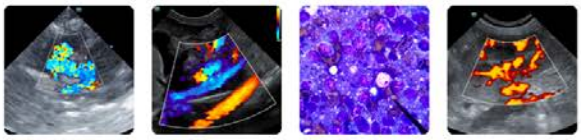


DATE

1/20/26

PATIENT

Winston Baran

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

7/1/20

WEIGHT

11.4 lbs

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Chadwell Animal Hospital

REFERRING VET

Dr. Schaupp

INVOICE

72298

PRESENTING CLINICAL SIGNS

Patient History: Chronic off and on vomiting. PE is unremarkable. Good appetite. Good weight. Empirically treated for IBDz at Edgewood with transdermal Prednisone in June 2025 post AUS. He is currently having a flare up where he has vomited every day for the past 9 days. Vomit is usually brown liquid, but today was all his breakfast. Owner reports that he is acting "normally" otherwise.

Current Medications: Prednisolone 5 mg tab PO BID - initially worked well, started in Nov 2025, Famotidine 10 mg PO QD in pm - this helped also, started end of Dec2025, Maropitant 24 mg 1/2 tab PO QD - not currently using. Last used Dec 8 2025.. Was using this to quickly stop vomiting, not for long term use.
Labwork Results: Labwork attached, reported as: Blood work from Nov 2025 - wnl. Some elevation in glucose (stress likely).
Date of Previous IntraPet Ultrasound: 6/25/25. See attached.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mildly echogenic urine. There is a small amount of suspended echogenic debris. Generally, the bladder wall appears of normal thickness with a smooth mucosal surface. There is a focal area of irregularity at the apical ventral bladder wall, measuring 0.34 cm x 1.08 cm. The appearance is most consistent with focal thickening, although an echogenic cystic region or similar cannot be ruled out.

The left kidney has a normal shape and size (3.62 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.86 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

*Current Prednisone use could result in mild atrophy.

Spleen

The spleen is subjectively normal in size (0.64 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver
The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

Gastrointestinal
The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.26 cm. Jejunum wall measures 0.24 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas
The right limb of the pancreas is prominent and hypoechoic as compared to the surrounding isoechoic mesentery. There is regional mesenteric inflammation in the right cranial abdomen associated with a hypoechoic nodule/mass. The mas could be associated with the cranial pole of the right limb or could be an overlapping LN/mass in the region.**see more under other

Free Abdomen
Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is no evidence of a diffuse lymphadenopathy. The omentum is hyperechoic in the right cranial abdomen around the hypoechoic lesion (*see under other).

Other
There is a small, hyperechoic nodule visualized in the left cranial abdomen measuring 0.70 cm x 0.64 cm. No association with other structures is clearly visualized. This could represent a small lipoma, an early bates body, etc. Continued monitoring is recommended.

There is a larger hypoechoic, mildly vascular mass/nodulevisualized in the right cranial abdomen measuring 1.26 cm x 1.58 cm. This structure is in close proximity to the cranial duodenal flexure and the cranial aspect of the right limb of the pancreas. There is surrounding reactive mesentery. This is concerning for a nodule/mass asscoated with the pancreas/or an overlapping LN/nodule.

ULTRASONOGRAPHIC FINDINGS

- Suspended echogenic debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.

- Focal irregularity at the cranioventral bladder wall – Findings could be consistent with focal thickening/cystitis or an echogenic cystic lesion. This could be in the region of a urachal anomaly (cyst, small unseen diverticula, etc.).

- Prominent right limb of the pancreas – Findings could be consistent with mild pancreatic remodeling or mild chronic pancreatitis.

- Hyperechoic nodule in the left cranial abdomen – This has the appearance most consistent with a benign structure (lipoma, unmineralized bates body, etc.). Recommend continued monitoring.

- Hypoechoic mass effect in the right cranial abdomen – findings are concerning for a pancreatic lesion, a LN or other mass effect is also possible.

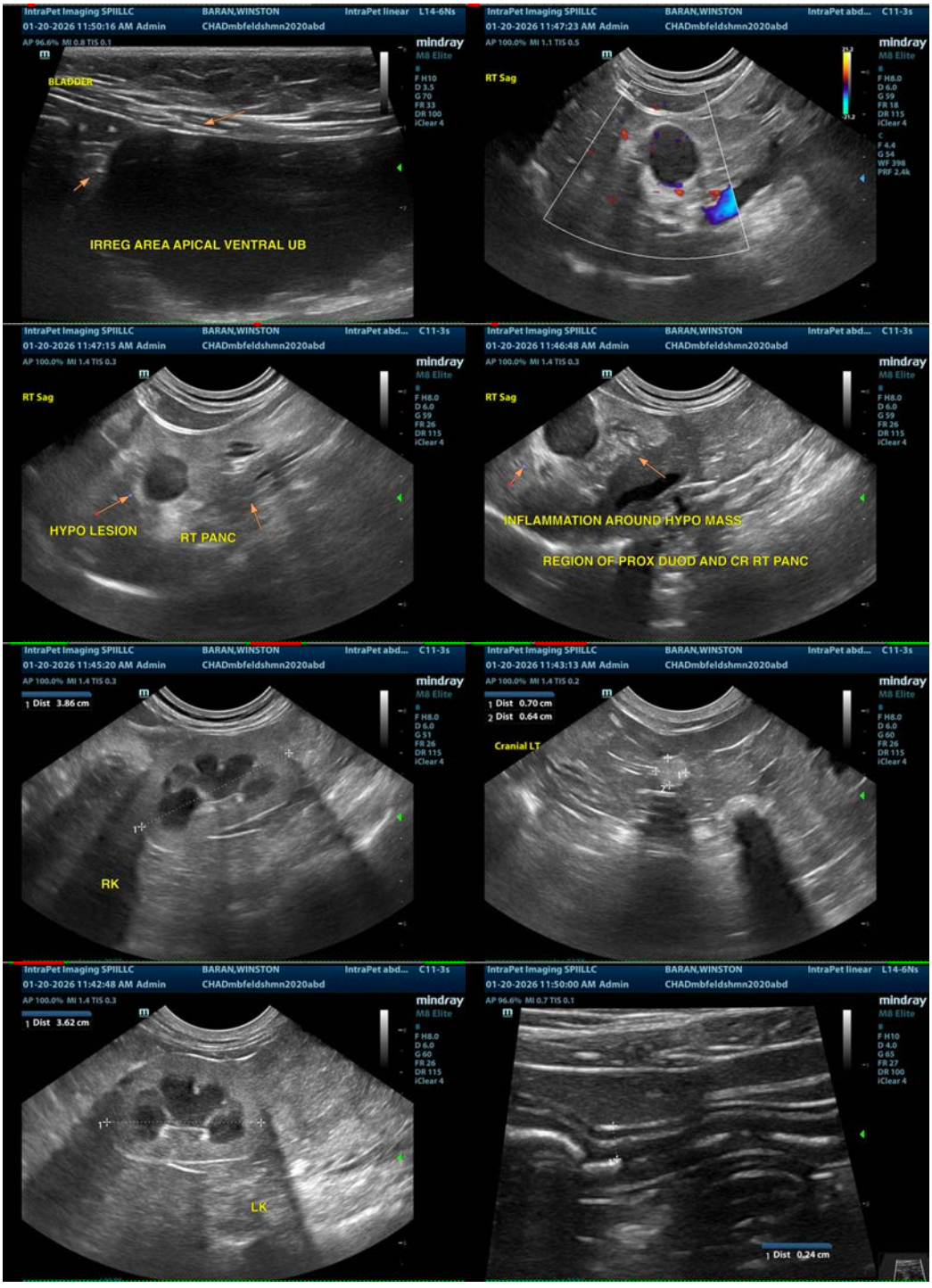
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a distinct, mildly vascular, hypoechoic structure in the right cranial abdomen. This is in the location of the cranial duodenal flexure/cranial pancreas with surrounding inflammation. A direct association with the bowel is not clearly visualized. This appears to overlap the cranial aspect of the right pancreas and could be associated with a pancreatic lesion (benign-hyperplasia, adenoma etc… or carcinoma/other).
It is very possible that the surrounding inflammation and the proximity to the duodenum is contributing to the acute vomiting reported.
If a safe window for sampling is available, consider a fine needle aspirate of this structure. If this is a lymph node, it could be highly reactive or a neoplastic lymph node. If this is associated with the pancreas, a benign or neoplastic nodule/mass effect is a possibility with mild surrounding inflammation/pancreatitis. If cytologic sampling is not possible, your options could include advanced imaging of the cranial abdomen, treatment for pancreatitis, and reevaluation with ultrasound (recheck in 2-3 weeks, sooner if concerned), or as a last resort, exploratory surgery.

There is focal irregularity at the cranioventral bladder wall. This has the appearance most consistent with focal wall thickening, but a slightly echogenic cystic lesion or similar cannot be ruled out. This is potentially in the region of a urachal anomaly. Recommend a urinalysis and culture. If the patient is asymptomatic and no infection is present, recommend continued monitoring (recheck in 2-3 months). If there is a history of recurrent urinary tract infections or similar, a contrast study may be beneficial to further evaluate.

Correlate today's findings with a PLI level, looking for additional evidence of pancreatitis.

The gastrointestinal tract appeared relatively normal on today's exam with no focal lesions identified. This does not exclude the possibility of underlying enteropathy, particularly with concurrent steroid use.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RT Sag
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REGION OF PROX DUOD AND CR RT PANC
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Cranial LT
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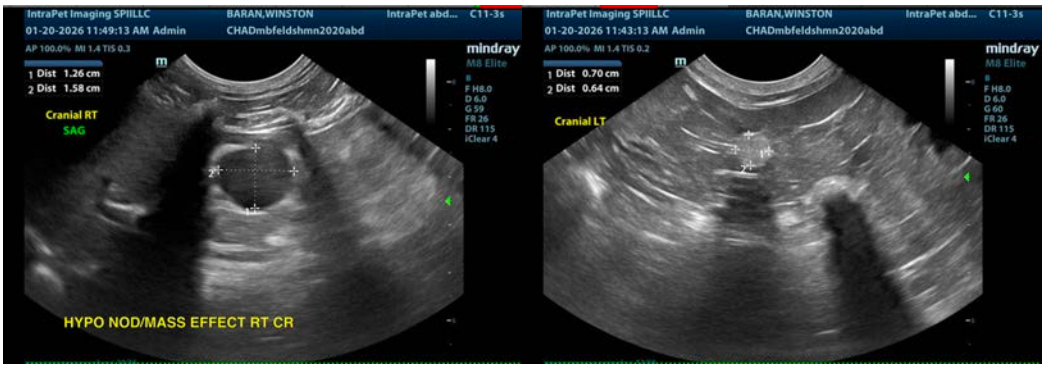
1 Dist 0.24 cm



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.

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