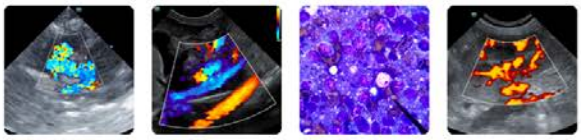


DATE

3/13/26

PATIENT

Pumpkin Herlihy

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

3/12/22

WEIGHT

4.97 kg

INTERPRETED BY

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

HOSPITAL NAME

Mason Dixon Animal Emergency Hospital

REFERRING VET

Dr. Hengst

INVOICE

73646

PRESENTING CLINICAL SIGNS

Patient History: Patient presents for vomiting, significantly decreased appetite, and recent episode of mild constipation that was treated by another facility 3/6. Patient had bowel movement on 3/7 but no additional bowel movements. Normal urinations per owner. Owner had to discontinue the prescribed lactulose because patient started vomiting 3/8 and has had vomiting episodes throughout the week. Owner stated that patient has history of vomiting episodes which improved when patient was transitioned to z/d diet about a year ago. PE: Anxious, dehydrated, H/L auscultate normal, tense with abdominal palpation, palpable splenomegaly.

Current Medications: Norm-R IVF twice maintenance, Maropitant 1mg/kg IV q24, Pantoprazole 1mg/kg IV once, Buprenorphine 0.015mg/kg IV q8, Plan to start Unasyn IV q8
Labwork Results: labwork not attached, reported as: -PCV 40%; TS 6.4g/dL-CBC normal -Chemistry: Total calcium 8.5 (ref 8.8-11.9), Total protein 5.7 (ref 6-8) -fPL normal 2.4 (<3.5 normal) -UA: USG>1.050, protein ++1, WBC 1-5/hpf, suspected cocci. Rad findings attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: IV Propofol.
Stat Report: STAT requested.
Imaging Performed by: Rachel Brilhart, RDMS.

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 (3.63 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 (3.94 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 0.57 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 0.54 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 large, mottled and irregular. The blood flow through the hilus and splenic parenchyma appears normal. The caudal aspect of the spleen appears somewhat scalloped and irregular, and has a curled conformation caudally, measuring 2.02 cm in width at the level of the hilus.

Liver
The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is mildly heterogenous in echotexture with subtle, indistinct focal mottling. 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. There is a moderate amount of non-organized echogenic debris. 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 distension. 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. Jejunum wall measures 0.25 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 pancreas is normal and isoechoic to surrounding 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 near the spleen. There are large, hypoechoic mesenteric lymph nodes, examples measure 0.67 cm x 1.84 cm and 0.77 cm x 2.65 cm. A lymph node near the ileocecal junction measures 0.41 cm. The omentum is hyperechoic around the spleen and prominent lymph nodes.

Other
Severe ringdown artifact visualized at the level of the diaphragm.

PRIMARY FINDINGS

- Large, mottled, scalloped spleen – Findings are concerning for possible infiltrative neoplasia. Other differentials could include lymphoid hyperplasia or similar.

- Mildly heterogeneous liver – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy. In the absence of liver enzyme elevations, the significance of this is uncertain.

- Moderate gallbladder debris – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting. Incidental gall bladder debris is less common in cats.

- Diffusely prominent “ropey” small intestine with some areas exhibiting a prominent muscularis layer – Findings are most consistent with inflammatory type change, although early neoplastic change cannot be ruled out.

- Large, hypoechoic mesenteric lymph nodes – Findings are concerning for neoplastic lymph nodes, although highly reactive lymph nodes can have a similar appearance.

- Severe ringdowns evident in the level of the diaphragm – Findings reflect the pulmonary parenchymal changes described on radiographs.

SECONDARY FINDINGS

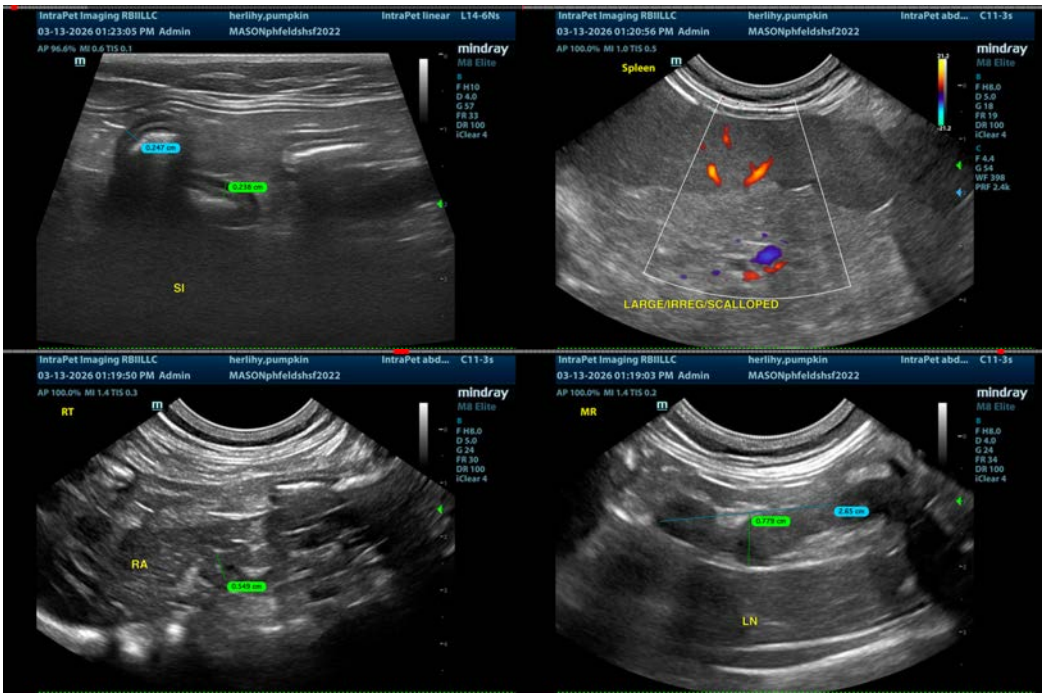
- Suspended echogenic debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.

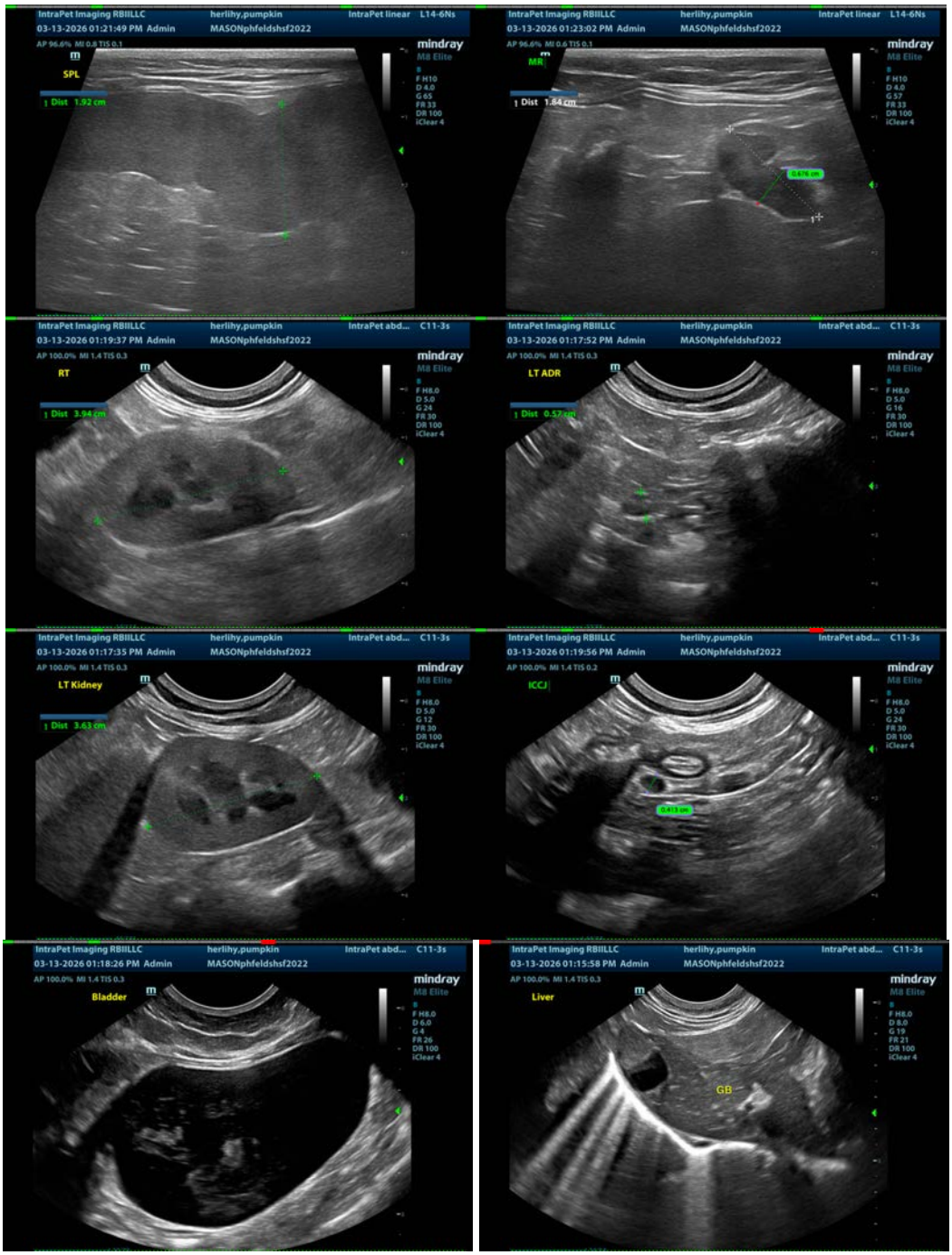
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The spleen is large, mottled and irregular in appearance. The changes are diffuse with no focal mass lesions observed, but there is concern for possible neoplastic infiltration. Recommend a fine needle aspirate of the spleen.

Additionally, there are enlarged, irregular, hypoechoic mesenteric lymph nodes. These are concerning for possible metastatic lymph nodes, although highly reactive lymph nodes are possible. If a safe window for sampling is available, consider a fine needle aspirate.

The small intestine appears somewhat ropey with no focal lesions observed. At this time these changes could be consistent with mild inflammatory type change. Recommend continued monitoring.

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Liver
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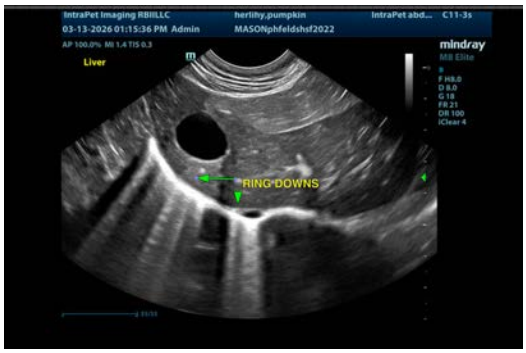

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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