



PATIENT

Rue Augustin

SPECIES

Feline

BREED

DSH

SEX

Female

AGE

10 Months

WEIGHT

11

INTERPRETED BY

Greg Kuhlman, DVM,
DACVIM (SAIM)

IMAGING PERFORMED BY

Dr. Sreenivasa
Maddineni

HOSPITAL NAME

West Babylon AH

REFERRING VET

Dr. Sreenivasa
Maddineni

INVOICE

35917

DATE

2/20/26

PRESENTING CLINICAL SIGNS

- Intermittent vomiting for 2 weeks eating and drink well.
- Radiograph consult showed possible partial GI obstruction.
- Abnormal PE/Chem/CBC/UA Results: WNL

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 right kidney presents normal size (3.5 cm) with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis.

The left kidney presents normal size (3.8 cm) with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis.

Adrenal Glands

The right adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The cranial pole measures 4.1 mm.

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The cranial pole measures 3.1 mm.

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 presents normal size with anechoic contents. Normal gallbladder wall. No evidence of bile duct distention or obstruction.

Gastrointestinal

The stomach is moderately fluid and gas filled and contains a moderate amount of ingesta as well. The stomach wall diffusely appears to have normal layering and thickness. It measures 1.6 mm in width. Diffusely, the small intestines are moderately distended with ingesta. No mechanical obstruction is seen on this ultrasound. It appears that the patient is not fully fasted for this exam or may have diffuse functional ileus present. There are segments of small intestine that are thickened, measuring up to 3.1 mm in width. Normal feline intestine should measure <2.8 mm in width. There are also segments of small bowel that have lost normal layering appearance. There is also an enlarged peripancreatic lymph node present, measuring 7.7 mm x 4.1 mm in width. Colon contains normal contents with normal wall thickness.



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Pancreas

Diffusely the pancreas is hypoechoic with mild surrounding hyperechoic fat. The pancreas measures 5.0 mm in width.

Free Abdomen

There is mild sublumbar lymphadenopathy. A representative node measures 1.1 cm x 0.5 cm in size. These nodes appear reactive and they are less likely to be enlarged due to neoplasia. No free abdominal fluid is seen.

ULTRASONOGRAPHIC FINDINGS

- Diffuse small intestinal thickening with segmental areas of loss of normal small bowel layering- Differentials include benign inflammatory bowel disease versus possible small cell GI lymphoma versus mast cell disease. And if geographically relevant for this patient, consider infectious disease, such as histoplasmosis.
- Hypoechoic pancreas, consistent with mild to moderate pancreatic inflammation.
- Enlarged peripancreatic and sublumbar lymph nodes- Differentials for the lymph nodes: They appear most likely to be reactive and less likely to be enlarged due to neoplastic cause.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If possible, attempt ultrasound guided aspirate of one of the enlarged lymph nodes described, preferably the peripancreatic lymph node and submit this for cytology. If clinically warranted based on cytology, submit a PCR for antigen receptor rearrangement (PARR assay) to screen the patient for small cell lymphoma. If lymph node aspirate is not possible, or is inconclusive, then recommend performing GI biopsies (either surgically or endoscopically) and submitting samples for histopathology to determine the etiology of the patient's GI disease. It does appear that the patient's clinical signs are attributed to primary gastrointestinal disease. It is suspected that the patient's pancreatitis is reactive, caused by the gastrointestinal disease. Once the gastrointestinal disease is diagnosed and treated, pancreatitis is suspected to resolve. Recommend submitting an FPLI to have a baseline so that response to treatment can be verified.



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