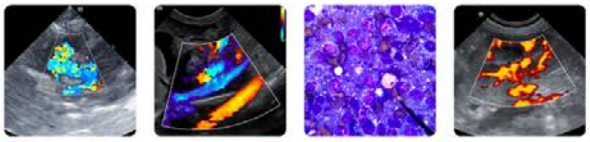


PATIENT

Zebra Tompkins

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

7 Years 3 Months

WEIGHT

11.0 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Katelyn Mazzochette, DVM

HOSPITAL NAME

Airpark Animal Hospital

REFERRING VET

Grace Kennedy, DVM

INVOICE

72103

DATE

1/8/26

PRESENTING CLINICAL SIGNS

Several month history (first examined for it 7/2025) of chronic vomiting. Dewormed and started i/d diet. Did pretty well on i/d diet for awhile, but began to not eat it that well and also started vomiting a little more, mixed food, bile and sometimes hair balls. Nothing else specifically on exam or clinically happening at home. ***Sedated with dexdomitor and butorphanol for scan***

Abnormal PE/Chem/CBC/UA Results: Everything normal HCT 37% Creatinine 1.1 mg/dL TP 6.8 g/dL (normal 6.3-8.8) Albumin 3.5 g/dL (normal 2.6-3.9) proBNP 24 Total T4 2.2 ug/dL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mild primarily suspended echogenic debris present. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (3.99 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 (3.97 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 left adrenal gland is normal in size measuring 0.40 cm at the cranial pole and 0.47 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

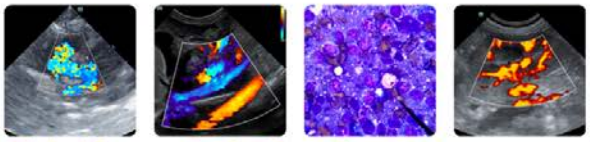
The right adrenal gland is “plump” measuring 0.51 cm at the cranial pole and 0.43 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (0.57 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.



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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 fluid/shadowing ingesta. 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 uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. Bowel loops follow a typical curvilinear path with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.23 cm. Jejunum wall measures 0.23 cm. Visualized peristalsis appears appropriate. There are some segmental areas of small intestine that appear more thickened with a prominent muscularis layer, measuring up to 0.28 cm.

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 pancreas is prominent and mottled compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is no significant lymphadenopathy. A small cluster of mesenteric lymph nodes is visualized measuring 0.25 cm and 0.24 cm. The omentum is normal in echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Mild suspended echogenic debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.
- Pancreatic changes most consistent with chronic pancreatic remodeling.
- Areas of mild small intestinal thickening with prominent muscularis – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes observed associated with the GI tract are relatively mild, but this does not rule out the possibility of a primary gastroenteropathy. Consider the following:

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)

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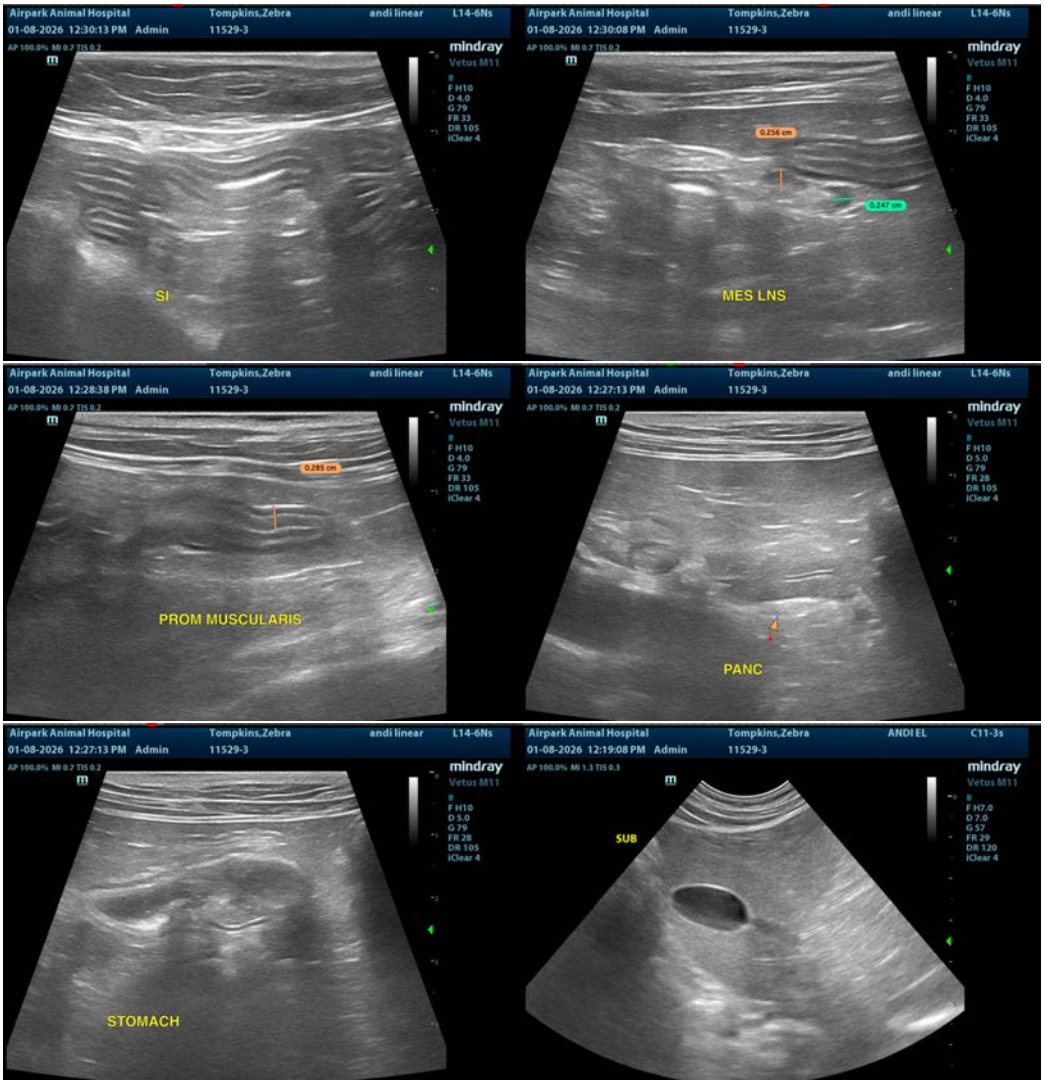
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.

If symptoms are persistent, consider upper GI endoscopy to further evaluate the GI tract and to obtain biopsies.



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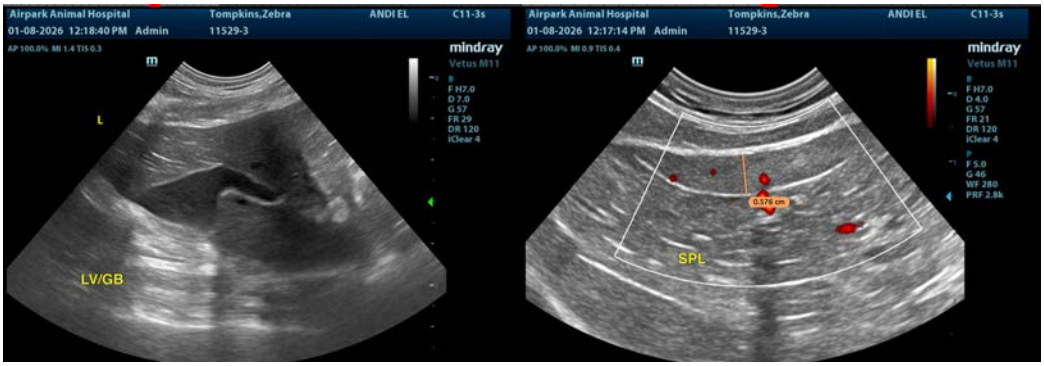

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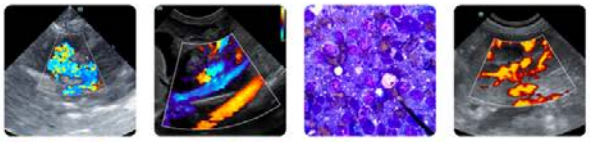

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@sonopath.com