

## PATIENT

Colby McGilvray

## SPECIES

Feline

## BREED

DSH

## SEX

Spayed Female

## AGE

11 Years

## WEIGHT

3.16 kg

## INTERPRETED BY

Greg Kuhlman, DVM,  
DACVIM (SAIM)

## IMAGING PERFORMED BY

Carlie Koltek, RVT

## HOSPITAL NAME

Tuxedo Animal  
Hospital

## REFERRING VET

Dr. Williams

## INVOICE

74072

## DATE

3/31/26

## PRESENTING CLINICAL SIGNS

Presented 3/20/2026 - Reduced appetite 24-28 hours. Vomiting bile for 24 hours and not eating or drinking. Cat not the type of cat to get into things it shouldn't. No diarrhea, energy level seems normal. Cat drank a lot of water in exam room while owner was waiting for blood test results. As of 3/28/2026 cat reported to be drinking more, but still not eating a lot -- needs to be coaxed to eat. Still some bile vomiting (had vomited 3/27/2026). Urinating well. Less energy, but not a huge difference from normal. 3/31/2026 - owner reports no longer vomiting.

Abnormal PE/Chem/CBC/UA Results: PE cat a bit dehydrated. Cat meowed a bit when abdomen palpated but did not tense abdomen and meowed off and on when handled in general. CBC Neut  $11.17 \times 10^9/L$  (2.3 - 10.29) Lymph  $0.53 \times 10^9/L$  (0.92 - 6.88) CHEM: TP 94 g/L (57 - 89) GLOB 62 g/L (28 - 51) K 3.2 mmol/L (3.5 - 5.8) PanLipase normal - 3.2 U/L (0 - 4.4) U/A: USG >1.050 RBC 4+ Hemoglobin 1+ Bacteria TNTC cocci on wet mount (rare on dry prep)

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a large amount of echogenic non-shadowing debris, most consistent with exfoliated cells, crystals, mucous and/or small blood clots likely combined with incidental suspended lipid. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The kidneys appear largely normal with a mildly hyperechoic cortex, most likely due to lipiduria. The left kidney measures 3.2 cm. The right kidney measures 3.4 cm.

### Adrenal Glands

The right adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The right adrenal gland measures 4.5 mm in width.

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The left adrenal gland measures 3.3 mm in width.

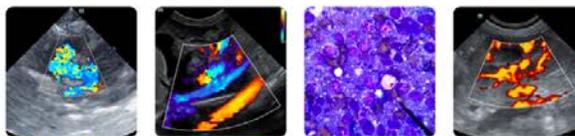
### Spleen

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

### 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.



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## ***Gastrointestinal***

The stomach and intestines have largely normal wall layering and thickness. The muscularis layer of the ileum appears mildly thickened at 3.3 mm in width. The colon contains formed stool. Diffusely the colon wall appears normal in thickness.

## ***Pancreas***

The pancreas is diffusely mildly hypoechoic without significant surrounding steatitis.

## ***Free Abdomen***

Mildly enlarged colic lymph nodes were present. A representative node measures 2.3 mm x 9.6 mm.

No free abdominal fluid is seen.

## **ULTRASONOGRAPHIC FINDINGS**

- Mildly thickened muscularis layer of the ileum – Potentially due to chronic enteropathy such as inflammatory bowel disease, small cell lymphoma, mast cell disease, or less likely an infectious etiology.
- Mild pancreatic inflammation, most likely reactive.
- Mildly enlarged colic lymph nodes – Appear reactive, less likely enlarged due to neoplasia.
- Urinary bladder debris.
- Mildly hyperechoic renal cortices.

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

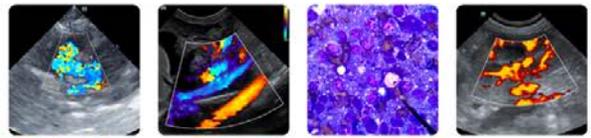
No obvious cause for the patient's recent GI signs seen on this exam. A possible urinary tract infection could be a related cause of the clinical signs.

Given the observed bacteria on urinalysis, recommend submitting urine culture and antibiotic sensitivity to determine appropriate antibiotic plan.

The pancreatic findings on this ultrasound correlates with recently obtained fPLI result. Pancreatitis is most likely not the patient's primary clinical issue. Given the mild pancreatic inflammation and the mild thickening of the muscularis of the ileum, primary gastrointestinal disease may be the cause of the GI signs.

Recommend submitting a GI panel. If chronic enteropathy is suspected due to low cobalamin or normal folate, consider GI biopsy, either surgically or endoscopically, to determine etiology and to formulate an appropriate treatment plan.

No cause of the patient's polydipsia is seen on this exam.



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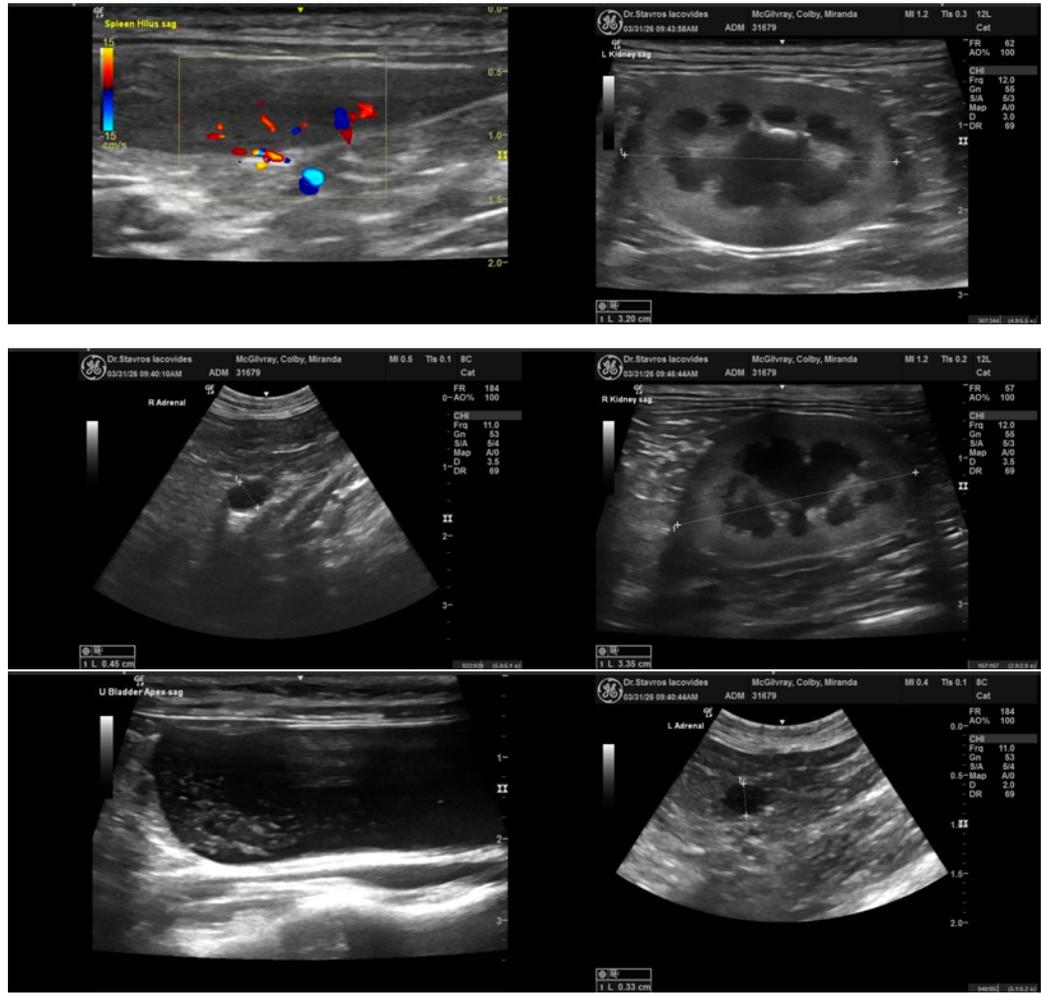
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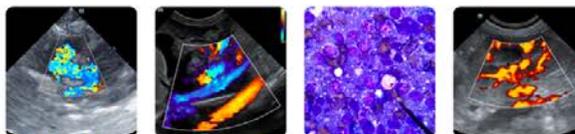
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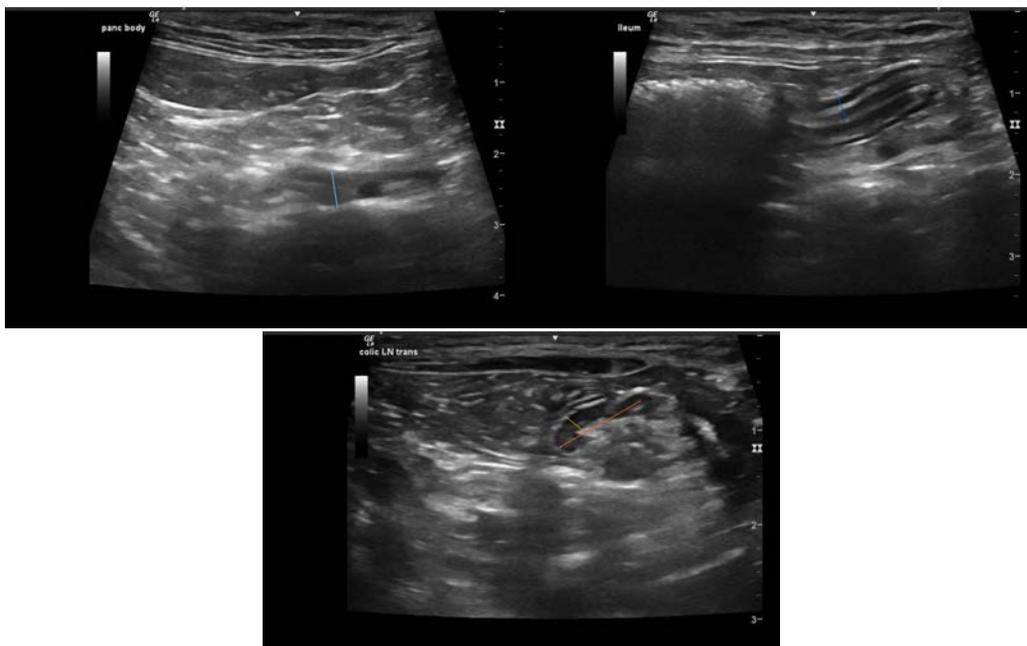
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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