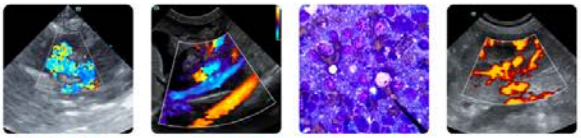


PATIENT

Charlie Merwath

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

13 Years

WEIGHT

10.44 lbs

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Shari Reffi, CVT

HOSPITAL NAME

VCA Northside Animal Hospital

REFERRING VET

Dr. Lehman

INVOICE

74505

DATE

4/16/26

PRESENTING CLINICAL SIGNS

BCS 5/9. Not eating, vomiting despite cerenia. New hyperthyroid, started oral Methimazole 2 wks ago. V+/not eating April 14-15. V+ & drooling after cerenia inj admin 4/14.

Current Medications: Methimazole 5mg PO SID; Albuterol rescue inhaler; Fluticasare inhaler BID; Zorfran 4mg TID; Miritaz transdermal; Cerenia inj 4/14 (Gabapentin)

Abnormal PE/Chem/CBC/UA Results: wnl

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 occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. At the dorsal aspect of the urinary bladder there is a 9.5 mm in width hyperechoic shadowing urolith present. No masses are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface. In the distal urethra there is a 3.0 mm in width hyperechoic urethral stone present. The bladder does not appear obstructed, nor does the urethra at this time.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia or mineral observed. Left kidney measured 3.7 cm. A large defect is noted in the ventrodorsal aspect of the right kidney, most likely due to previous infarction. Right kidney measured 3.8 cm.

Adrenal Glands

The right adrenal gland is not seen on this exam.

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The left adrenal gland measured 2.1 mm in width.

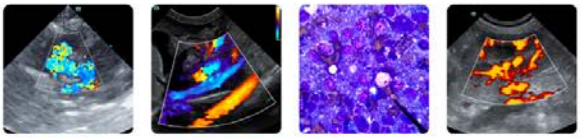
Spleen

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.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.



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Gastrointestinal

The stomach has normal wall layering and thickness. The stomach is empty. There are segments of small bowel that have a moderately thickened muscularis layer and are at the upper end of normal for thickness, measuring approximately 2.8 mm in width. Colon contains normal contents with normal wall thickness.

Pancreas

No pathology seen in the area of the left pancreas. The right pancreas is enlarged at 1.8 cm in width, and hypoechoic with a nodular appearance. There is no significant surrounding hyperechoic fat around the right limb of the pancreas.

Free Abdomen

There are several mildly to moderately enlarged mesenteric lymph nodes. A representative node measures 4.0 mm x 3.0 mm with mild surrounding hyperechoic fat. No free abdominal fluid is seen.

ULTRASONOGRAPHIC FINDINGS

- Urinary bladder and urethral stones.
- Enlarged, hypoechoic, nodular right pancreatic limb - Consistent with pancreatic hyperplasia, less likely pancreatic carcinoma or abscess.
- Enlarged mesenteric lymph nodes – Likely due to reactive cause from patient's suspected GI disease or less likely enlarged due to a neoplastic cause.
- Age related renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommend starting urinary dissolution diet, if possible, to determine if the bladder stone can be resolved over the next month. Recheck ultrasound in one month to determine if the urolith is smaller or resolved. If not, consider cystotomy, submitting the stone for analysis. If the urethral stone is currently causing clinical signs or lower urinary tract disease, consider cystotomy. Otherwise, continue with dissolution plan.

Given the appearance of the small bowel, primary GI disease such as inflammatory bowel disease, small cell lymphoma, or mast cell disease is suspected. Consider submitting a Texas A&M GI panel to screen further for chronic GI disease. If chronic GI disease is identified, consider GI biopsies either surgically or endoscopically to determine appropriate treatment plan. Patient's clinical signs may be attributed to primary GI disease.

Consider submitting a fPLI to determine if the patient's clinical signs may be due to pancreatitis. If the patient is diagnosed with pancreatitis, it is most likely secondary to patient's suspected GI disease.

Recommend staging, monitoring, and management of the kidneys per IRIS guidelines.

New Jersey Mobile
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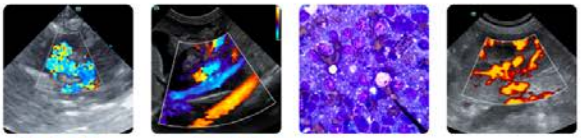

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Educational Teleconsultation Services™

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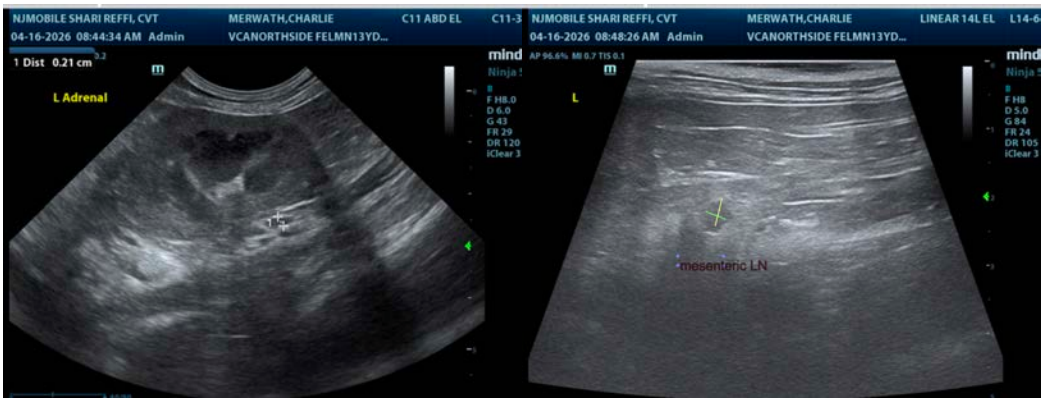

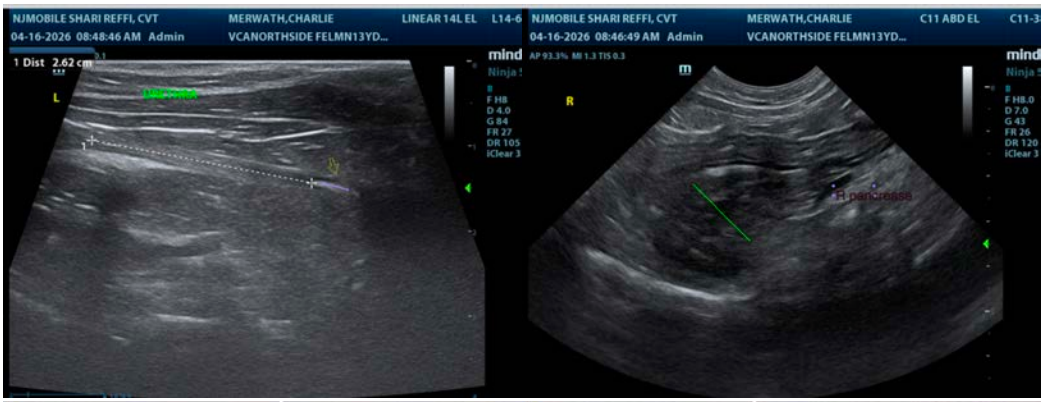

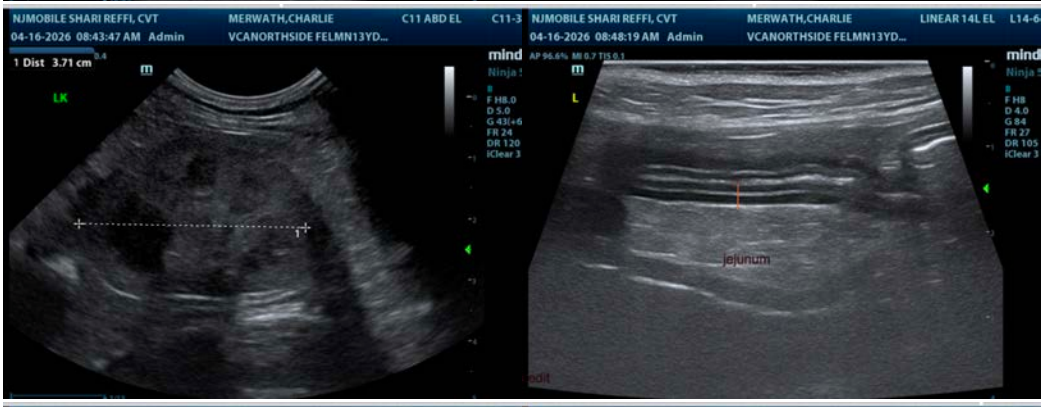

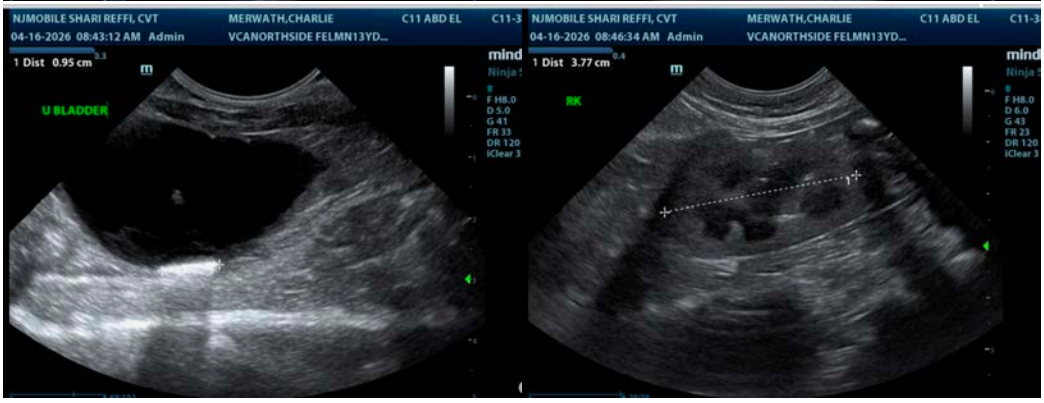

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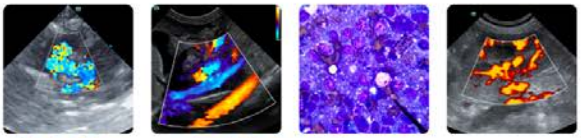

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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