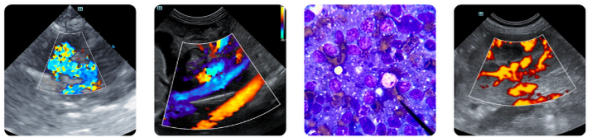


PATIENT

Rigby Corbin

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

12.5 years

WEIGHT

4.3 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary Emergency Center

REFERRING VET

Dr. Logan Law

INVOICE

10760

DATE

11/19/2025

PRESENTING CLINICAL SIGNS

Has had chronic vomiting since June 2025 with hairballs. July vomiting increased to daily. Was seen at rdvm and started on cat lax. vomiting frequency decreased. Mid to end of October vomiting resumed with 1-2 times a day. seen at rdvm on 11/4, diagnosed as hyperthyroid. 11/4 radiographs were done, ingesta vs FB?. started on methimazole transdermal. Vomiting every day 1 time for 1 week. hyporexia for 7 days. eating very small amounts of wet food and treats, not eating dry food. possible diarrhea yesterday and/or today, (owner has another cat who is diabetic with pancreatitis). Since Sunday (3 days) of less stool in litter box. Seen again today at rdvm for fasted radiographs, concern for FB +/- obstruction with more gas noted. Is known to chew on plastic and will shred tissues. concern for weight loss 6/2025 was 11.14 pounds (5.06 kg). *Concern for gastritis, gi FB, IBD, other.

Abnormal PE/Chem/CBC/UA Results: *PE: thin BCS 4/9, thickened small intestinal loops palpable, non-reactive to abdominal palpation *11/4 rdvm: T4 5.6 H; 11/7 T4 3.5 *11/4 rads rdvm: possible foreign material in stomach at pylorus on left lat. ingesta also in stomach. slight thickening of the intestines. rest of abd appeared WNL *11/19 rdvm rads: stomach appears empty. colon is empty with some gas present in SI. possible soft tissue opacity present in cranial mid abd. rest of abd WNL. 11/19 Shores cbc: wbc 17.68 H, neu 14.62 H chem: creatinine 0.7 L, calcium 7.8 L, TP 5.6 L, glucose 162, K+ 3.5 L.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. 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 cystic calculi.

The left kidney has a normal shape and size (4.17 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.

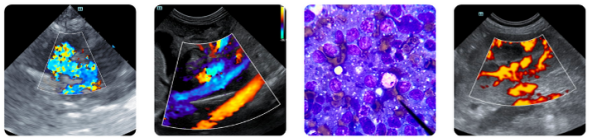
The right kidney has a normal shape and size (4.52 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.45 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 normal in size measuring 0.47 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



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The spleen is subjectively large in size (1.15 cm.) The spleen echotexture is heterogenous and mottled, 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. The pylorus is somewhat prominent, measuring 0.47 cm in wall thickness with intact wall layering. There's mild shadowing and gas visualized at the level of the pylorus. No evidence of a a definitive obstruction is visualized.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is increased (duodenum measures 0.37 cm, and the jejunum measures 0.27 cm). Bowel loops follow a typical curvilinear path. Visualized peristalsis appears appropriate. The muscularis laeyr appears diffusely prominent. The proximal duodenum appears mildly fluid distended.

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 left limb of the pancreas is prominent, hypoechoic and mottled with some mildly reactive mesentery most consistent with mind pancreatitis. There is no evidence of nodules or cystic lesions.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is no significant lymphadenopathy. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is mildly, diffusely hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- Large, mottled spleen. The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.
- Prominent, hypoechoic left limb of the pancreas. Findings are most consistent with mild pancreatitis.
- Prominent/mildly thickened pylorus. Findings could be consistent with imaging artifact, mild inflammation, etc. No definitive obstruction was visualized.

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- Diffusely thickened small intestine with a 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 stomach appears empty and the pylorus appears slightly prominent with some gas and a mild amount of fluid at the pyloroduodenal junction. Proximal duodenum is mildly fluid distended, but evidence of a definitive obstruction is visualized. There is diffuse generalized small intestinal thickening and a prominent muscularis layer. These changes are most consistent with inflammatory type change, although early neoplastic change cannot be ruled out.

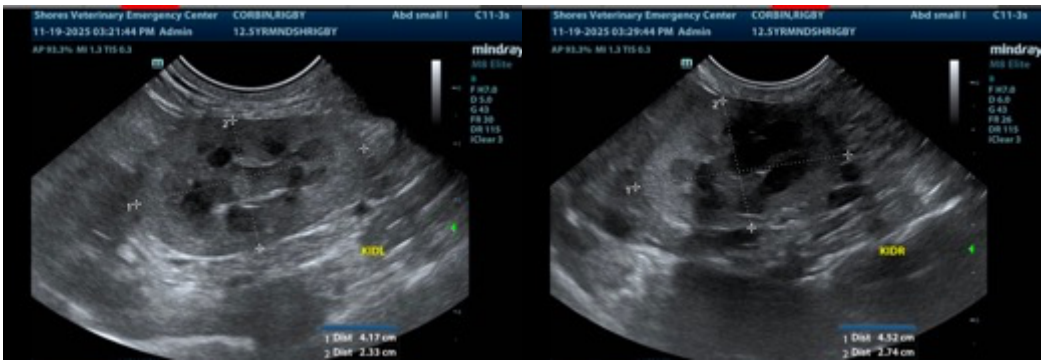
Additionally, the left limb of the pancreas is prominent and hypoechoic with a small amount of surrounding reactive mesentery, possibly consistent with significant pancreatic remodeling +/- mild pancreatitis. Correlate with a PLI level. If this is significantly elevated, recommend empirical treatment for pancreatitis. Otherwise consider the following:

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks.)
- 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, biopsies are likely necessary. Fi there is significant concern for a gastric foreign body, you could consider upper GI endoscopy to further evaluate and to obtain biopsies of the proximal GI tract. Additionally, surgical biopsies could be considered, which would provide the ability to evaluate the full extent of the GI tract.

Alternately, you could consider repeat imaging in the future, looking for the progression of today's changes.

The spleen appears subjectively mildly enlarged and mottled. Options moving forward would include a fine needle aspirate or continued monitoring with ultrasound.



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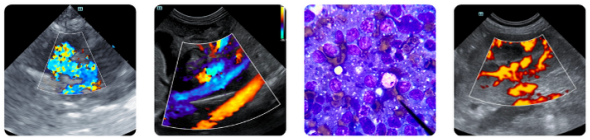

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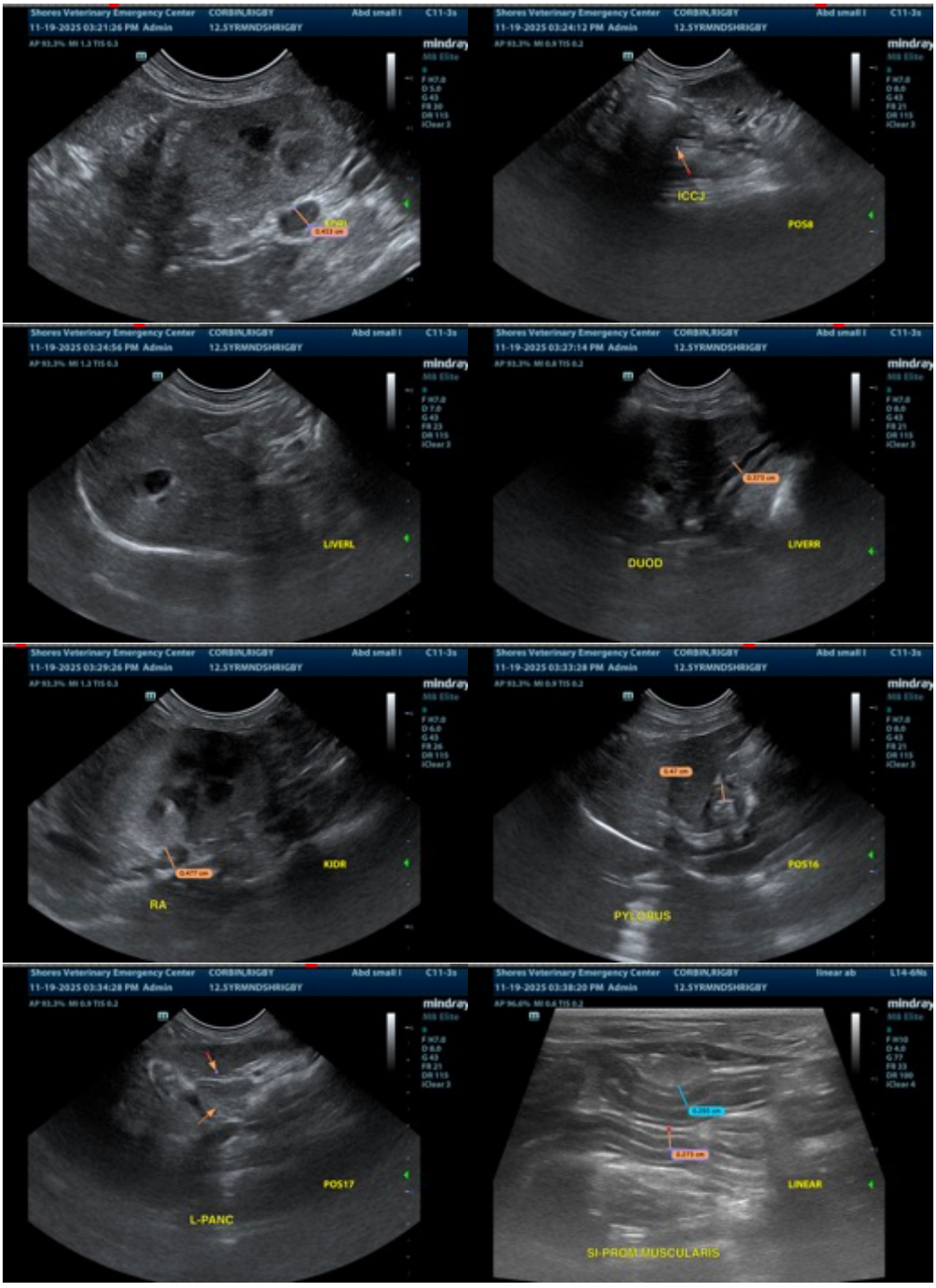

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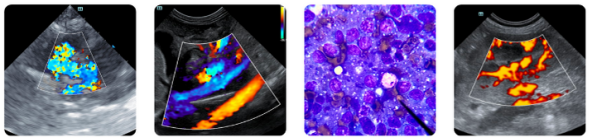

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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