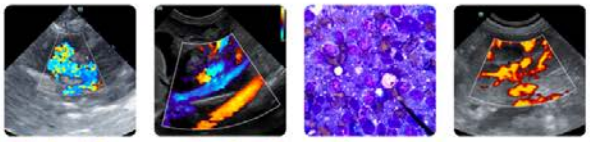


PATIENT

Wesley Dirr

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

7 Years

WEIGHT

9.28 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Mariusz Chmielinski, DVM

HOSPITAL NAME

Apex Veterinary Services, Ltd.

REFERRING VET

Alpine 24/7 ER

INVOICE

72268

DATE

12/2/25

PRESENTING CLINICAL SIGNS

Presented to the clinic for ongoing vomiting, diarrhea, inappetence and lethargy. Also seeming uncomfortable and hunched. Was seen hee on the 29th for same symptoms, sent home with bup, metronidazole, omeprazole (last given last night) and given SQ fluids and emavert at that time. Vomiting resolved but continues to have diarrhea and seem uncomfortable. This morning began vomiting bile multiple times again. On a mix of proplan arctic char and hill sensitive stomach. Has a long chronic history of vomiting and bloodwork has been unremarkable and has had radiographs for rDVM which were also unremarkable.

Abnormal PE/Chem/CBC/UA Results: HR: 160/bpm Respiratory Rate: 24 Mucous Membranes: pink CRT: <2 BCS: 8/9 General Appearance/Attitude: BAR Hydration: mild dehydration Gastrointestinal: Normal/No significant findings. uncomfortable on palpation.

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 (4.06 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 (4.19 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

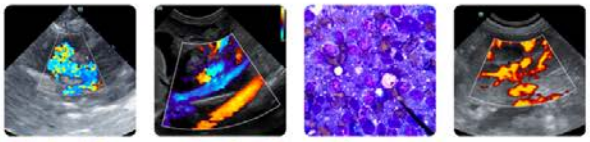
The left adrenal gland is normal in size measuring 0.37 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.50 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 (0.78 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



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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 uniform diameter with minimal to mild fluid and gas. 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 0.26 cm. Jejunum wall measures 0.24 cm. Visualized peristalsis appears appropriate. Some of the sections of small intestine have a prominent muscularis layer, and there are some areas with mild to moderate fluid and gas distention. No focal lesions are visualized.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. The colon is distended with non-formed/liquid 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

There is scant free fluid noted. There is a mild mesenteric/jejunal lymphadenopathy. An example of a mesenteric lymph node measures 0.54 cm. A lymph node near the ileocecal junction measures 0.41 cm. The omentum is mildly hyperechoic in some regions.

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 – Mild chronic pancreatitis is possible.
- Prominent, mildly thickened small intestine with a 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.
- Mild lymphadenopathy – most consistent with reactive lymphadenopathy.

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- Scant free abdominal fluid.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is the general impression of inflammatory type change associated with the small intestine. Some areas appear moderately fluid and gas distended, and other areas exhibit a prominent muscularis layer. No focal lesions are observed. These changes are most consistent with active enteritis and possibly a chronic enteropathy. An early neoplastic process or partial obstruction, etc. cannot be ruled out but is not clearly observed.

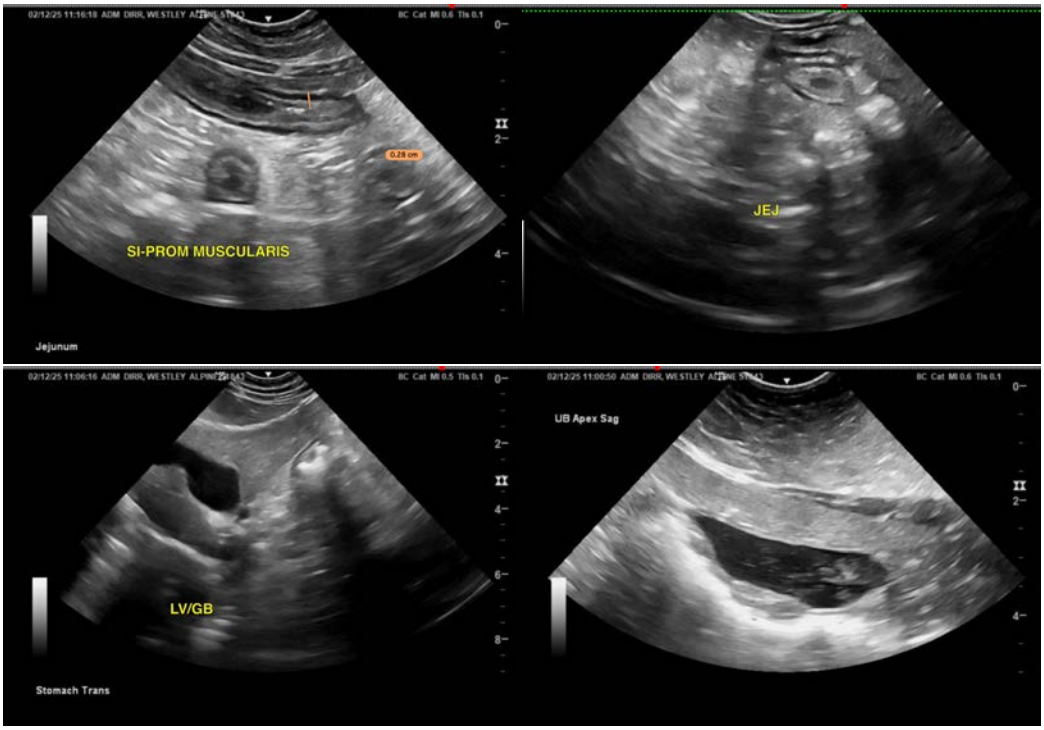
The pancreas is somewhat prominent but does not appear overtly inflamed. These changes are most consistent with pancreatic remodeling. Recommend evaluation of a PLI level. If there are significant elevations, then chronic active pancreatitis may also be present.

The colon is fluid distended, and there are some mildly reactive lymph nodes visualized in the abdomen.

Consider the following for further evaluation of a possible underlying enteropathy:

- 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 of the GI tract may eventually be warranted. Additionally, you could consider repeat imaging, looking for progression of today's lesions or development of a focal lesion.



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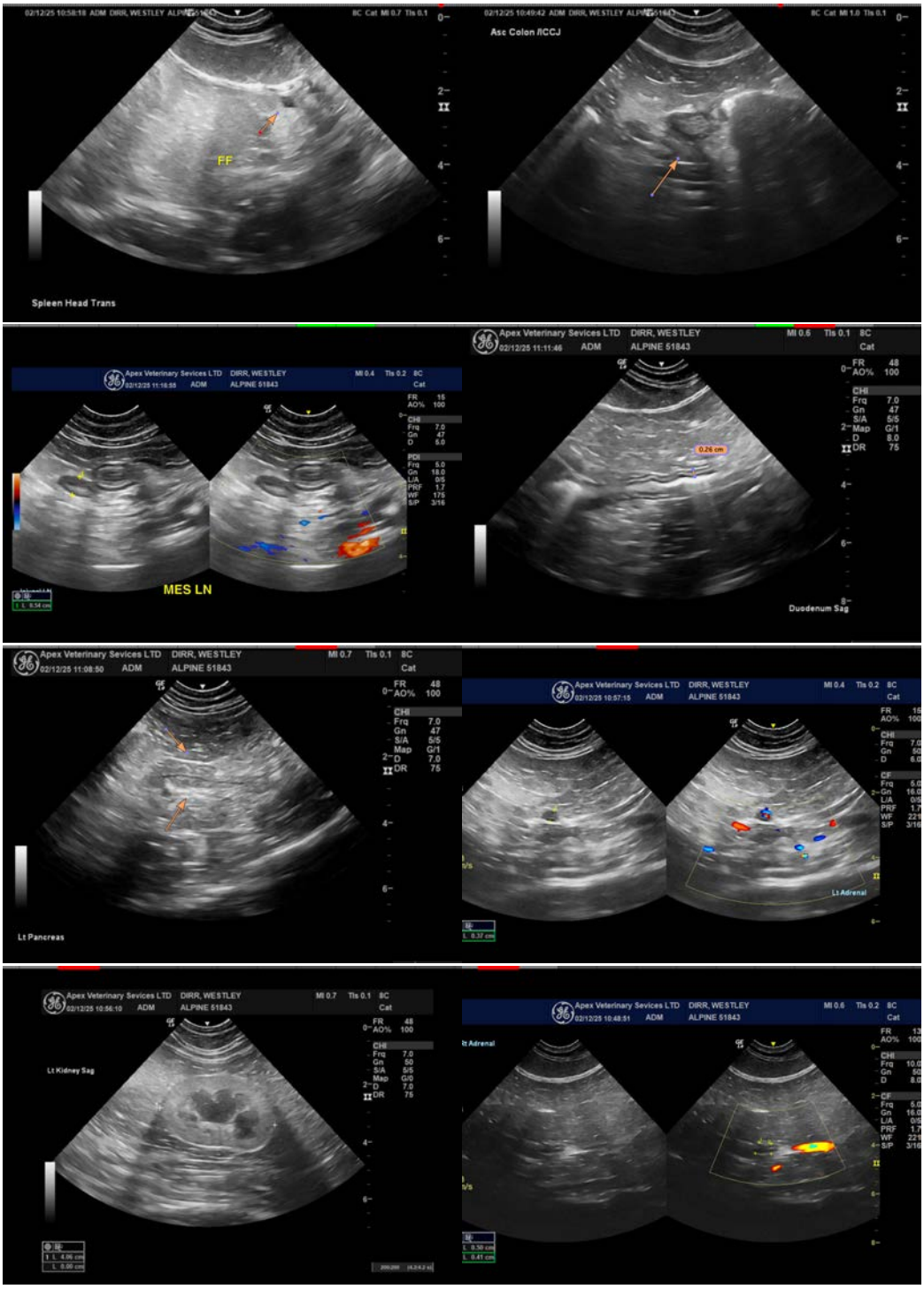

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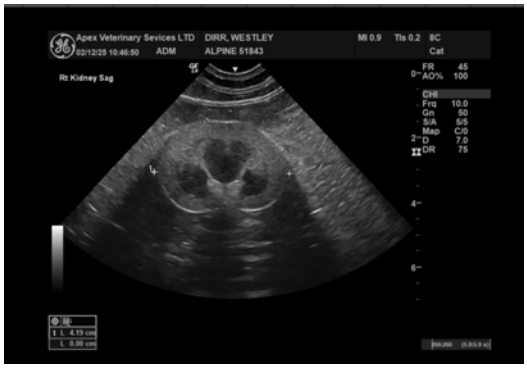

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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