



PATIENT

Minx Peebles

SPECIES

Feline

BREED

Savannah

SEX

Spayed Female

AGE

15 Years

WEIGHT

2.72 kg

INTERPRETED BY

Dr Brittany Sinclair,
 BVSc(hons),
 DACVECC

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

The Cat Clinic
 Hamilton

REFERRING VET

Dr. Maxwell

INVOICE

73434

DATE

3/5/26

PRESENTING CLINICAL SIGNS

Daily vomiting and weight loss over the recent months. Appetite is reported as not great, but she has not stopped eating. She is still drinking. Meds: cerenia 4mg SID

Abnormal PE/Chem/CBC/UA Results: CBC All WNL Biochem All WNL TT4 WNL UA pending B12 pending

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 hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present. There is a hyperechoic band between the cortex and medulla in the right kidney. The left kidney is visualized and measured at an oblique angle, which likely underestimates its true length. Left kidney measures 3.2 cm. Right kidney measures 4.05 cm.

Adrenal Glands

Adrenal glands were visualized on still images only. They appear to have normal shape, size, position and echogenicity for this breed and age though this could not be confirmed on cine loops. Left measures 0.23 cm in thickness. Right measures 0.34 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 stomach contains minimal luminal contents. The stomach wall is diffusely thickened 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.



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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

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The area of the pancreas was isoechoic to surrounding tissue with no overt inflammation. Pancreatic tissue was not distinctly visualized which is common.

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Free Abdomen

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

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- Thickened stomach and small intestines with prominent muscularis layer of the small intestines.
- Aging renal changes.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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The gastric and small intestinal changes are most consistent with infiltrative disease of the GI tract 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.

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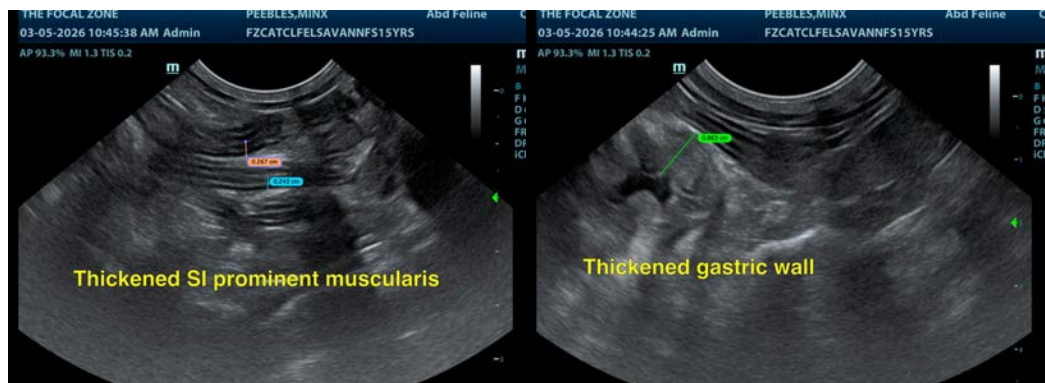
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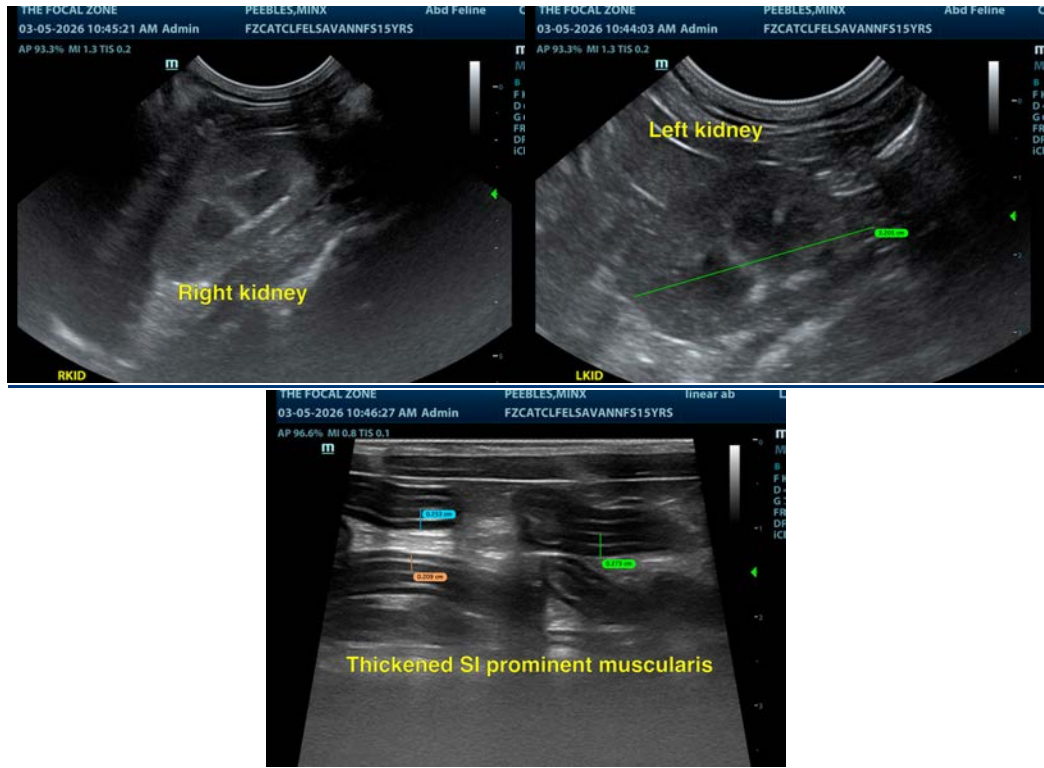
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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