



PATIENT

Whitecat Bolker

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

11 Years

WEIGHT

6.15 kg

INTERPRETED BY

Dr Brittany Sinclair,
BVSc(hons),
DACVECC

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Hamilton Region Vet
Emergency Clinic

REFERRING VET

Dr. Vercaigne

INVOICE

73286

DATE

2/26/26

PRESENTING CLINICAL SIGNS

Presented for acute hematemesis, 3x large volume frank blood liquid/mucousy vomit, not observed by owner. Was transiently shallow breathing afterwards. PE mild abdominal discomfort, mild dehydration, normal vital signs. Grade 2/6 systolic murmur. Hx chronic regurgitating/vomiting undigested kibble after breakfast. Hairballs have resolved with hairball paste. No known dietary indiscretion, foreign material ingestion, toxin exposure. UTD vaccines, indoor only. Current Medications: Maropitant SQ.

Abnormal PE/Chem/CBC/UA Results: Chem, lytes, CBC pending (results to follow)

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. Mobile debris present in the urinary bladder. No evidence of inflammatory or neoplastic changes were noted.

The left kidney has a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present. Area of indentation noted in the left renal capsule with underlying triangular shaped hyperechoic parenchyma consistent with an area of previous infarct. Left kidney measures 4.45 cm.

The right kidney is normal in 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. Right kidney measures 4.32 cm.

Adrenal Glands

Adrenal glands are visualized and measured on still images only. Resolution is inadequate to assess glandular detail or confirm measurement. Left measures 0.49 cm in thickness. Right measures 0.28 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.

Gastrointestinal

The gastric wall is diffusely mildly thickened with a prominent mucosal layer. There is a small volume of fluid within the lumen with no significant distention. There is hyperechoic non-shadowing material in the pylorus. There is no visible foreign material in the PDJ.



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The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is diffusely mildly 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 visualized and exhibited normal intact wall layering and is subjectively of normal thickness. 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 area of the pancreas was isoechoic to surrounding tissue with no overt inflammation. Pancreatic tissue was not distinctly visualized which is common.

Free Abdomen

No clinically significant lymphadenopathy or abnormalities noted. No free fluid noted.

ULTRASONOGRAPHIC FINDINGS

- Thickened gastric wall, consistent with mild gastritis.
- Diffusely thickened small intestines with prominent muscularis.
- Left renal infarct, likely chronic incidental change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gastric wall thickening is consistent with reported recent vomiting and likely represents acute gastritis. There were no focal lesions concerning for a mass or neoplasia. Ultimately, gastric biopsy should be considered, especially if signs are persistent or recurrent.

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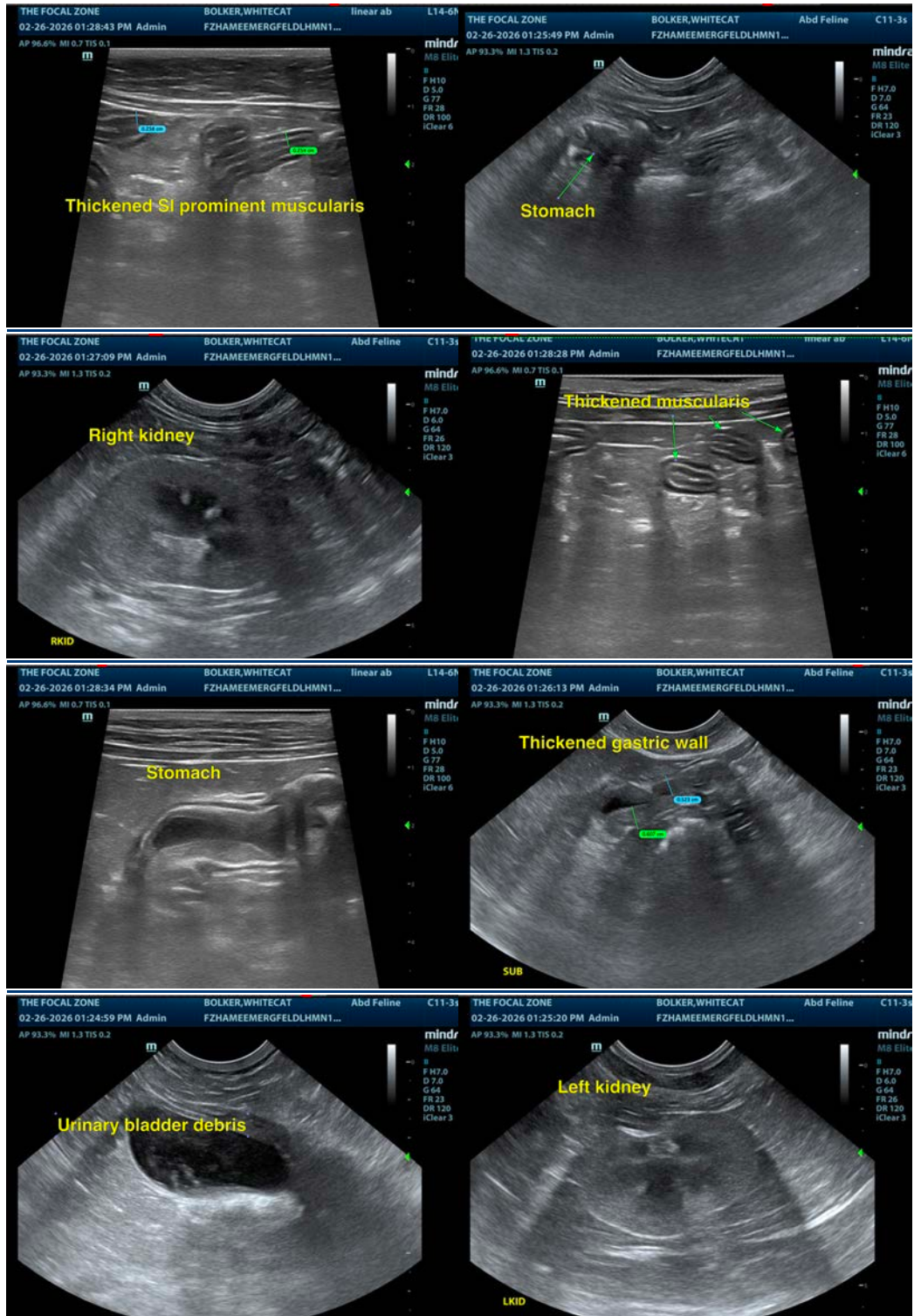
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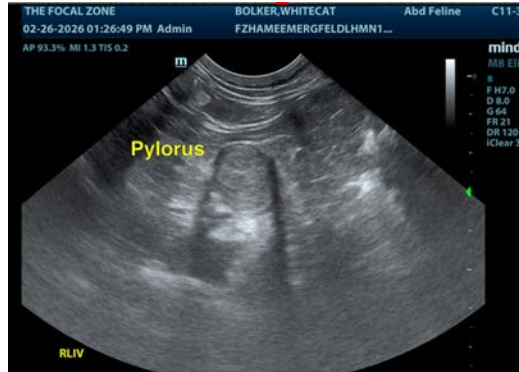
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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