PATIENT

Maia Swindle

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

7 years 7 months

WEIGHT

12.83 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

VCA Feline Animal Hospital

REFERRING VET

Dr. Smith

INVOICE

10918

DATE

12/10/2025

PRESENTING CLINICAL SIGNS

12/4/2025 History - Presenting concerns: Pt appetite decrease resolved with antibiotic administration. However, began vomiting 2 days after stopping antibiotics. Vomiting yellow liquid 2-3x daily, but appetite is wnl. Duration- On and off/Continuous At home care attempted? What kind? C/S/V/D? No Diet: FF, RC HP and RC HP + GI Supplements: none Medications: Amoxiclav d/c'd last saturday, gabapentin this AM. Indoor/Outdoor: indoor only Parasite prevention: none ***Chronic vomiting- weight loss- 11/20/2025- History - Presenting concerns: Only licking gravy off of food since tuesday. O notes pt had vomiting episode last Friday. Pt seen at Caughlin vet Ranch. Labs showed mild neutrophilia, stress hyperglycemia, mild hyperglobulinemia. Rads wnl. Seemed to do well with cerenia injection IH until Tuesday. O notes pt has not defecated since Tuesday either. Duration- On and off/Continuous.

Abnormal PE/Chem/CBC/UA Results: RADS attached to supplement- CBC wnl. Chem - BG 149 mg/dL (r/o persistent stress hyperglycemia).

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 (3.75 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 (3.81 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 0.39 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 0.38 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 (0.84 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.

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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. The duodenum measured as normal (0.21 cm in wall thickness) and the jejunum measured as normal (0.22 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. The cecum wasll was slightly prominent at 0.23 cm.

Pancreas

The pancreas is slightly prominent and hyperechoic. 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 are occasional visible/mildly prominent lymph nodes. Examples near the ileocecal junction measure 0.52 cm and 0.24 cm in diameter. Pancreaticoduodenal lymph node measures 0.59 cm in diameter. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Occasional prominent/reactive mesenteric lymph nodes.
- Pancreatic changes most consistent with chronic pancreatic remodeling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Today's scan is relatively normal. No focal GI lesions are visualized to explain the chronic vomiting reported. Unfortunately, there are many differentials for chronic vomiting which cannot be definitively diagnosed by ultrasound alone.

Given the history of less vomiting with antibiotic use, dysbiosis could be a concern. Consider a GI panel to Texas A&M for a qualitative PLI/TLI, cobalamin, and folate to further evaluate for an underlying enteropathy, dysbiosis, pancreatitis, etc. Recommend probiotic therapy and consider a

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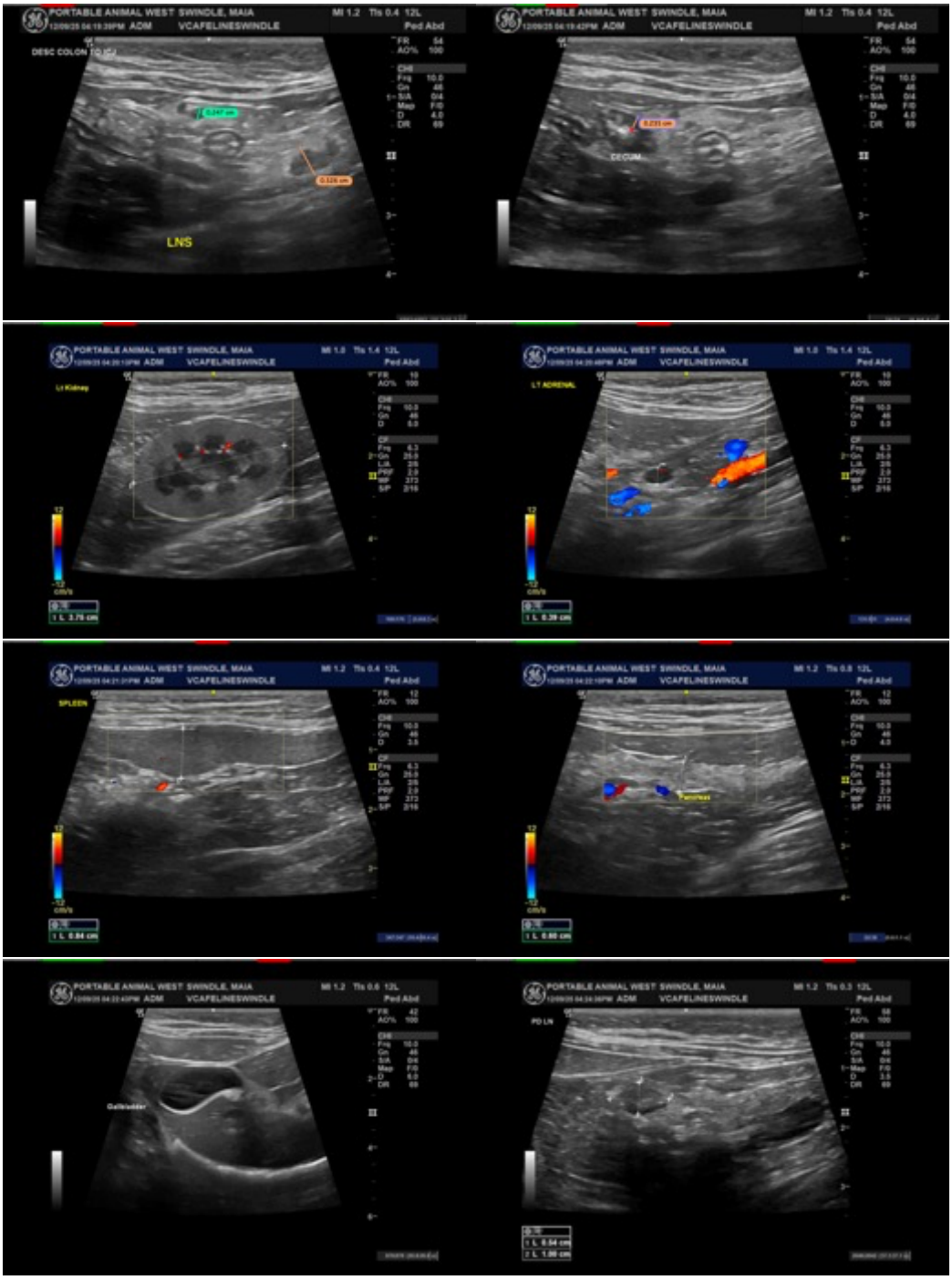
hydrolyzed protein prescription diet. If symptoms are persistent despite taking these measures, biopsies of the GI tract may eventually be warranted.

Additionally, if symptoms are worsening, you could consider repeat imaging in the future looking for the progression of today's lesions.



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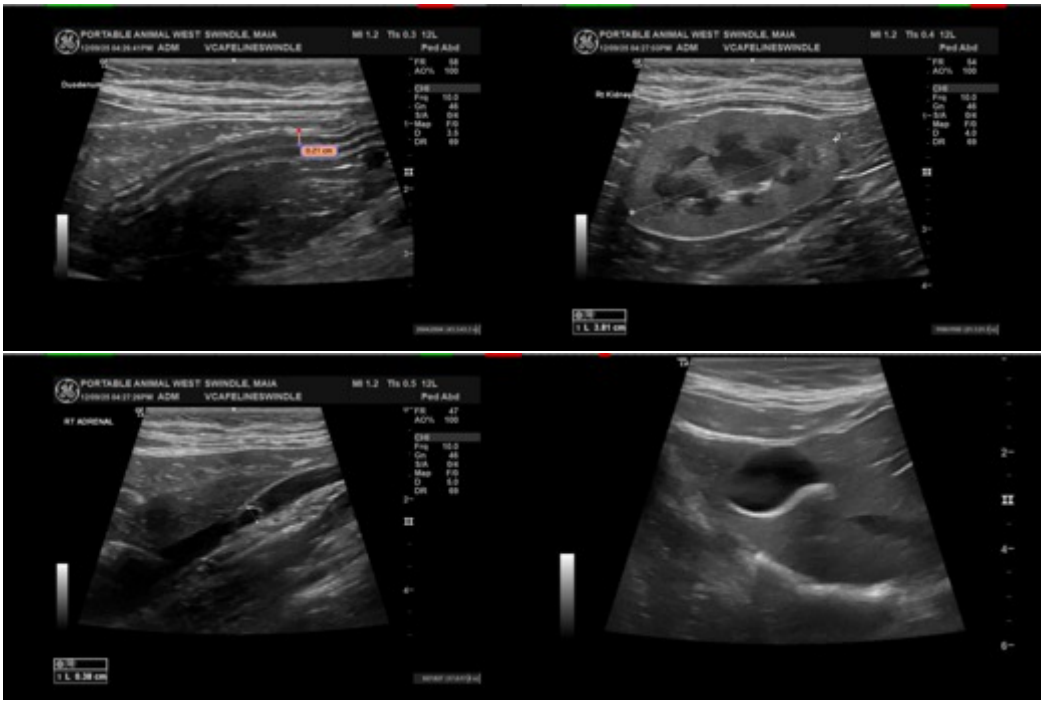

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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