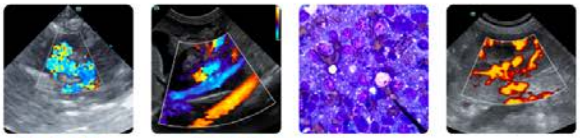


PATIENT

Steven Doornekamp

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

12 Years

WEIGHT

3.2 kg

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Buck Animal Hospital

REFERRING VET

Dr. Hirzer

INVOICE

75963

DATE

6/17/26

PRESENTING CLINICAL SIGNS

Jaundice, increased vomiting, suspect Triaditis, U/s done 5/8/2026. Current Medications: Clavaseptin 62.5mg, Metronidazole 50mg, Ursodiol 50mg

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 right kidney presents normal size (5.0 cm). The cortex is diffusely hyperechoic, and there appears to be mild decreased loss of corticomedullary distinction.

The left kidney presents normal size (5.0 cm). Mild pyelectasia is present. The renal pelvis measures approximately 4.5 mm in width. The cortex is diffusely hyperechoic, and there appears to be mild decreased loss of corticomedullary distinction. There are two hyperechoic nephroliths present in the region pelvis measuring 3.1 mm and 1.6 mm in diameter.

Adrenal Glands

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

The left adrenal gland is not clearly visualized on this exam.

Spleen

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

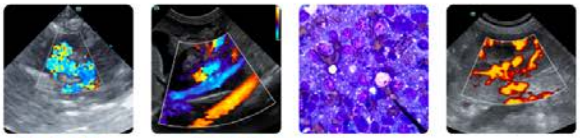
Liver

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder contains only a small amount of bile. The gallbladder wall is hyperechoic and appears subjectively thickened, measuring approximately 2.0 mm in width. There is a moderate amount of echogenic debris present within the lumen of the gallbladder. Bile duct dilation is not seen on this exam.

Gastrointestinal

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,



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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.

The small intestines have normal wall layering and thickness. However, small bowel thickness cannot be determined, given the distention of the bowel. Diffusely, the small bowel is markedly distended with ingesta. No evidence of a mechanical obstruction seen on this exam. Colon contains normal contents with normal wall thickness.

Pancreas

The pancreas is prominent and mottled compared to the surrounding isoechoic mesentery. No evidence of nodules or cystic lesion. No evidence of regional mesenteric inflammation. No dilated pancreatic ducts noted. However, the entire pancreas is not visualized on this exam given the large amount of ingesta within the GI tract causing a significant amount of shadowing throughout the abdomen.

Free Abdomen

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

ULTRASONOGRAPHIC FINDINGS

- Urinary bladder debris.
- Hyperechoic renal cortices and decreased corticomedullary distinction bilaterally.
- Hyperechoic hepatomegaly.
- Thickened gallbladder wall and gallbladder debris.
- Full stomach and markedly ingesta distended small bowel.
- Prominent, mottled pancreas.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The hyperechoic cortex of both kidneys is most likely lipid deposition and is suspected to be insignificant at this time. The mildly decreased corticomedullary distinction bilaterally may indicate early chronic kidney disease. Recommend full staging, monitoring and managing of the patient per IRIS guidelines. The left kidney renal pelvic dilation and nephroliths may suggest possible ureteral obstruction. No definitive obstruction seen on this exam. Consider further advanced imaging such as CT scan to determine if an obstruction is present.

The hyperechoic dependent urinary bladder debris seen on the previous ultrasound from May 2026 is not seen on this exam. However, there is a marked amount of echogenic suspended debris within the urinary bladder. If not already performed, recommend urinalysis. If active urine sediment, recommend urine culture and antibiotic sensitivity.

If patient was fully fasted for this exam, suspect severe gastric ileus and recommend treating supportively. Given the large amount of food material throughout the GI tract, there is concern that possible primary GI disease may be contributing to the patient's problems. Consider submitting GI panel to screen further for chronic enteropathy. If chronic enteropathy is identified, consider GI biopsies either surgically or endoscopically.

The findings of the liver and gallbladder are similar to those seen on previous ultrasound from May 2026. The appearance of the liver is non-specific, consistent with vacuolar hepatopathy. Suspect hepatic

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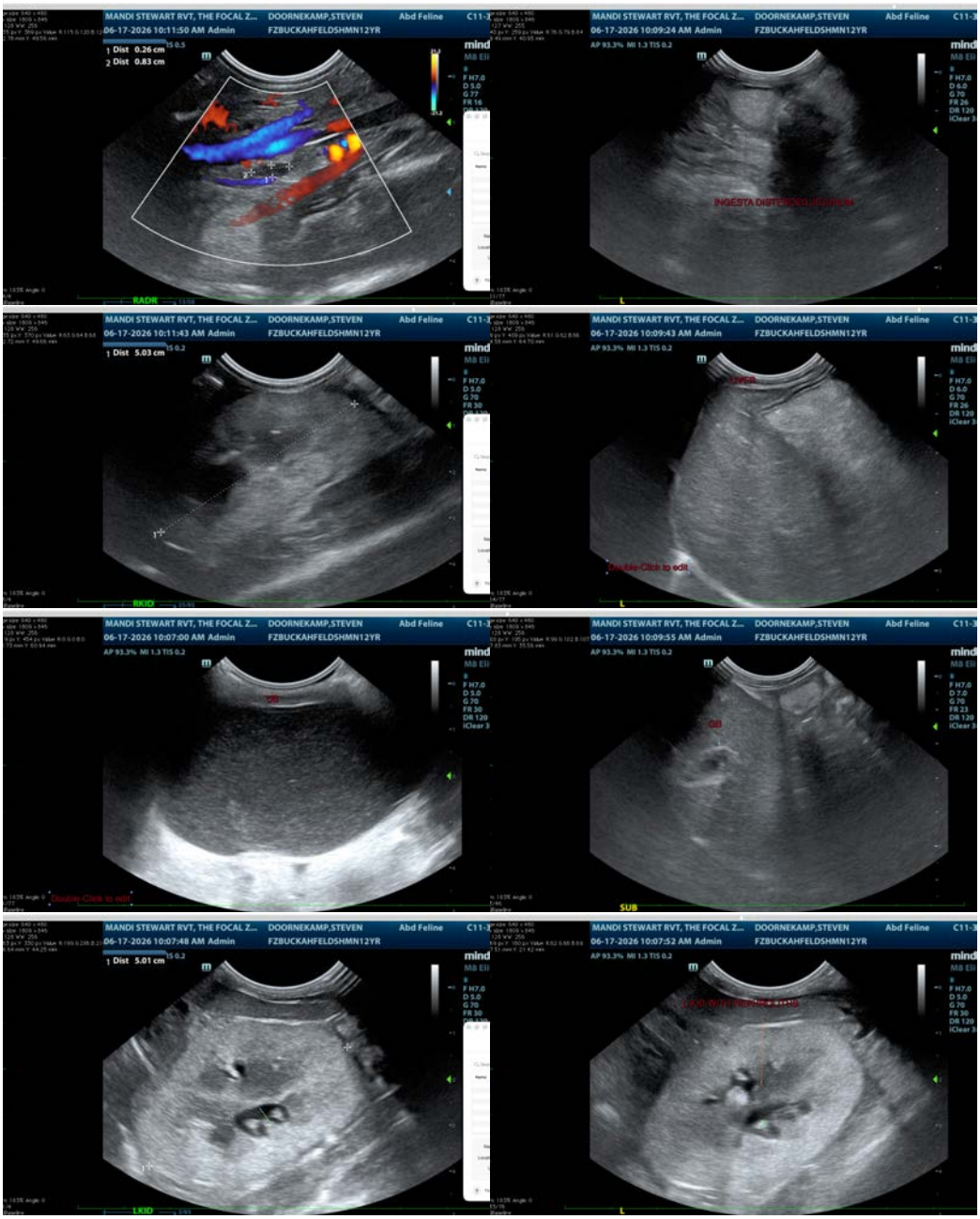
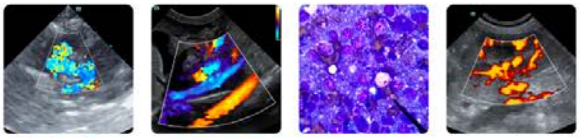
lipidosis, possible inflammatory or infectious disease, infiltrative neoplasia, or possibly other hepatopathy. If not already performed, recommend a fine needle aspirate of the liver to help further characterize changes seen. If inconclusive, consider liver biopsy.





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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