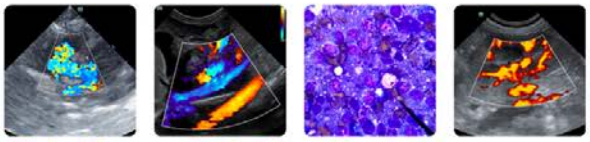


PATIENT

Swiss Hill

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

11 Years 1 Month

WEIGHT

6.45 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Cypress Veterinary Clinic

REFERRING VET

Laura Johnson, VMD

INVOICE

75342

DATE

5/21/26

PRESENTING CLINICAL SIGNS

AUS to further evaluate chronic constipation with incomplete response to lactulose, Vomiting associated with constipation, hyporexia, and radiographic evidence of colonic displacement and persistent abdominal mottling. BW shows mild elevation of total calcium. Working DDx: intra-abdominal mass, carcinomatosis, adhesions, colonic motility disorder, chronic enteropathy vs other. Meds: Lactulose

Abnormal PE/Chem/CBC/UA Results: CBC: Normal, Low eosinophils (not clinically significant) - Chemistry: Normal except elevated calcium- 11.9 H (8.2-11.2), r/o lymphoma vs other - TT4: 2.5 - UA: USG 1.058, pro 2+. NSF - Radiographic evidence of colonic displacement and persistent abdominal mottling - r/o intra-abdominal pathology (e.g., carcinomatosis, adhesions, space-occupying lesion)

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 overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measured 4.1 cm. Right kidney measured 3.6 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.39 cm at cranial pole and 0.33 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.48 cm at cranial pole and 0.32 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

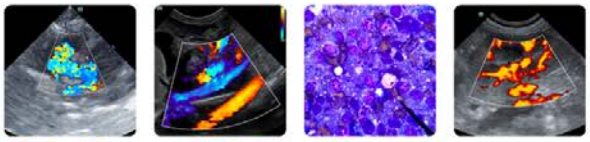
Spleen

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. 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.



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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. The colon is largely distended with mildly soft stool and fluid with some formed stool visible in some areas. Just distal to the ileocecocolic junction is an approximately 1.3 cm x 1.7 cm subjectively subtly more discrete hypoechoic density that could represent tissue, but in most views it appears to be some fluid in the colon. Color flow doppler or power doppler may help differentiate tissue versus normal or liquid colonic contents.

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

- 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.

- A soft tissue density within the colon can't be ruled out, but in most views the appearance of the density described above is consistent with a normal fecal ball or even echogenic fluid material.

SECONDARY FINDINGS

- Mild age related kidney changes and a mild amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Mild or emerging concurrent small bowel disease as described above can't be ruled out, nor can a soft tissue density within the colon at the level of the ileocecocolic junction. However, based on imaging, in my opinion the top differential for the constipation is underlying metabolic disease potentially the hypercalcemia or subclinical dehydration versus other.

Therefore, a malignancy panel (PTH, PTHrP, iCa) to Michigan State College of Veterinary Medicine is recommended for further investigation of the reported hypercalcemia.

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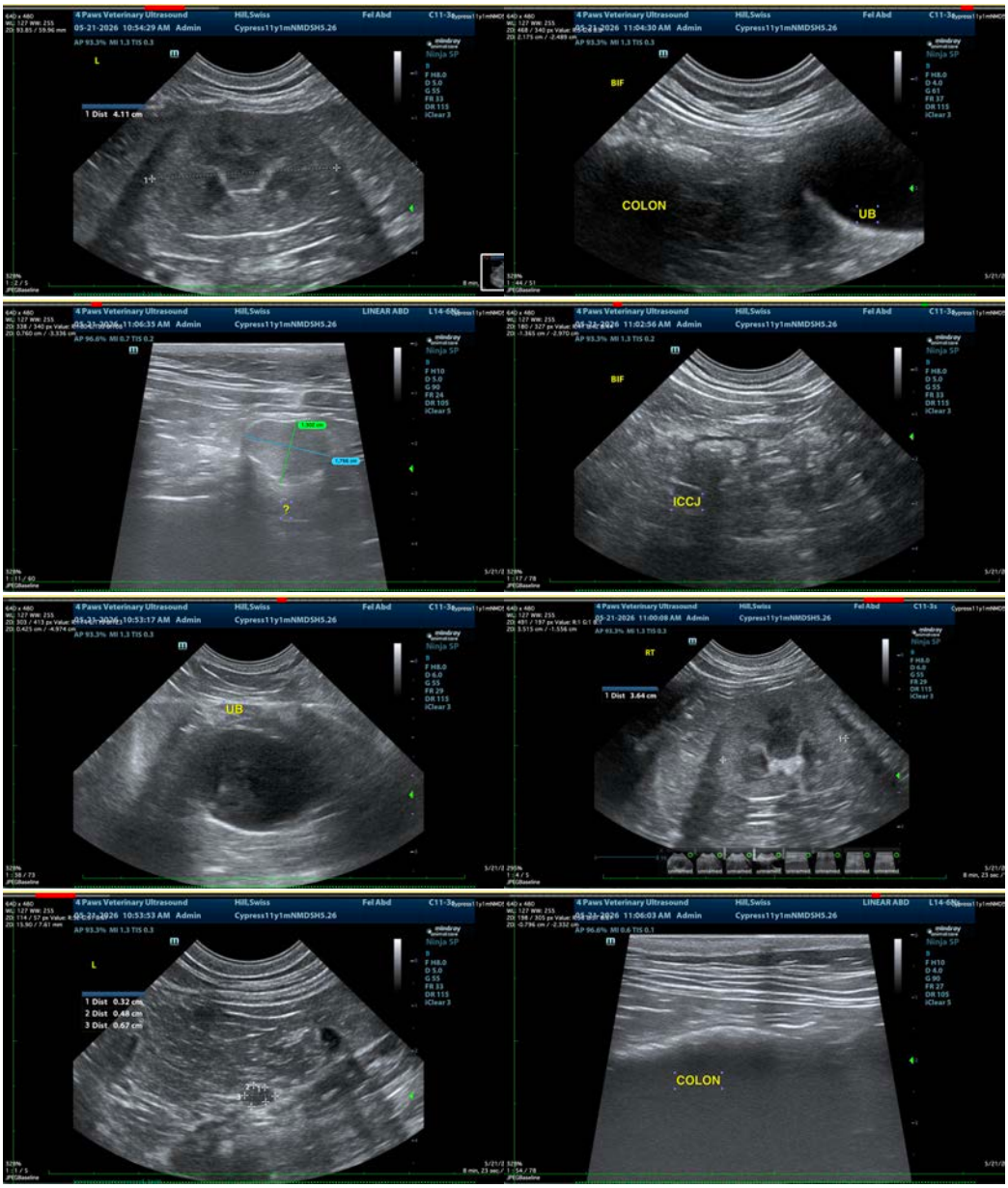
Addressing hydration, managing hypercalcemia if possible, and continuing or even increasing supportive/symptomatic medical management of constipation is recommended while monitoring the density adjacent to the Ileocecocolic junction, if possible. Alternatively, colonoscopy could be considered after adequate prep to further evaluate the lumen in that area.

In the meantime, 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.



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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