



## PATIENT

Marsh Depew

## SPECIES

Feline

## BREED

DSH

## SEX

Suspected Spayed

## AGE

1.9 Years

## WEIGHT

7.5 lbs

## INTERPRETED BY

Dr Brittany Sinclair,  
BVSc(hons),  
DACVECC

## IMAGING PERFORMED BY

Dr. Kristen Carpenter

## HOSPITAL NAME

Pennridge Animal  
Hospital

## REFERRING VET

Dr. Anastasia Depew

## INVOICE

72321

## DATE

1/20/26

## PRESENTING CLINICAL SIGNS

Recently adopted kitten (owner surrender) late 2025 .Severe feline atopica skin syndrome (confirmed on histopathology). Probable pemphigus foliaceus (high level of suspicion on histopathology). Superficial pyoderma – resolving. Severe leukocytosis r/o inflammation from severe skin disease vs neoplasia vs leukocyte adhesion deficiency. Peripheral lymphadenopathy (mature lymphocytes, several mast cells and few eosinophils, possible cocci shaped bacteria) r/o inflammation from severe skin disease vs neoplasia vs systemic mastocytosis. Weight loss, muscle atrophy. Episodes of shock/lethargy and other episode of febrile, anorexia, vomiting r/o atypical feline Addison's disease vs occult closed pyometra (no history of spay cert) or other cause of internal infection vs infections FIP? vs pediatric neoplasia (lymphoma vs other) vs systemic mastocytosis. r/o primary GI disease based on most recent rads

P is on Orbax 5 mg/kg SID, Cerenia 10 mg 1/4 tab po SID, Dex SP 4 mg/mL 0.1 mg/kg SID, Zyrtec 5 mg PO SID

Abnormal PE/Chem/CBC/UA Results: Diagnostics: Thorough skin diagnostics have been performed @ Dermatologist 12/30/25 CBC/Chem - WBC 49.0 (H), PLT 699 (H), Neutrophils 35,280 (H), Lymphocytes 10,290 (H) Eosinophils 2940 (H). Chem ALP 5 (L), Creat 0.4 (L), BUN/Creat Ratio 83 (H), Sodium 166 (H), Potassium 5.7 (H), Na:K ratio 29 (L), T4 1.4. FIV/FelV negative/negative, fecal negative 1/1/26 - UA, culture: USG 1.061, pH 5.5, 2+ protein, fat droplets. Culture showed no growth 1/17/26 - probable platelike atelectasis otherwise thorax unremarkable, gastric contents unexpected due to recent history of V+, abd distended, abnormal SI, foreign material present - r/o enteritis vs partial FBO 1/19/26 - repeat CBC/Chem pending, LN aspirates pending for path review

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys were both normal size and structure, with smooth capsule and normal corticomedullary definition and ratio. Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. Left kidney measures 3.88 cm. Right kidney measures 4.13 cm.

### Adrenal Glands

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. Right measures 0.48 cm in thickness. Left measures 0.29 cm in thickness.

### Spleen

The spleen was normal with age appropriate homogeneous parenchyma and a smooth capsule with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.



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## Liver

The liver is subjectively normal in size with normal contours and structure. There is age appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

Gall bladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.

## Gastrointestinal

The stomach is minimally distended but contains somewhat angular shadowing material concerning for foreign material.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is diffusely increased with normal wall layering and maintenance of normal mucosa/muscularis ratio. There is a curvilinear shadowing object visible in the small intestine consistent with foreign material. Surrounding intestine is non-distended.

Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

## Pancreas

The visible pancreas was observed to be largely isoechoic to surrounding omental fat.

## Free Abdomen

Inguinal lymphadenopathy was noted. No intraabdominal lymphadenopathy appreciated. No free fluid noted.

A tubular structure deep to the bladder distinct from the colon is visible, suspicious for a uterus.

## ULTRASONOGRAPHIC FINDINGS

- Shadowing material in stomach and small intestine, concerning for foreign material.
- Diffusely thickened small intestines with normal wall layering.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The presence of foreign material within the GI tract is concerning for GI foreign material. It does not appear overtly obstructive at this time. The small intestines are diffusely thickened, and a structure consistent with uterus is visible in the caudal abdomen distinct from colon and deep to the urinary bladder. Given the history and ultrasound findings, abdominal explore should be considered to further evaluate the foreign material visualized within the GI tract, as it appears persistent across several days of imaging. GI biopsies are recommended at the time of explore. This could also confirm the presence of a uterus, and pending patient stability, ovariohysterectomy may be performed at that time.



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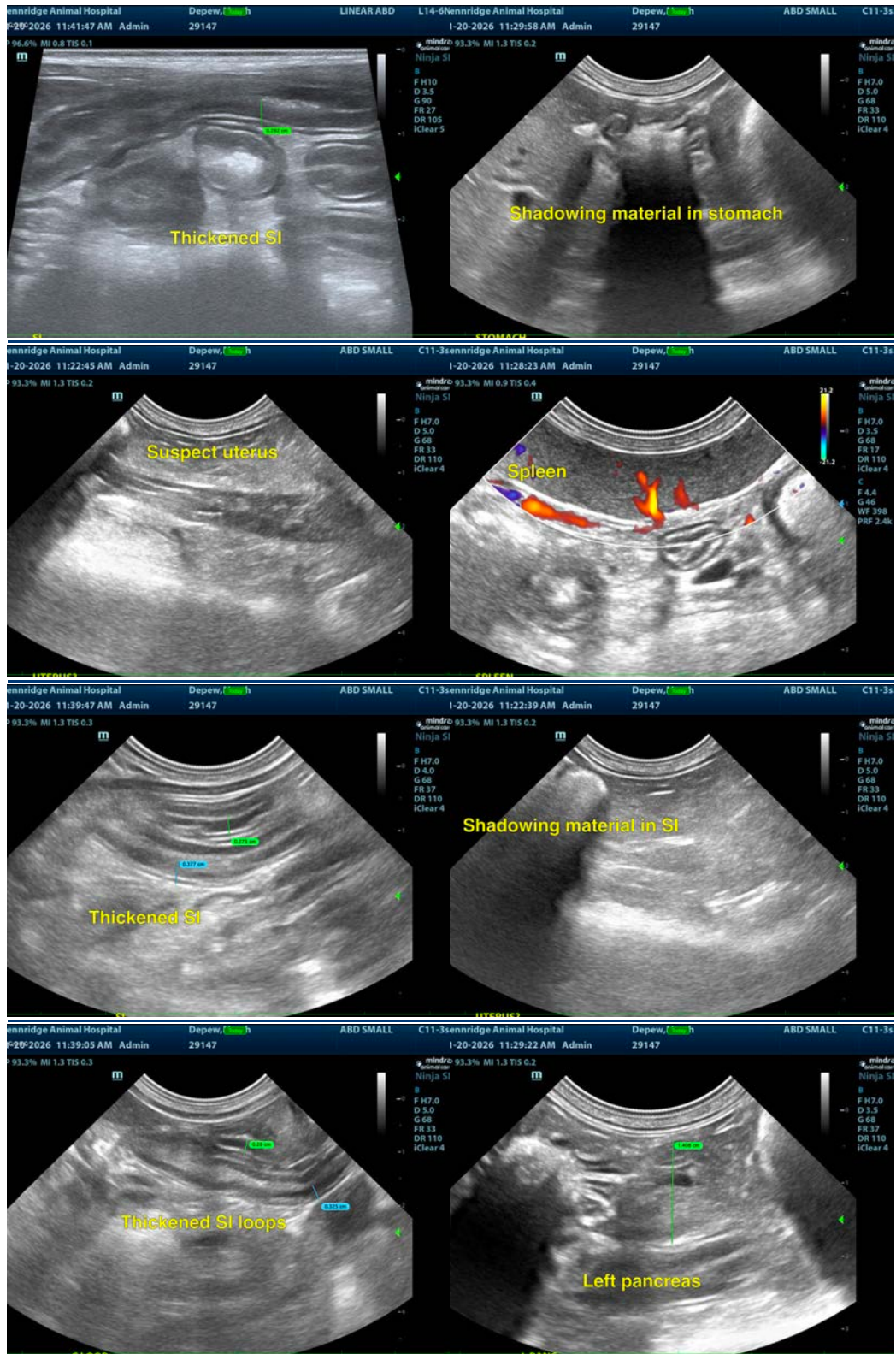
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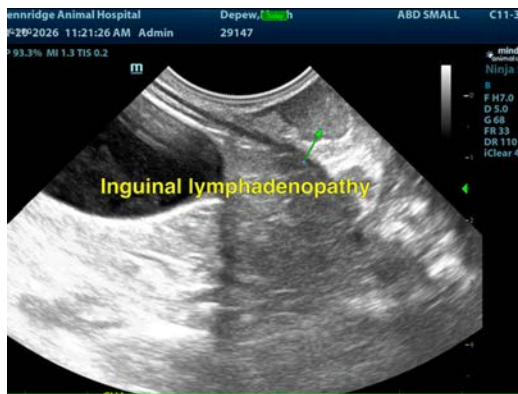
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

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