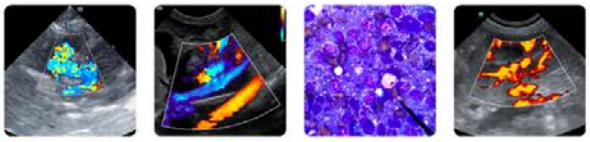


PATIENT

Lucy Ali

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

7 Years

WEIGHT

4.9 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Gira

HOSPITAL NAME

Praire Winds Animal Clinic

REFERRING VET

Dr. Rohini Bhardwaj

INVOICE

73984

DATE

3/24/26

PRESENTING CLINICAL SIGNS

Vomiting for the past 2 months (1-2 times a day).

Abnormal PE/Chem/CBC/UA Results: BW and rads unremarkable. Spec fPL and T4 normal

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 is slightly irregular (due to previous infarct), measuring 3.75 cm. Overall echogenicity is slightly hyperechoic with poor 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 or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.99 cm). Overall echogenicity is slightly hyperechoic with mildly reduced 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 0.47 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 0.45 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.

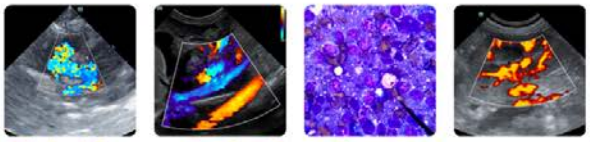
Spleen

The spleen is normal/borderline plump (1.0 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 0.33 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. The pylorus is prominent with intact wall layering, measuring at 0.39 cm. This falls into normal wall thickness, but the prominence is concerning for focal inflammation.

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 0.26 cm. Jejunum wall measures 0.21 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 prominent, hypoechoic and mottled in the left limb. There is no evidence of nodules or cystic lesions. There is mild reactive mesentery in the region.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are occasional prominent mesenteric lymph nodes. A lymph node in the cranial abdomen near the pyloroduodenal junction measures 0.85 cm x 0.53 cm. A lymph node near the ileocecal junction measures 0.44 cm x 0.62 cm. A jejunal lymph node is visualized measuring 0.43 cm x 1.38 cm. The omentum is hyperechoic in the cranial abdomen in the region of the pylorus and in the left limb of the pancreas.

ULTRASONOGRAPHIC FINDINGS

- Age related changes visualized associated with both kidneys.
- Pancreatic changes consistent with chronic pancreatic remodeling and possible mild pancreatitis in the left limb.
- Prominent pylorus – Wall measurements fall into normal range, but it is prominent with intact wall layering, possibly consistent with focal inflammation. Early neoplastic change is possible but less likely.
- Suspect reactive lymphadenopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The left limb of the pancreas is prominent with some reactive mesentery in the region. This could be secondary to pancreatitis and pancreatic remodeling, although with a normal PLI level this is questionable. Consider empirical treatment for pancreatitis and continued monitoring to be safe.

The pylorus and proximal duodenum appear slightly prominent with intact wall layering, and there is some reactive mesentery in the region. This could be secondary to gastritis/duodenitis, less likely early neoplastic infiltration. Recommend symptomatic treatment and reevaluaton in the future, looking for

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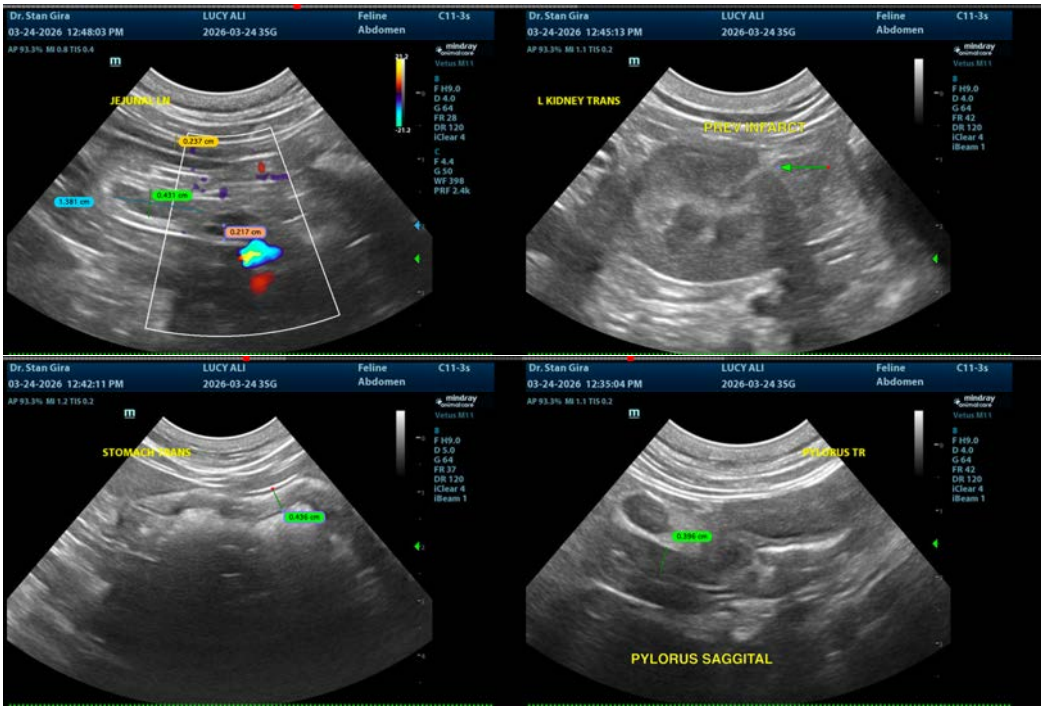
progression of these changes.

No focal lesions were visualized associated with the distal GI tract. This does not rule out the possibility of a primary enteropathy. Consider the following for further evaluation/therapy:

- Recommend empirical treatment for pancreatitis/gastroenteritis.
- 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.
- Consider a hydrolyzed protein prescription diet (Royal Canin has a combination ultra low-fat and hydrolyzed protein prescription diet, which may be helpful if pancreatitis is a concern.
- Recommend abdominal and thoracic radiographs.

If symptoms are persistent, ultimately biopsies of the GI tract may be warranted. Additionally consider repeat imaging of the pyloric region and proximal duodenum, looking for any evidence of progression of the changes described.



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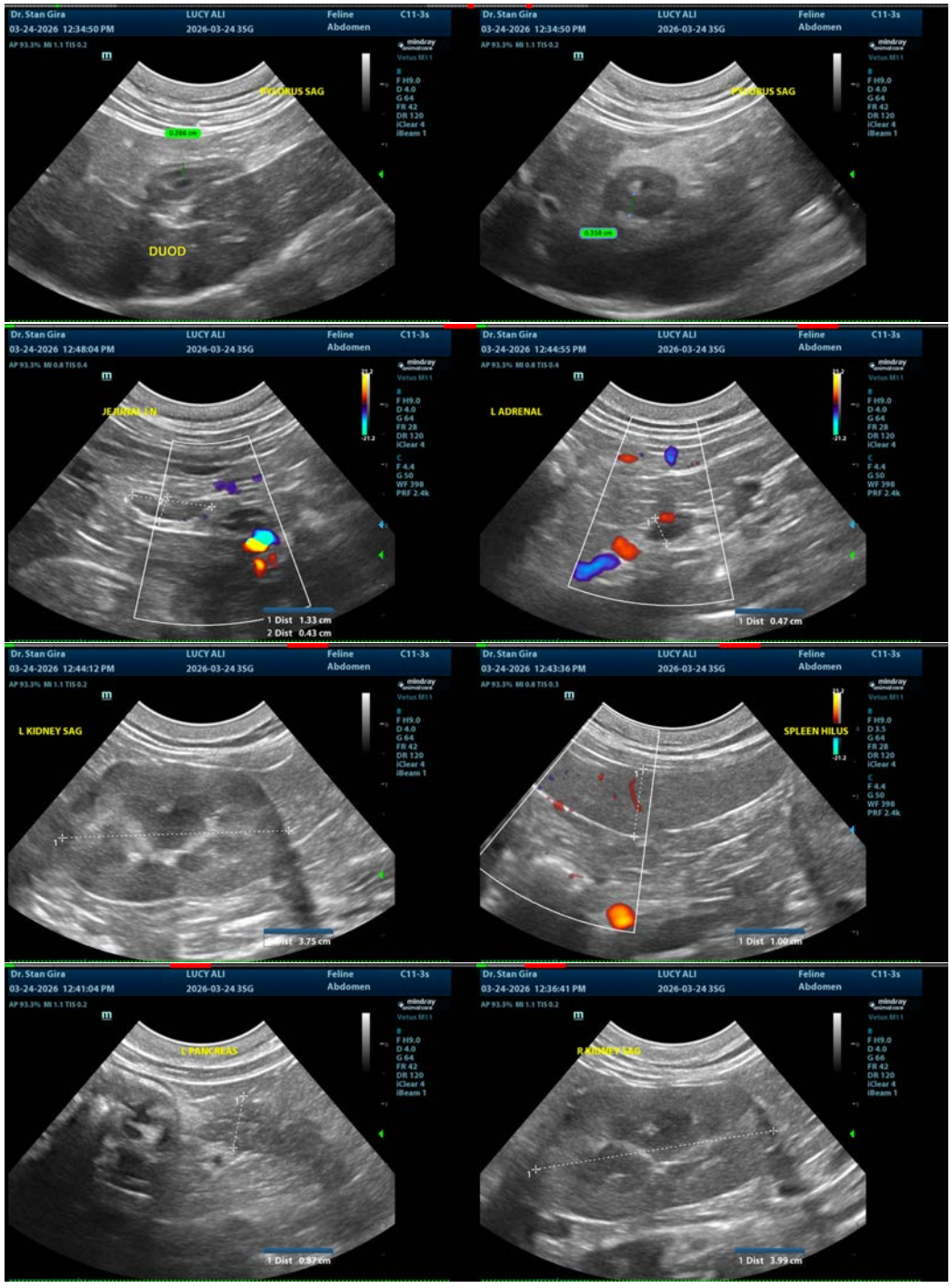

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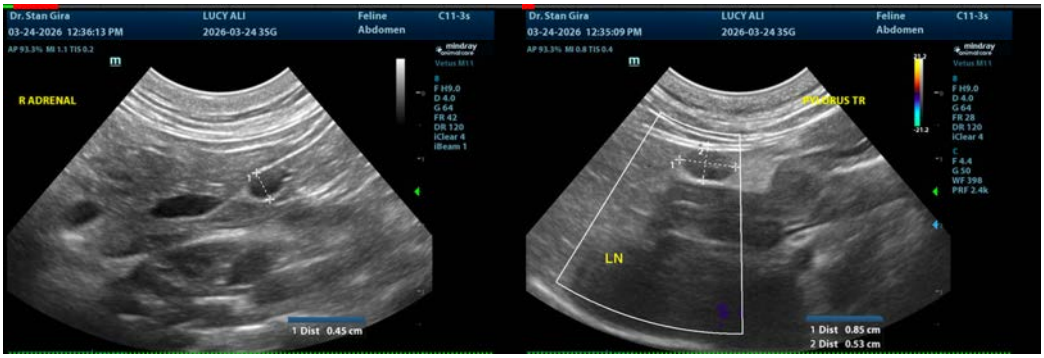

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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