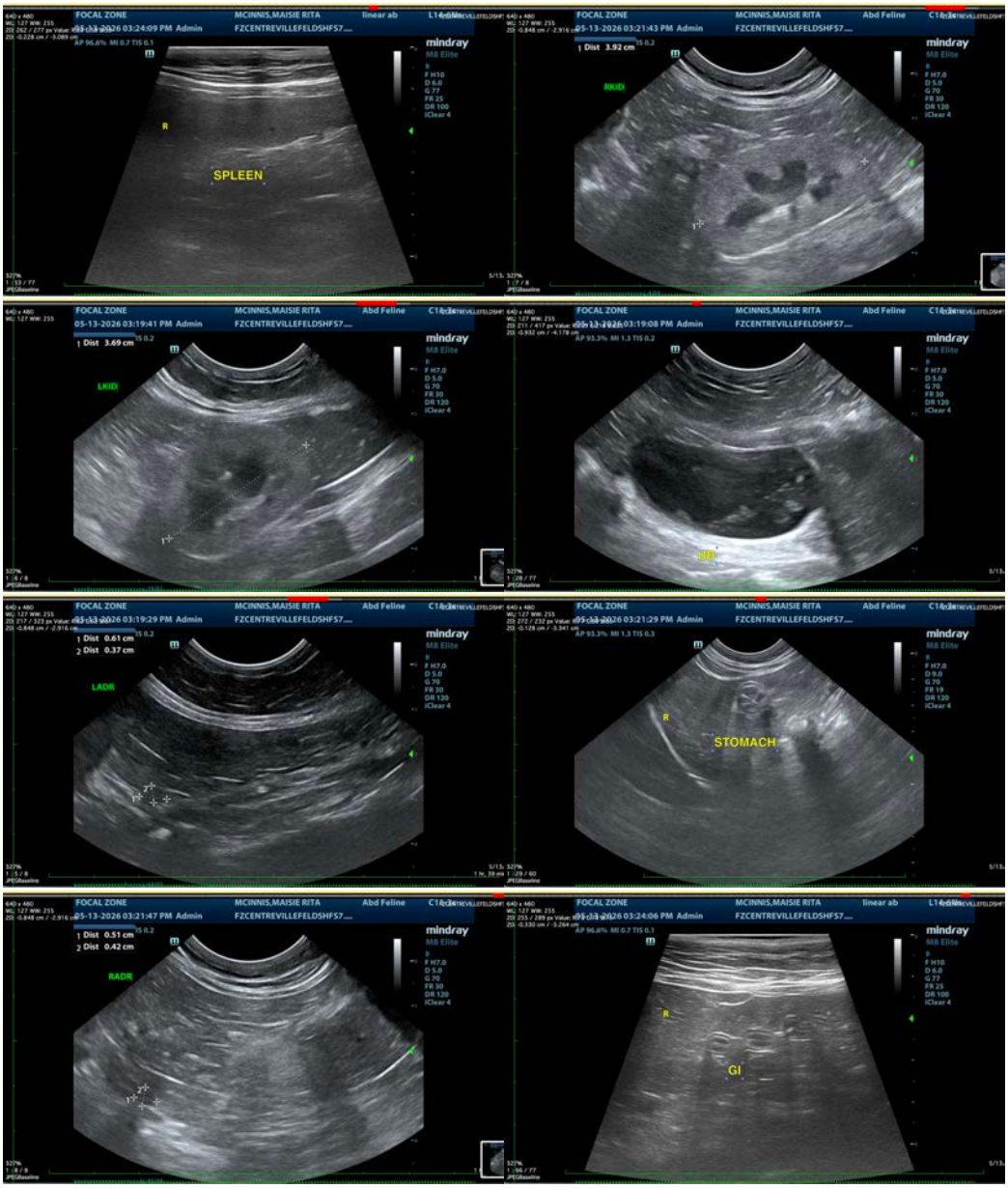
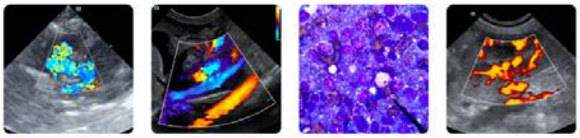
In the meantime, in addition to supportive/symptomatic medical management of clinical signs, empirical deworming with a 5 day course of Panacur is recommended.

If tolerated, a transition in diet is recommended, based on trial-and-error response.

Some options to consider include a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs a fiber response/colitis diet vs a bland, easy to digest or low-fat diet vs other.





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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