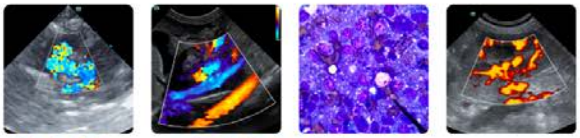


SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Bogie Dawson

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

3.5 Years

WEIGHT

6.5 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

West Brant Animal Hospital

REFERRING VET

Dr. Balaraju

INVOICE

73782

DATE

3/18/26

PRESENTING CLINICAL SIGNS

Decreased appetite over the last two weeks, will still eat but only half of the amount. History of GI upset and vomiting but vomiting resolved with intro and transition to Z/D diet. Owner now reintroduced RC dental kibble and C/D canned to get Bogie eating. Appears to drop crumbs from mouth when eating. Less cuddly and less social and noted decreased activity levels at home. PE unremarkable - BCS 6/9. Gave gabapentin for AUS,

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly to moderately distended with urine. There is a small amount of suspended echogenic debris visualized. 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 (4.12 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 (4.23 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 0.38 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 0.42 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.

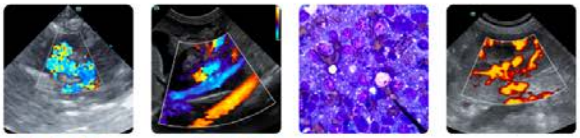
Spleen

The spleen is subjectively normal in size (0.90 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 and common bile ducts are normal/not visible.



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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. Jejunum wall measures 0.23 cm. Visualized peristalsis appears appropriate. Some sections of small intestine appear slightly "ropey" with a prominent but not overtly thickened muscularis layer.

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 a subtle isoechoic rounded structure possibly consistent with an isoechoic lymph node or pancreatic nodule visualized in the region of the left limb measuring 1.02 cm x 1.27 cm. 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 subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

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.
- Mildly mottled left limb of the pancreas with an ill-defined hypoechoic rounded structure (isoechoic lymph node versus nodule) – Findings could be consistent with mild pancreatic remodeling. The significance of the rounded structure is uncertain, as it is very subtle and could represent a slightly prominent lymph node. Recommend continued monitoring.
- Areas of slightly "ropey" small intestine – Findings could be consistent with mild inflammatory type change/enteritis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes observed on today's scan are very mild and of uncertain significance. Unfortunately, there are many causes for inappetence, which cannot be definitively diagnosed by ultrasound alone.

Given the history of underlying gastrointestinal disease, consider a GI panel to Texas A&M for qualitative fPLI, TLI, cobalamin and folate both to evaluate for evidence of pancreatic inflammation and to look for evidence of B12 deficiency, underlying small intestinal disease, etc.

Consider empirical antiemetic therapy. If there is a significant response to this, the aversion to food may be due to nausea, and you could consider an upper GI endoscopy to further investigate.

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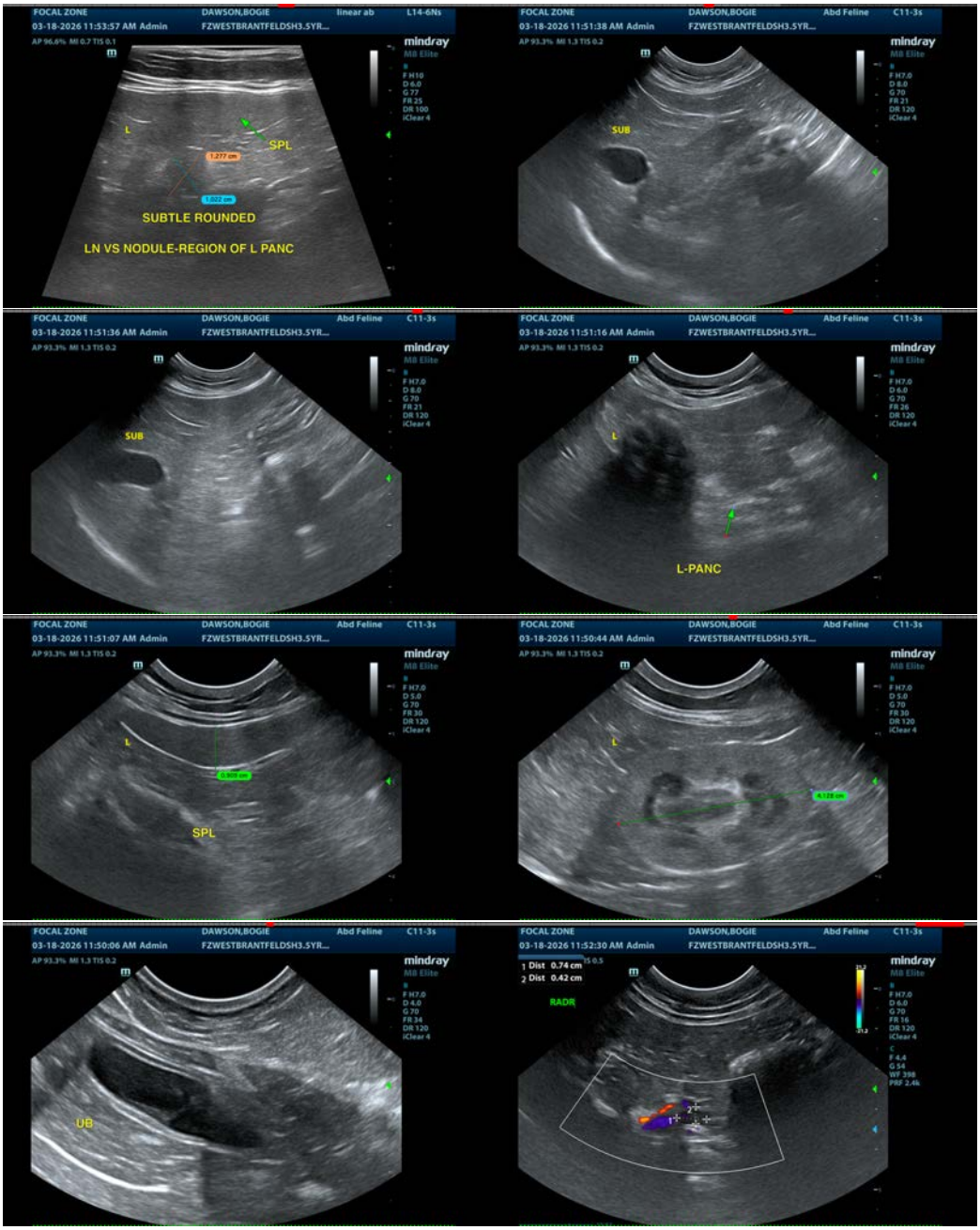
If not already done, recommend full lab work to evaluate for any metabolic causes of these symptoms.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement (disregard if this has already been done).

If symptoms are persistent despite symptomatic therapy and a good oral exam, you could consider repeat imaging, looking for progression of today's lesions or development of new lesions.



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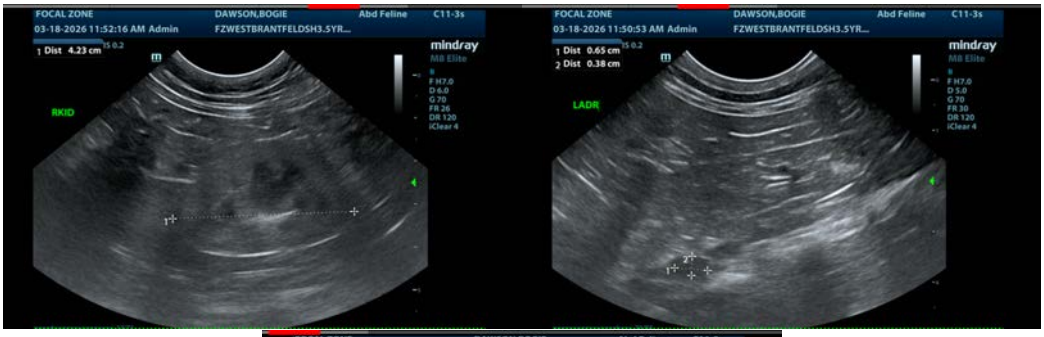

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com