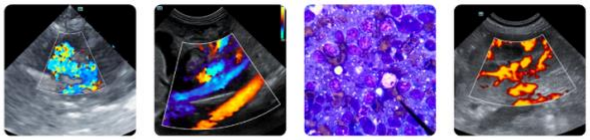

PATIENT

Salonna Williamson

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

15

WEIGHT

8.0 pounds

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Dr. Wes Sopangler

HOSPITAL NAME

TotalBond Veterinary Hospitals- Paw Creek

REFERRING VET

Dr. Wes Spangler

INVOICE

13831

DATE

02/16/26

PRESENTING CLINICAL SIGNS

- 15yo FS DSH with progressive chronic intermittent vomiting and diarrhea, worsening over the last 2-3 weeks. Mild weight loss of 1/2 pound over the last 4 months.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder is moderately distended with anechoic urine. No uroliths are seen. The bladder wall is normal in appearance and thickness. No masses are seen.

The left kidney presents normal size with normal shape and architecture. Mild loss of corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis. The left kidney measured 3.6 cm in length.

The right kidney presents normal size with normal shape and architecture. Moderate loss of corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis. The right kidney measured 3.8 cm in length.

Adrenal Glands

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The left adrenal gland measured 2.6 mm in width.

The right adrenal gland was not clearly seen on this exam.

Spleen

The spleen is normal in size, shape, margination and echogenicity. No masses are seen.

Liver

The liver presents normal size and shape with smooth lobar margins. The parenchyma has normal echogenicity with normal echotexture. No focal lesions are seen. Intrahepatic bile ducts are normal. Normal vascular pattern.

The gallbladder wall diffusely appears hyperechoic and mildly thickened measuring 1.7 mm in width. There's a mild amount of suspended echogenic debris within the gallbladder wall. The visible common bile duct does not appear distended. There is no free fluid seen surrounding the gallbladder.

Gastrointestinal

The stomach contains a moderate amount of ingesta and gas. The stomach wall appears to have normal layering and thickness. It measures approximately 1.7 mm in width. It appears patient may not be fully fasted for this exam. The jejunum appears to have normal thickness, however, there is a moderate amount of ingesta within the lumen of the jejunum, making exact measurement of the jejunal wall difficult. The thickest section measured was 2.5 mm in width, however, the jejunum does appear to have a moderately thickened muscularis layer diffusely. Colon wall is markedly thickened with abnormal layering present. The muscularis layer of the colon is markedly thickened and the mucosa appears hyperechoic and to be potentially sloughing on the luminal aspect. The ileum is mildly thickened at 3.6 mm in width and has a moderately to markedly thickened muscularis layer.

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Pancreas

The visible pancreas is normal in size with normal echogenic parenchyma and surrounded by normal peri-pancreatic mesentery.

Free Abdomen

There are no enlarged abdominal lymph nodes seen on this exam. No free abdominal fluid is seen.

ULTRASONOGRAPHIC FINDINGS

- Moderately to markedly diffusely thickened colon- infectious etiology is less likely.
- Thickened ileum.
- The jejunum appears to be normal in thickness but has a thickened muscularis layer.
- Hyperechoic mildly thickened gallbladder wall- normal variation or possibly an inflammatory/infectious process. Consider bacterial cholangitis as a possibility.
- Decreased corticomedullary distinction bilaterally.

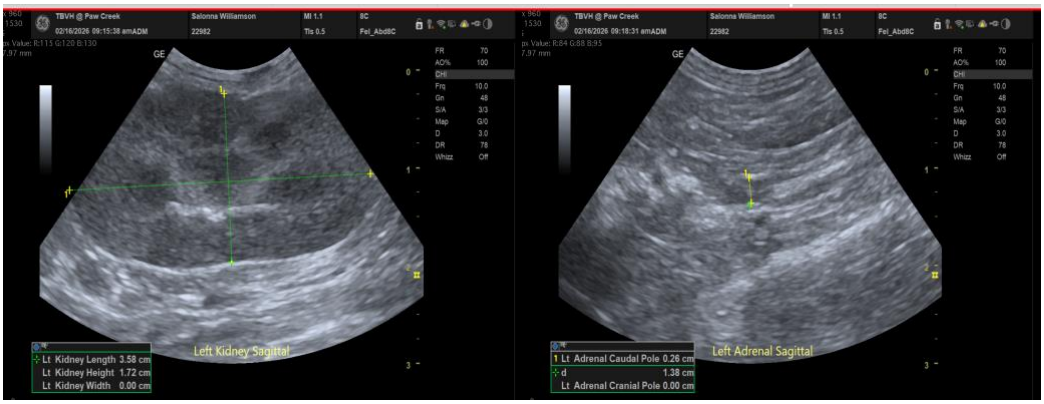
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Consider gallbladder aspirate and submitting bile for aerobic and anaerobic bacterial culture as well as cytology.

Recommend submitting a fecal pathogen PCR panel to screen for protozoa such as tritrichomonas and other parasites and protozoa. Other differentials for the GI tract include neoplasia and specifically either small cell lymphoma or in this case, possibly lymphoblastic lymphoma or mass cell tumor is a likely differential as well.

At this time, I recommend endoscopic biopsies of the GI tract. Both upper and lower endoscopy be performed. Biopsies of the stomach, duodenum, colon, and ileum be obtained and submitted for histopathology and determine the etiology of the patient's GI disease. Recommend ruling out infectious disease as quickly as possible and then moving to biopsies as rapidly as is feasible. Prognosis at this time appears guarded given pending final diagnosis as to the cause of the patient's GI tract changes.

Recommend full staging, monitoring, and managing of the patient's suspected chronic kidney disease via the International Renal Interest Society guidelines.



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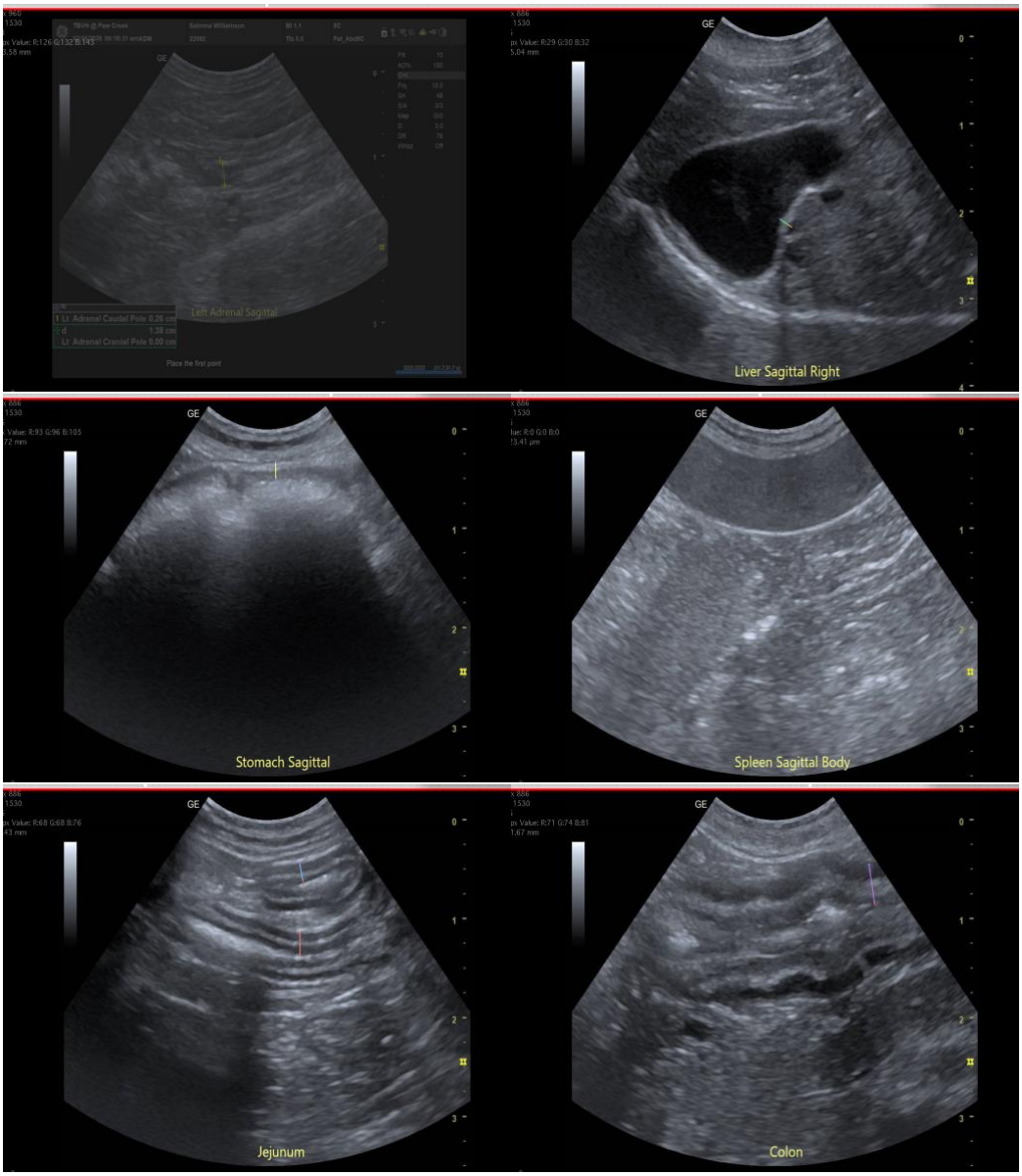

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Greg Kuhlman, DVM, DACVIM (SAIM)
Veterinary Internal Medicine Specialist
info@SonoPath.com