



PATIENT

Susie Proudfoot

SPECIES

Feline

BREED

DLH

SEX

Spayed Female

AGE

4 Years

WEIGHT

6.6 kg

INTERPRETED BY

Dr Brittany Sinclair,
BVSc(hons),
DACVECC

IMAGING PERFORMED BY

Dr. Meghan Myers

HOSPITAL NAME

Hershey Animal
Emergency Center

REFERRING VET

Dr. Cara Sinopoli

INVOICE

14594

DATE

03/25/26

PRESENTING CLINICAL SIGNS

- Anorexia since Saturday, vomiting multiple times, large volume since Sunday, lethargic and hiding, not urinating or defecating. Not known to get into things, no diet changes or changes in household.
- Bradycardia ~120bpm, hypothermic 97.6, weak pulses, 6-8% dehydrated, Tense on abdominal palpation, large bladder, but easily expressed foul smelling urine.

Abnormal PE/Chem/CBC/UA Results: PCV/TS: 50%/9 EPOC: HCT 51% H, glu 238 H, creat. 4.13 H, BUN 109 H, lactate 3.82 H, iCa 1.02 L, Cl 97 L, K 3.2 L, Na 146 L, BE 7.5 H, pH 7.368, TCO2 31.8 H, bicarb 32.8 H, pCO2 56.9 H Doppler BP: 120 Post fluid bolus: CBC: HCT 50.6% H, WBC normal, suspected bands Chem: glu 215 H, creat. 2.3 H, BUN 115 H, P 8.8 H, ALP <10 L Pancreatic lipase: 1 N U/A: USG >1.050, protein 100, suspected cocci xrays: - The stomach contains a moderate amount of gas that fills the pyloric antrum appropriately on left lateral projection. Small intestines are diffusely gas and soft tissue opaque filled with no evidence of distention, malposition, or plication. The colon contains formed fecal material admixed with gas. Kidneys are mildly decreased in size/rounded with regions of renal cortical flattening.

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 kidneys were both generally normal size and structure, with somewhat irregular capsules and normal corticomedullary definition and ratio. Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. Irregularity of the capsule is likely due to areas of previous infarction. The left kidney measured 4.14 cm in length. The right kidney measured 4.26 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 gland measured 0.35 cm in thickness. The right adrenal gland measured 0.31 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



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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 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. There's a focal loop with a small volume of fluid with no overt distention and no shadowing material.

The ileocecal junction was not visualized. 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.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

No masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

- Urinary bladder debris.
- Normal kidneys.
- Focal small intestine loop with small volume of fluid- likely mild enteritis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Kidneys are ultrasonographically normal. In light of the azotemia, an acute renal insult is likely. Progression of chronic renal disease (not yet ultrasonographically evident), toxin exposure, leptospirosis, bacterial pyelonephritis, other infectious insults, recently resolved ureterolithiasis, among other things are possible. GI signs are likely secondary to acute severe azotemia causing gastritis/enteritis.

Additional diagnostics to be considered include urine culture, leptospirosis testing, and careful questioning for the possibility of exposure to renal toxins (NSAIDs, lilies, vitamin D, rodenticide (primary or secondary exposure), etc). Doppler blood pressure measurement is recommended to screen for hypertension which can be present in both acute and chronic renal disease and worsens renal function.



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Treatment with intravenous fluid therapy, GI support as needed including enteral nutrition and monitoring for improvement or resolution of azotemia every 24-48 hours is recommended. Antibiotics are reasonable while awaiting infectious disease testing.

If azotemia fails to resolve with fluid therapy, permanent renal dysfunction is likely. Management for any patient with chronic renal dysfunction includes renal specific diet (protein and phosphorus limited), encouraging increased water intake with canned food and providing clean, running water source, and management of proteinuria and hypertension with ACE-inhibitor with addition of more anti-hypertensives as required. Monitoring of bloodwork, urinalysis and blood pressure every 3-6 months, or sooner if feeling unwell, is recommended.



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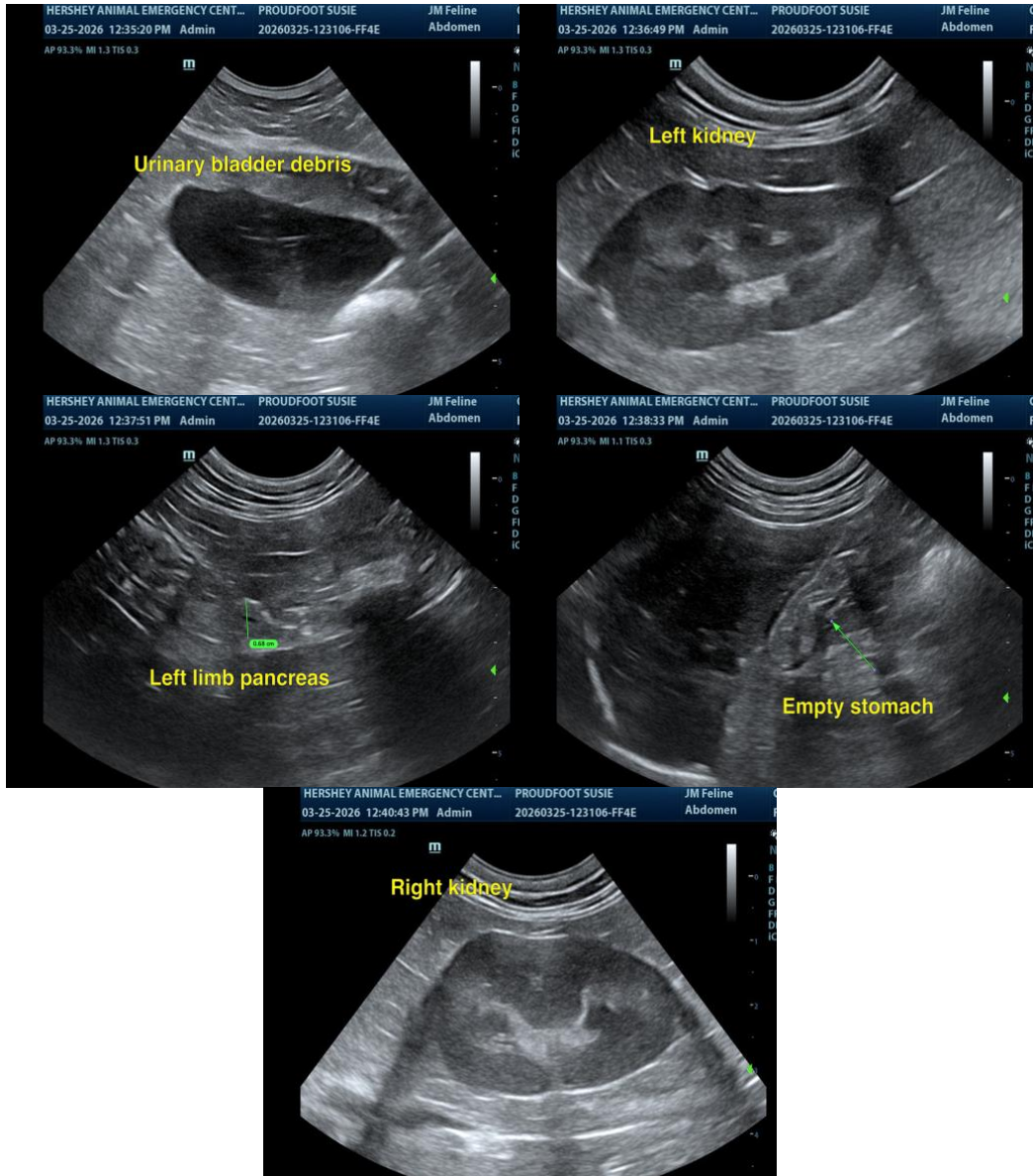
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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