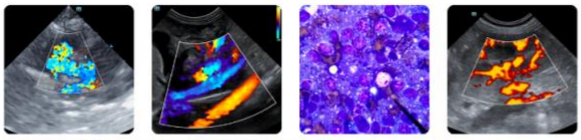


DATE

12/19/25

PATIENT

Dobby Tanner

SPECIES

Feline

BREED

Sphynx

SEX

Neutered Male

AGE

12/18/2018

WEIGHT

10.4 pounds

INTERPRETED BY

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

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Reynolds

INVOICE

12772

PRESENTING CLINICAL SIGNS

Patient History: Dobby presents for evaluation of vomiting refractory to oral Cerenia, anorexia, and diarrhea. Patient History: - Two housemates, Footie and Farkus, recently had similar signs of vomiting but are reportedly improving with medical management. - Dobby's signs began over the weekend, concurrent with his housemates. - History of events: - Sunday: Client administered half a Cerenia tablet at home. - Monday: Examined at rDVM (Chadwell). Received medications (unspecified, but similar to housemate's, excluding an antibiotic). That evening vomited 10-15 minutes after receiving oral Cerenia with his heart medications. The pill was not seen in the vomitus. - Tuesday: Continued vomiting. Vomited after oral Cerenia administration (pill not seen in vomitus). Diarrhea began on this day. - Wednesday: Re-examined at Chadwell. Received an injection of Cerenia and an injection of Pepcid at 3 PM. Client reports he was doing well for approximately 24 hours post-injection. - Ate small, frequent meals of ZD prescription diet with water mixed in enthusiastically. - Exhibited pica (seeking non-food items to ingest), which client attributed to hunger. - Had a small amount of diarrhea. - Thursday (today): At 3 PM, he ate and kept down an oral Cerenia tablet. At approximately 6 PM, he was given a sucralfate slurry and Pepcid. He subsequently ate a very small amount of food and then began vomiting again, prompting presentation to the emergency hospital. - Vomitus: Contained blood initially over the weekend but has been free of blood since starting sucralfate and Pepcid. - Feces: Stools were normal until Tuesday when diarrhea began. Diarrhea is described as non-bloody. He has not defecated today. A fecal sample from one of the housemates was submitted to Chadwell on Wednesday; results are pending. - Appetite: Was very good after the injectable Cerenia on Wednesday, but anorexic this evening after vomiting resumed. - Hydration: Client reports he kept a significant amount of liquid down today prior to the evening's vomiting episode. - Past Medical History: - Hypertrophic Cardiomyopathy (HCM) with an obstructive component, reportedly well-managed. - A cardiac report was previously emailed to the hospital. - The report noted a thickened stomach wall. - History of idiopathic hypercalcemia approximately 3 years ago, which resolved with a diet change to WD. Calcium levels have reportedly been normal since. Client will have records from the internal medicine specialist sent over. – Chronic history of intermittent vomiting, more frequent than housemates, often after eating too quickly in the morning. Stools have historically been normal. - Current Medications: - Clopidogrel and enalapril for HCM (dosages are in the cardiology report). The evening dose was not administered today due to vomiting. - Cerenia, Pepcid, and a sucralfate slurry for GI signs.

Current Medications: Cerenia, Protonix, Buprenorphine.
Labwork Results: Labwork submitted and attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Sedated with Propofol.
Stat Report: Not requested.
Imaging Performed by: Andi Parkinson, BS, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with suspended echogenic debris. The bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2.0 cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (4.49 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. A small nonobstructive nephrolith was visualized measuring 0.32 cm. Renal vasculature is normal.

The right kidney has a normal shape and size (4.97 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 0.42 cm width. 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 0.41 cm width. 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, 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 with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in 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 primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7 cm 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 increased (enter measurement if given). Bowel loops follow a typical curvilinear path. Visualized peristalsis appears appropriate. The duodenum wall measured 0.25 cm width. The jejunum wall measured 0.38 cm width. The small intestine generally appear diffusely thickened with a prominent muscularis layer.

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 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, or severe lymphadenomegaly. The medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is generally of normal uniform echogenicity. There is a prominent cranial abdominal/gastric lymph node measuring 0.56 cm. Additionally, there is a large mesenteric lymph node visualized measuring 0.80 cm x 2.1 cm.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Prominent mottled left limb of the pancreas- findings could be consistent with pancreatic remodeling or mild pancreatitis.
- Diffusely thickened small intestine with prominent muscularis layer- The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.
- Prominent mesenteric and cranial abdominal lymph nodes- findings are most consistent with reactive lymph nodes although early neoplastic lymph nodes cannot be ruled out.

Secondary Findings

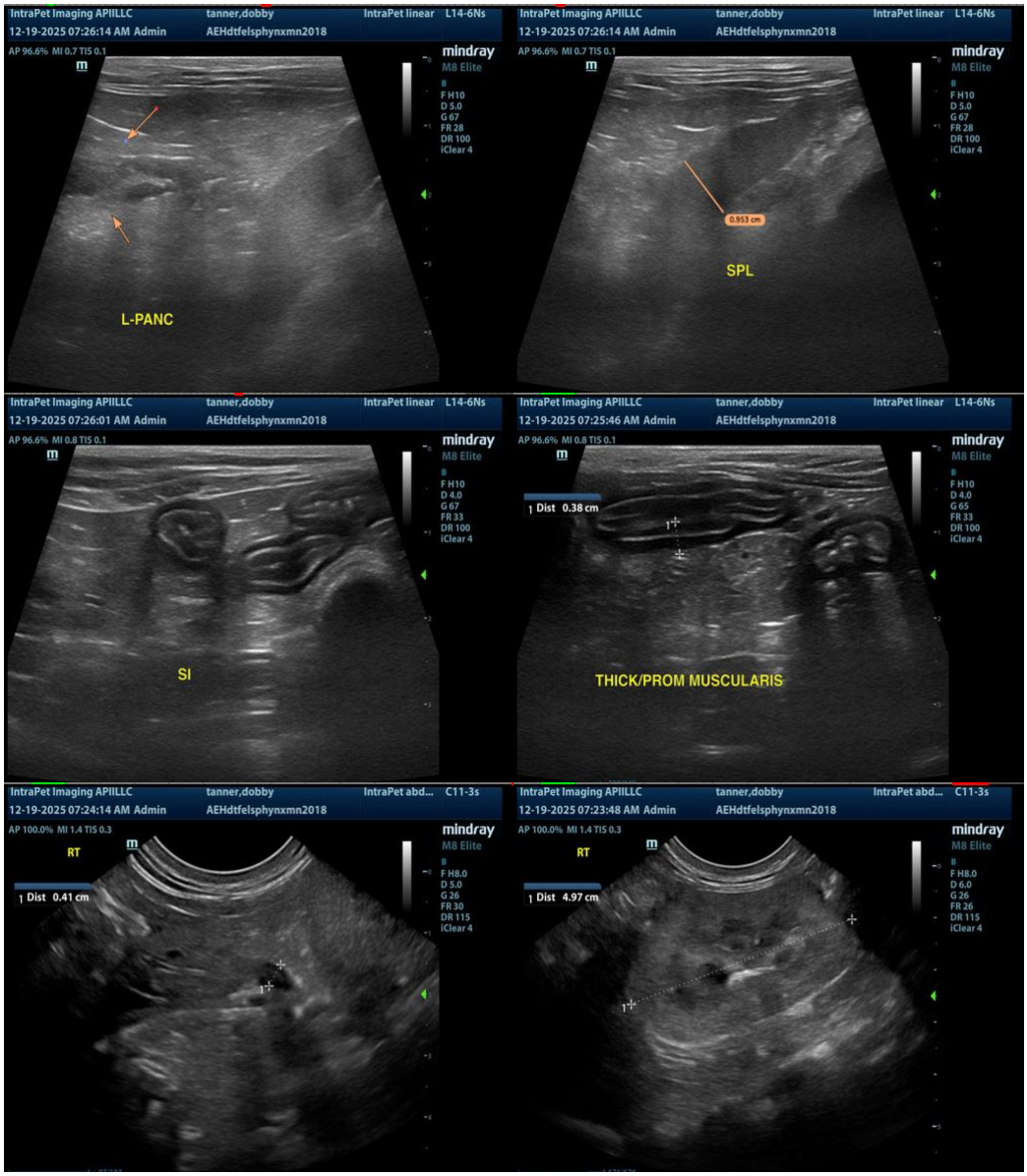
- Suspended echogenic debris in the urinary bladder- The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus. Recommend urinalysis and culture

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine appears diffusely thickened with a prominent muscularis layer. At this time, these changes are most consistent with an inflammatory type change. It is possible that there has been a chronic low-grade enteritis present with an acute cause super imposed causing more severe symptoms in this individual? Recommend aggressive supportive care and close continued monitoring. If symptoms are persistent, you could consider further evaluation possibly with a GI panel to Texas A&M (PLI, TLI, cobalamin and folate) and/or even GI biopsies looking for underlying IBD, early neoplasia, etc.

The left limb of the pancreas is prominent and somewhat mottled. Correlate with a PLI level. If this is significantly elevated, concurrent treatment for pancreatitis.

Some of the lymph nodes in the cranial abdomen are prominent and I suspect these represent reactive lymph nodes although if the patient is not responding to therapy, revaluation for further enlargement may be warranted.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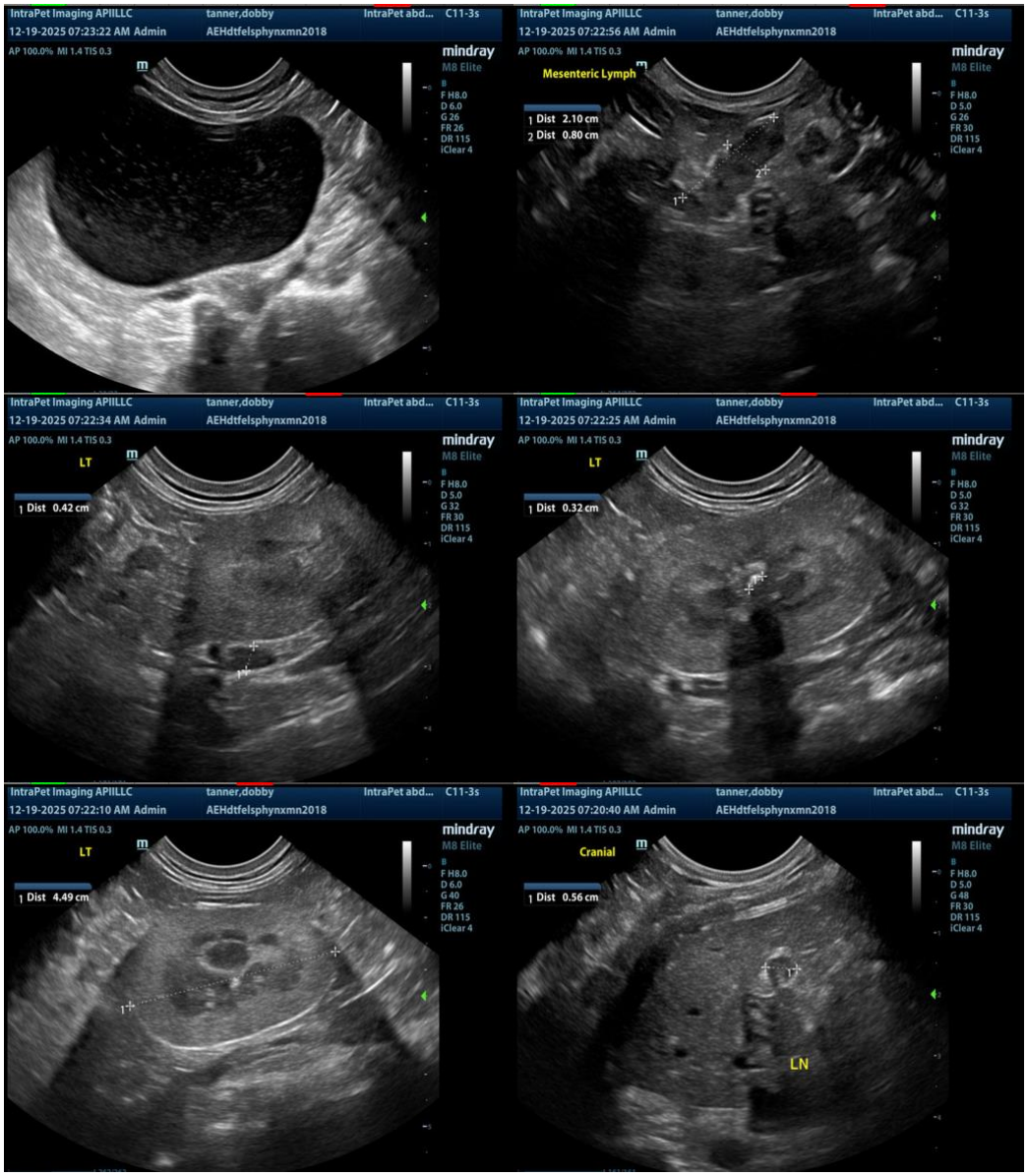
Dist 4.97 cm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AP 100.0% MI 1.4 TIS 0.3
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Cranial
1 Dist 0.56 cm
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The information and recommendations provided are based on the images presented by 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.

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