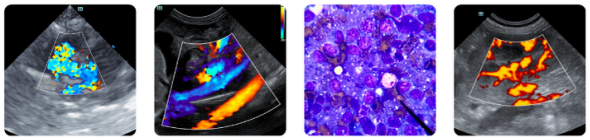


PATIENT

Cream Puff Healy

SPECIES

Feline

BREED

DLH

SEX

MN

AGE

13 years

WEIGHT

5.22 kg

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Dr. Mariusz Chmielinski

HOSPITAL NAME

Apex Veterinary Services Ltd.

REFERRING VET

Alpine 24/7 – ER Dr.

INVOICE

11992

DATE

5/20/2026

PRESENTING CLINICAL SIGNS

Cream Puff presented for abdominal ultrasound due to progressive hyporexia over several weeks and complete anorexia today. Previous history includes intermittent vomiting, occasional hairballs, and soft stool/diarrhea.

Abnormal PE/Chem/CBC/UA Results: T: 39.3°C, HR: 180 bpm, 1:1 pulse ratio, RR: 26/min, Respiratory Effort: Eupneic, MM/CRT: Pink, tacky / CRT <2 sec, Mentation: QAR, Hydration: ~6% dehydrated, BP: 149/132 Prior diagnostics noted mild amylase/CK elevation, hematuria/proteinuria, calcium oxalate crystals, possible urinary mineralization, and normal TT4/renal values.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder contains hyperechoic dependent debris. This debris at this time measures 12.0 mm in width and is causing mild shadowing. It appears the patient has numerous small uroliths, or sand present within the bladder.

The left kidney presents normal size with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia or ureteral dilation. Non-obstructive areas of hyperechoic mineralization/ nephroliths are noted creating hard shadowing. A representative nephrolith measures 2.8 mm in width. The left kidney measured 3.8 cm in length.

The right kidney presents normal size with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis. The right kidney measured 4.1 cm in length.

Adrenal Glands

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The left adrenal measures 3.7 mm.

The right adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The right adrenal measures 3.9 mm.

Spleen

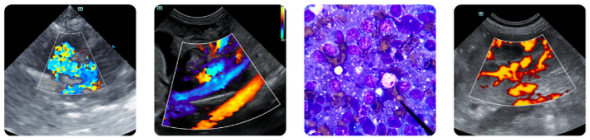
The spleen is diffusely hypoechoic with scalloped margins. It measures at the upper end of normal in size, measuring 9.0 mm in width.

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



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The visible stomach wall is normal in thickness and layering. The stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out. If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

Jejunum is normal in thickness and layering and measures up to 2.8 mm in width. Duodenal papillae is observed and measures 3.4 mm in width. The muscularis layer of the ileum is diffusely moderately to markedly thickened measuring 4.3 mm in width.

Colon contains normal contents with normal wall thickness.

Pancreas

The visible pancreas is diffusely hypoechoic with a nodular echotexture consistent with pancreatic hyperplasia. There is a mild to moderate amount of hyperechoic peripancreatic fat present. Patient appears to potentially clinically significant pancreatitis.

Free Abdomen

There is an enlarged hypoechoic, and rounded ileocolic, as well as mesenteric lymph nodes. The ileocolic lymph node measuring 8.6 mm x 3.4 mm in size. There is surrounding hyperechoic fat.

There is a scant pocket of free fluid near the head of the spleen.

ULTRASONOGRAPHIC FINDINGS

- Diffusely hypoechoic and nodular pancreas with a mild to moderate amount of hyperechoic peripancreatic fat. Patient appears to potentially have significant pancreatitis.
- Enlarged, hypoechoic, rounded ileocecal lymph node. This appears to be enlarged from a potential neoplastic cause. Differentials include infiltrative neoplasia such as lymphoma or mast cell disease, possibly metastatic neoplasia. However, this lymph node may be enlarged due to a reactive cause.
- Hypoechoic scalloped spleen. The appearance of the spleen may be normal patient variant or may be due to infiltrative neoplasia such as lymphoma or mast cell disease, less likely an infectious disease such as bartonellosis.
- Hyperechoic dependent debris in the urinary bladder with numerous small uroliths/sand.
- Hyperechoic, non-obstructive nephroliths noted in the left kidney causing hard shadowing.
- Scant pocket of free fluid near the head of the spleen.
- The thickened ileum is concerning for infiltrative GI disease. Possibly, but unlikely inflammatory bowel disease. Differentials could include infiltrative neoplastic such as GI Lymphoma, or mast cell disease.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not already performed, recommend submission fPLI to evaluate further for clinically significant pancreatitis. The patient's chronic pancreatic inflammation is most likely reactive and less likely to be a primary disease process.

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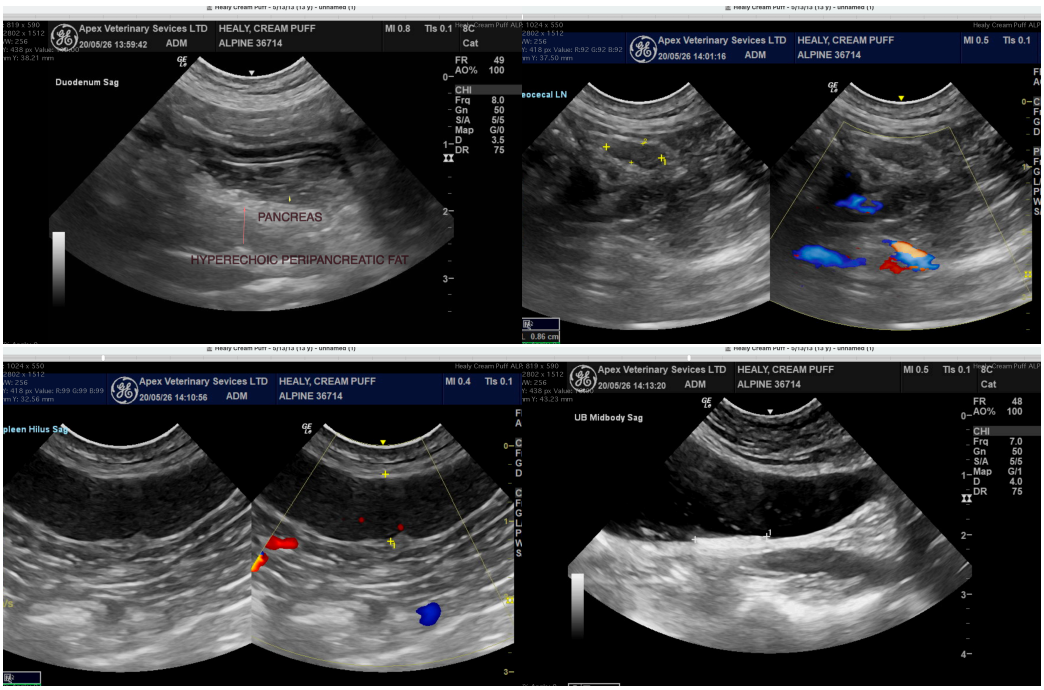
Recommend a fine needle aspirate of the spleen and submission for cytology to help rule out neoplasia or infectious causes.

If not already performed, urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

Also consider switching this patient to a urinary dissolution diet to determine if the debris can be dissolved with dietary management. Recheck ultrasound in 4 weeks is recommended. Upon recheck, if this has still not resolved after 4 weeks with dietary management and patient is still showing clinical signs, consider cystotomy and submission of debris/uroliths to University of Minnesota Urolith lab for analysis and to determine the appropriate treatment plan.

Recommend rechecking the nephroliths in the left kidney via ultrasound every 3-6 months to rule out possibility of moving into the ureter and causing hydronephrosis.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function. If cobalamin is low then consider GI biopsies (either surgically or endoscopically is possible) and submission for histopathology to determine the underlying cause of the changes within the ileum.



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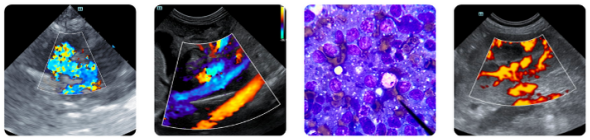

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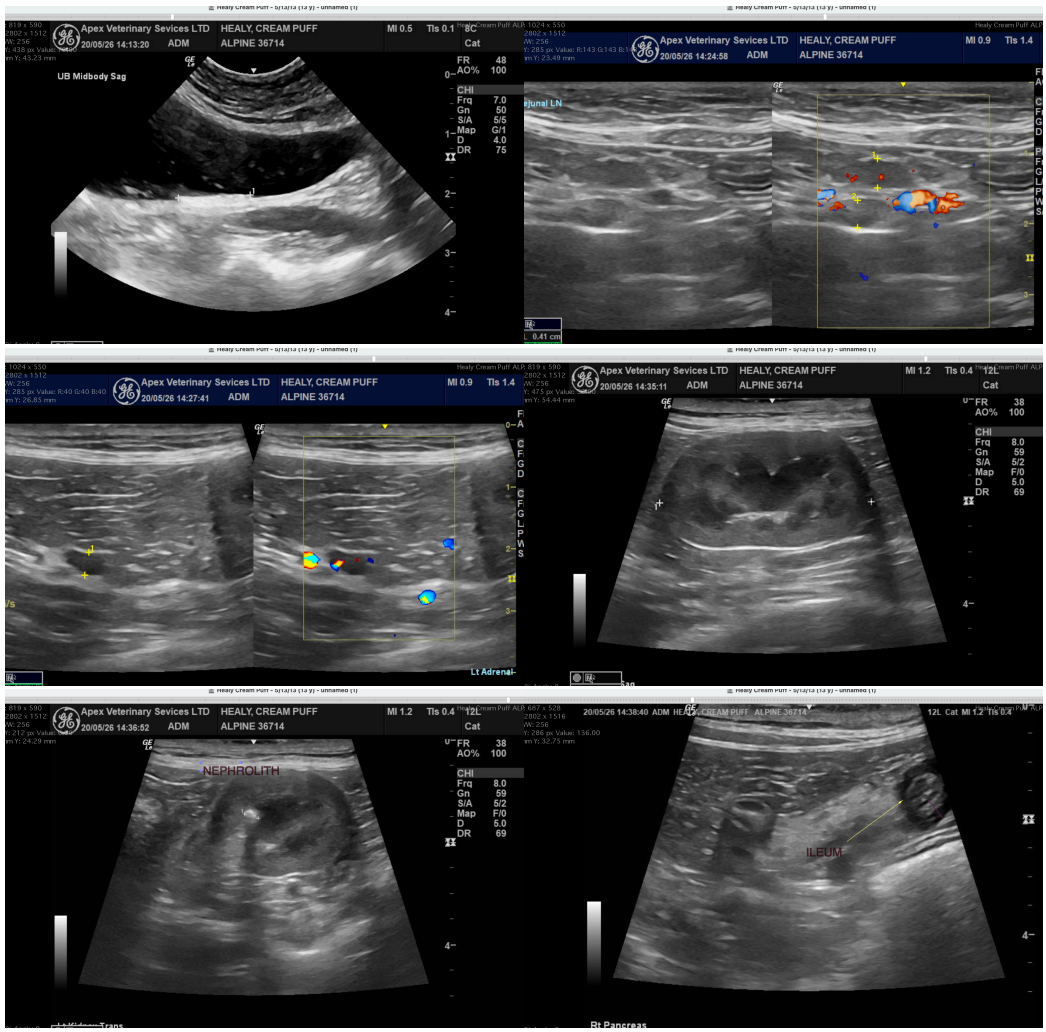

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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