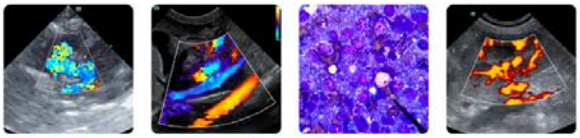


PATIENT

Bruce Verdone

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

15 Years

WEIGHT

5.95 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Snelgrove Veterinary Services

REFERRING VET

Dr. Somal

INVOICE

74454

DATE

4/15/26

PRESENTING CLINICAL SIGNS

Bruce has been presented with complaint of vomiting. As per O Bruce started vomiting 3 days ago, has been vomiting randomly 3-4 times a day. Still interested in eating. Has been drinking. O mentioned change food abruptly recently as well. Bruce had similar episode in February, Blood work and Radiographs were done; Shown Marked Neutrophils with left shift. Elevated GGT. Radiographs shown urolith. No obvious mechanical blockage. Bruce was treated with Clavamox and Maropitant injection. Got better, no concerns up until now. No obvious relevant Physical exam findings. No meds.

Abnormal PE/Chem/CBC/UA Results: Neu 2.01 (2.3-10.29) QPL 5.5 U/L (0.0-4.4) Radiographic Findings 4 images of the thorax and abdomen dated 2/13/2026 are available for review. Assessment: 1. The gastric contents likely represent partially digested food. Correlate with the timing of the last meal. There is no small intestinal mechanical obstruction. 2. Urinary cystic calculus. 3. The mild bronchial pattern noted is likely a normal age-related change. Inflammatory, allergic, or infectious causes are less likely. There is no pulmonary metastasis or intrathoracic lymphadenopathy. The thorax is otherwise unremarkable. Primary Question to Be Answered in This Exam Chronic Pancreatitis, Neoplasia, IBD

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly 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, or masses. Bladder wall measures 0.31 cm. On one view there is some very small hyperechoic material visualized in the region of the urethra, possibly consistent with some sandy debris, measuring <0.1 cm. *Lack of urine distention interferes with full evaluation of the urinary bladder.

The left kidney has a normal shape and size (3.82 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.

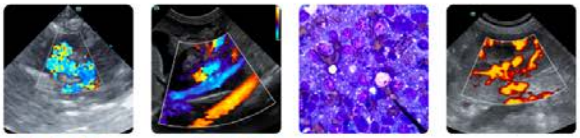
The right kidney has a normal shape and size (4.27 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.33 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



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

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The spleen is subjectively normal in size (0.54 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 bile duct appears dilated and somewhat tortuous, measuring 0.38 cm. A focal obstruction is not clearly visualized.

Gastrointestinal

The stomach contains moderate fluid and shadowing ingesta. 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. The region of the pylorus is difficult to clearly visualize, but there appears to be some fluid and shadowing material in the pylorus. No evidence of a definitive obstruction is visualized, but a partial obstruction cannot be ruled out.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal to moderate fluid 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. Duodenum wall measures 0.30 cm. Jejunum wall measures 0.25 cm. Visualized peristalsis appears appropriate. Several loops of bowel appear somewhat fluid and gas distended. A focal lesion is not clearly visualized.

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 area of 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

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

- Questionable sandy debris visualized in the urethra – Correlate with urinalysis.
- Dilated/mildly tortuous bile duct – Dilation of the common bile duct could be consistent with a functional obstruction (i.e. primary hepatic disease resulting in hepatocellular swelling) or with an extrahepatic bile duct obstruction (ie. choledocholith, bile duct tumor, pancreatic disease, other).

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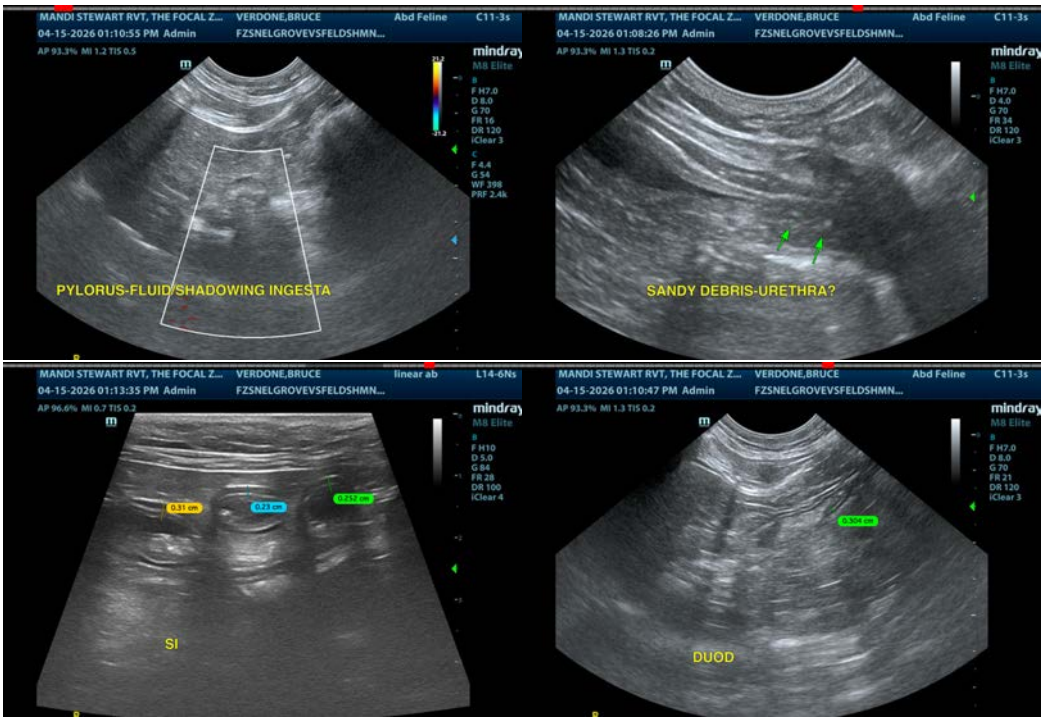
- Moderate fluid/gas/ingesta distention of the stomach – Correlate with feeding history. If the patient was adequately fasted, this could represent delayed gastric emptying or partial outflow tract obstruction.

- Segmental fluid and gas distention of the small intestine with a prominent muscularis layer in some areas – Findings are suggestive of an enteritis type pattern. A focal partial obstruction cannot be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach is distended with fluid and some shadowing ingesta. Correlate with feeding history. If the patient was not fasted, this could represent normal ingesta. If the patient had a significant fast, this could represent delayed gastric emptying, a partial outflow tract obstruction, etc. Recommend empirical treatment for acute gastroenteritis. No evidence of pancreatitis is noted, but if a PLI is significantly elevated, consider concurrent treatment for pancreatitis. If symptoms are persistent, consider reevaluation with a more prolonged fast to reassess. Correlate with abdominal radiographs.

The bile duct appears dilated and somewhat tortuous with no evidence of a focal lesion observed. Correlate with current full lab work and liver values. If there is significant elevations, consider empirical treatment for cholecystitis and reassessment after treatment. If values continue to rise and dilation is progressive, further evaluation for a focal biliary obstruction may need to be considered.



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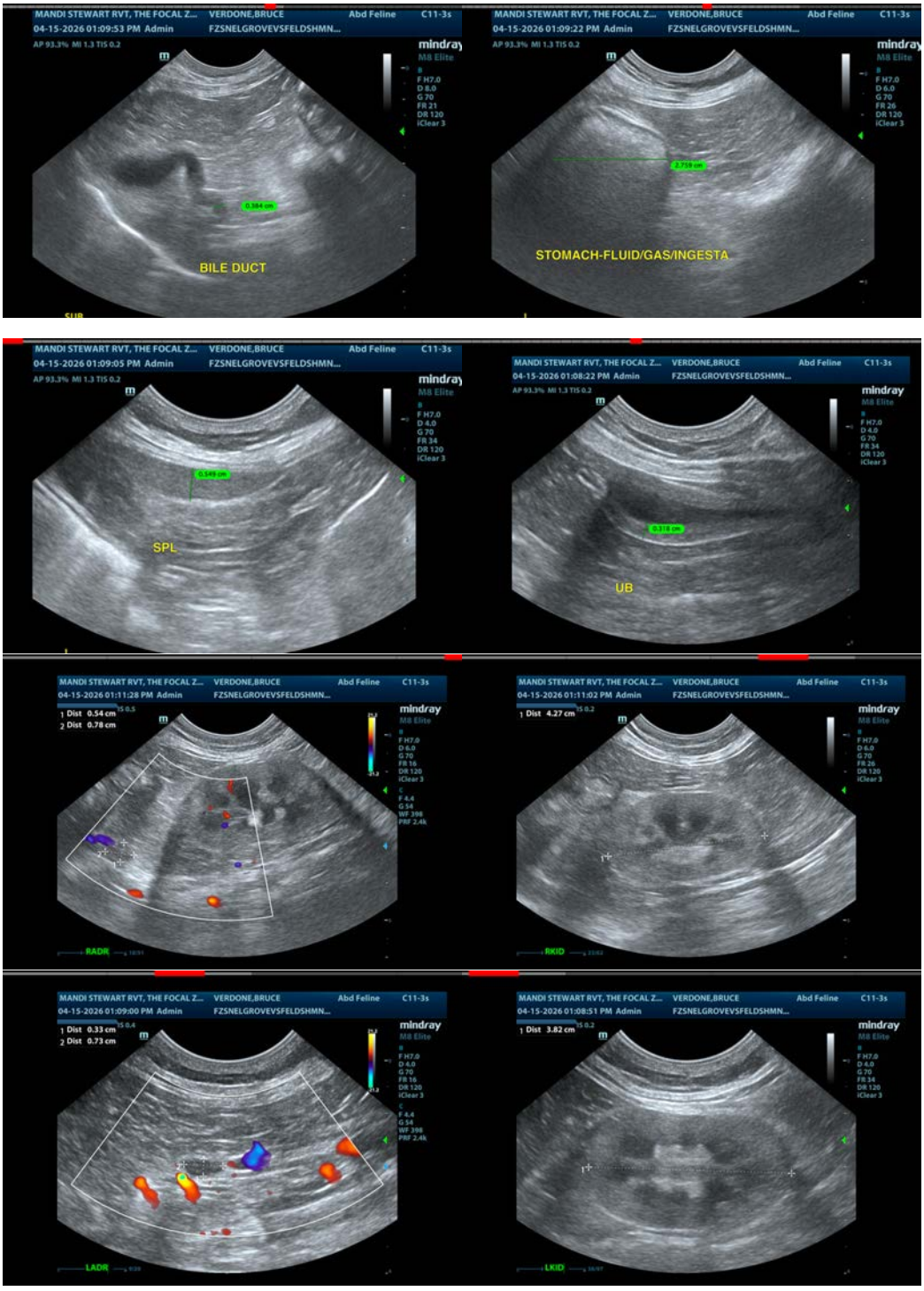

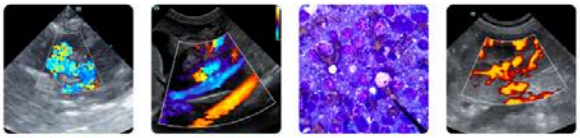

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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