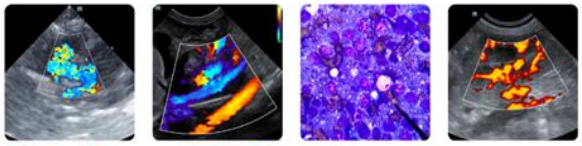


PATIENT
Turbo Traboulsi

SPECIES
Feline

BREED
DSH

SEX
MN

AGE
12.5yr

WEIGHT
9.08lb

INTERPRETED BY
Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY
Sara Hansen

HOSPITAL NAME
BPH North Eugene

REFERRING VET
Dr Fioretti

INVOICE
23887

DATE
02/13/2026

PRESENTING CLINICAL SIGNS

- Turbo presents for intermittent vomiting. Last Thursday he vomited a hairball and then seem fine, eating/drinking normal, seemed to have an increased appetite. Yesterday (02/03/2026) he started having vomiting and diarrhea throughout the day. He vomited food the first time, and then foam each time after. He was also vocal before each vomiting episode. Lower appetite as of yesterday as well. O did have a repair man around the house on 02/02- which stresses Turbo out.
- Turbo has been dealing with intermittent vomiting since November. O feels like's it due to stressful events in the house. Pet was sent home with Cerenia in January and did well on that.
- ABNORMAL Labwork Values blood work today 02/04 WBC 18.39 (H), LYM 7.63 (H) chemistry panel and electrolytes: NSF
- January 22nd 2026 FPL normal, WBC 14.04 (normal), LYM 6.8 (normal), chemistry panel and electrolytes were normal on this day as well
- Current Medications Cernia 24mg give 0.5 tab po sid x 8 days sent home today, Forta flora sent home on 01/16/26

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 have a smooth capsule and with mild hazing of corticomedullary definition. No evidence of pelvic dilation was present. The left kidney is 3.24 cm in length; the right kidney is 3.65 cm in length.

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.

The left adrenal is 0.4 cm in thickness; the right adrenal is 0.3 cm in thickness.

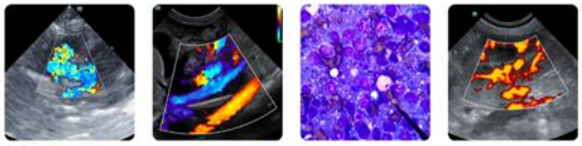
Spleen

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.

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.



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Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is diffusely increased and wall layering is distinct with a prominent muscularis layer. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was not visualized.

Pancreas

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

Lymph Nodes

Mesenteric lymph nodes are prominent and hypoechoic with general maintenance of length to width ratio

Free Abdomen

No masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

- Diffusely thickened small intestines with prominent muscularis
- Mild mesenteric lymphadenopathy with maintenance of normal length to width ratio
- Mild aging renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Small intestinal changes together with mild mesenteric lymphadenopathy are most consistent with infiltrative disease of the small intestine with inflammatory bowel disease or GI lymphoma being the top differentials. No overt neoplastic criteria present in the bowel given that curvilinear layering is still intact. Ultrasound cannot differentiate between small cell lymphoma and inflammatory bowel disease and GI biopsies are recommended for definitive diagnosis, especially if there is a poor response to empirical efforts or recurrence of clinical signs after initial control. Endoscopic biopsy is less invasive but may miss lesions due to inability to obtain samples from all sections of the GI tract, especially the jejunum which is the most common site of development of disease. Surgical biopsies are more likely to be diagnostic but are more invasive. A GI panel (TLI/PLI/cobalamin/folate) will help determine the severity of SI dysfunction, and need for vitamin supplementation.

Empiric treatment for IBD includes diet trial with either hydrolyzed or select protein diet, vitamin b-12 supplementation, GI support as needed (anti-nausea, appetite stimulant). Treatment with steroids (budesonide vs prednisolone) is often required – biopsies should be acquired prior to treatment with steroids. Steroids may ultimately be tapered to the lowest effective dose or discontinued in some cases.

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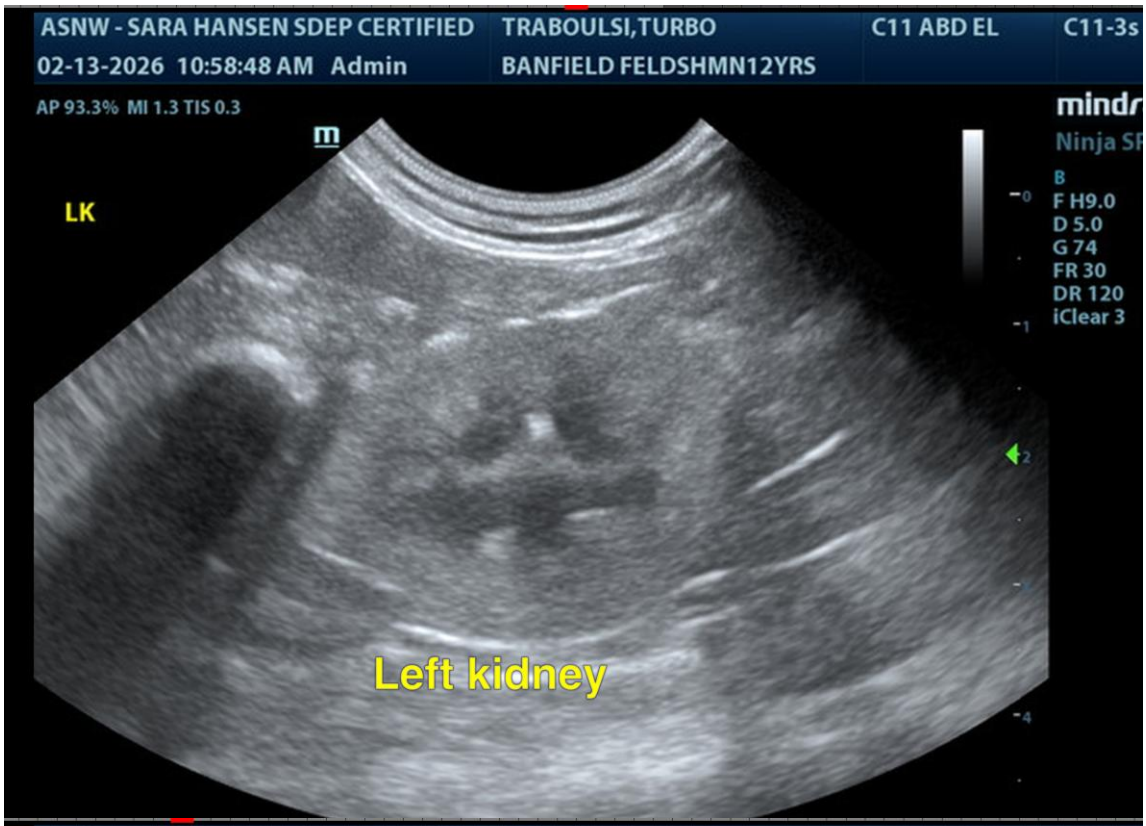

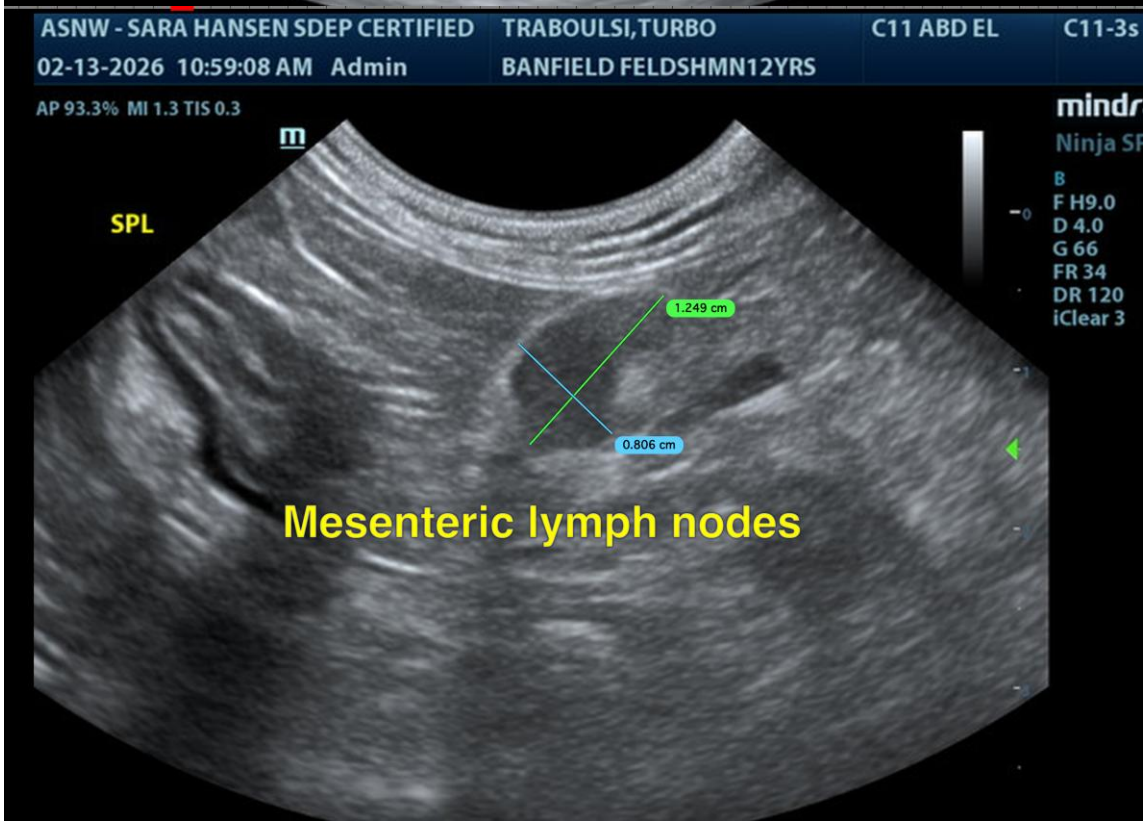

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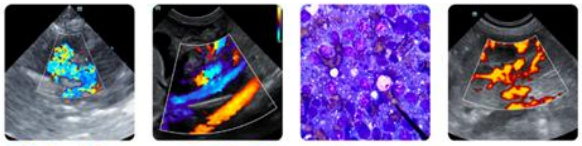

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

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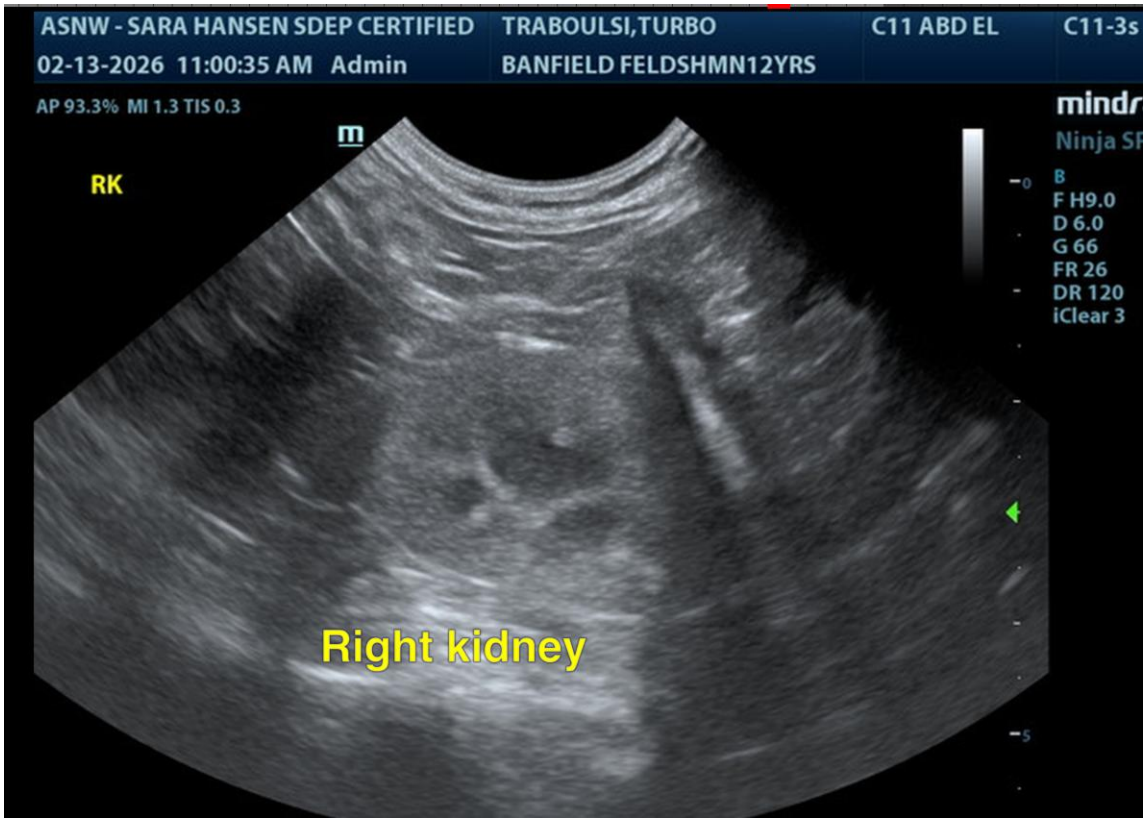

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

info@SonoPath.com