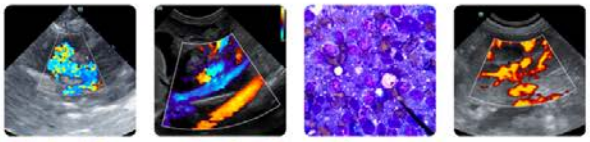


PATIENT

Hamilton Basden-Moroz

SPECIES

Feline

BREED

Highland Lynx

SEX

Neutered Male

AGE

5 Years

WEIGHT

14.25 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Casper

HOSPITAL NAME

Hometown Animal Hospital (Florida)

REFERRING VET

Dr. Gavin Casper

INVOICE

72525

DATE

12/12/25

PRESENTING CLINICAL SIGNS

Chronic hx of intermittent weekly vomiting/regurg, recently becoming more frequent. Prev dx w/ idiopathic hypercalcemia after w/u and cystotomy for CaOxDih uroliths. P is on combination of c/d and purina one live clear

Abnormal PE/Chem/CBC/UA Results: Recent results attached. Hypercalcemia has resolved as per prev panel. No abn on most recent UA. Fecal - nPS. Planning for GI panel + cortisol

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 (4.52 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.

The right kidney has a normal shape and size (4.58 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 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.

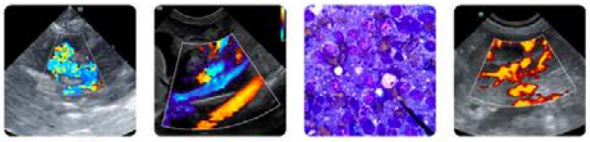
Spleen

The spleen is subjectively normal in size (0.72 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 duct appears mildly dilated. The common bile duct is lost to visualization distally.



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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 0.20 cm. Jejunum wall measures 0.17 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 body of the pancreas is prominent and hypoechoic as 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 a prominent lymph node visualized near the ileocecal junction measuring 0.38 cm x 0.72 cm. A jejunal lymph node is visualized measuring 0.25 cm. The omentum is of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Prominent, hypoechoic pancreas – Findings are most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.
- Occasional prominent mesenteric lymph nodes – Findings are most consistent with reactive lymph nodes. Early neoplastic change cannot be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the GI tract to explain the vomiting and regurgitation reported. Unfortunately, this does not rule out underlying gastrointestinal disease, as not all causes for vomiting can be diagnosed by ultrasound alone. Consider the following:

- Recommend 3-view thoracic radiographs to evaluate the esophagus and thoracic cavity. A barium swallow could be considered to look for any abnormalities in the flow of barium or motility issues, etc.
- Recommend a hydrolyzed protein prescription diet.
- A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.
- Recommend chronic probiotic therapy.

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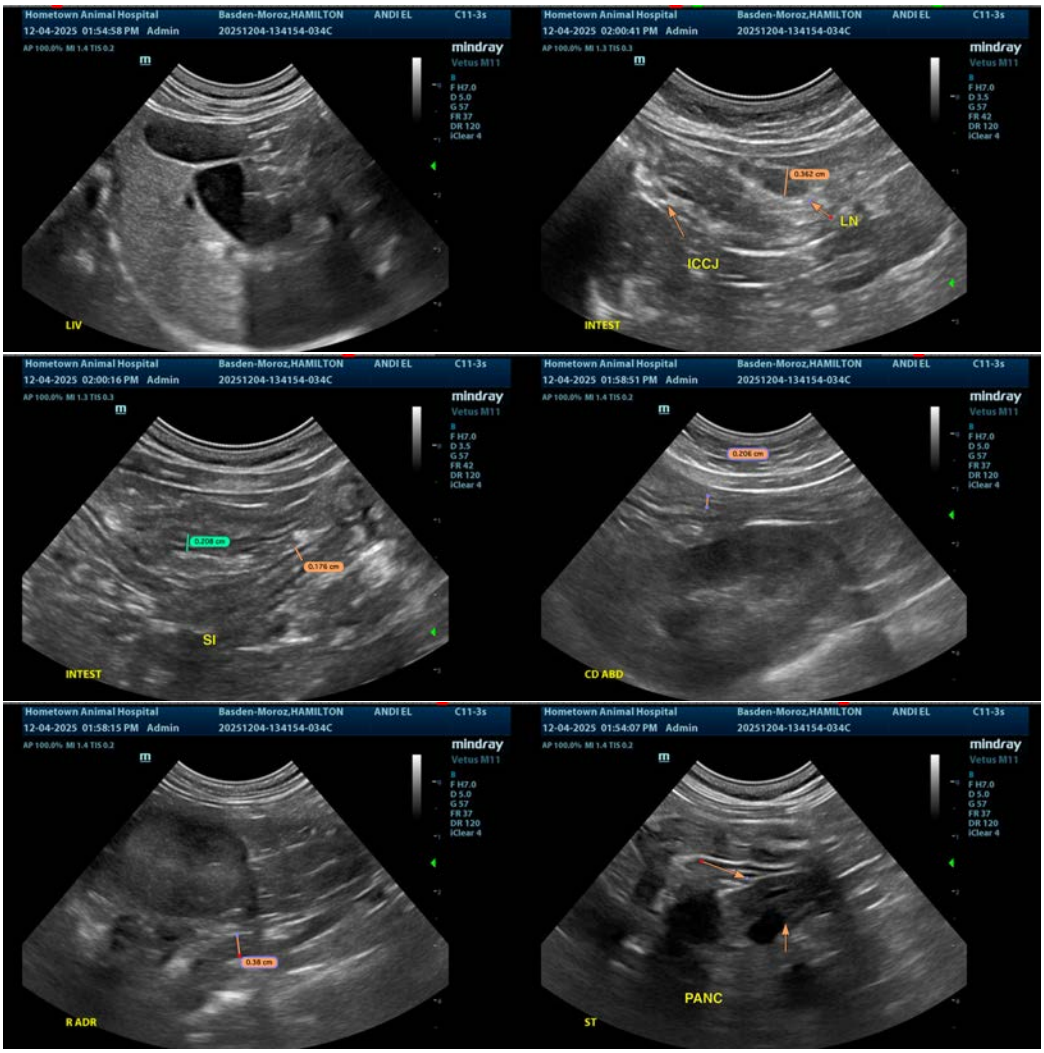
If the PLI is significantly elevated, consider treatment for chronic pancreatitis, considering the pancreatic changes observed. If symptoms are persistent and a primary enteropathy is strongly suspected, consider obtaining GI biopsies for further evaluation (possibly endoscopic to evaluate the esophagus and stomach as well?).

Additionally, repeat imaging in the future could be considered, looking for possible progression of a lesion or development of new lesions.



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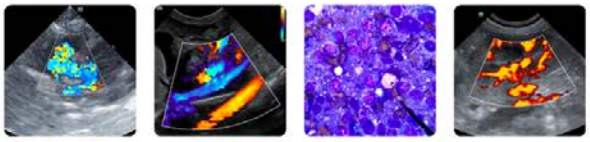

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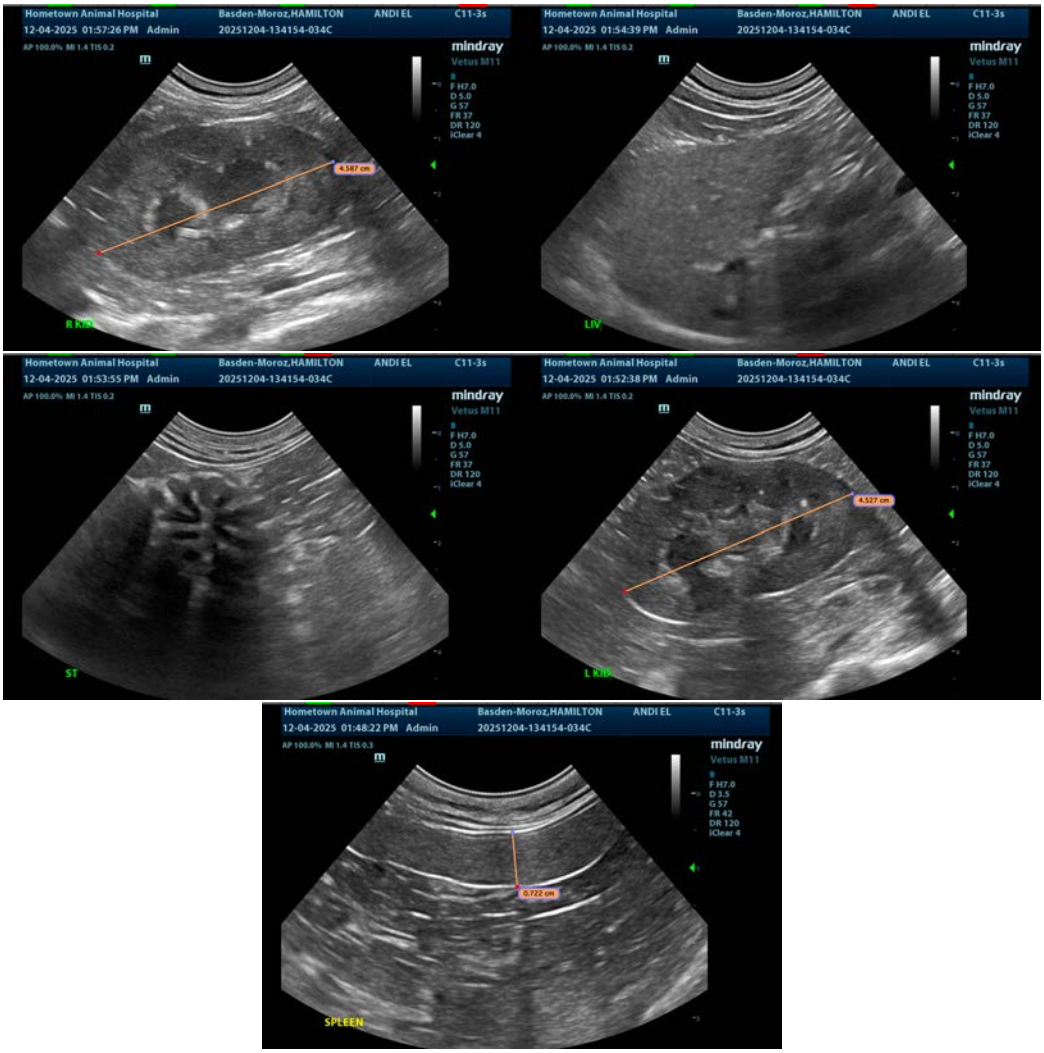

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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