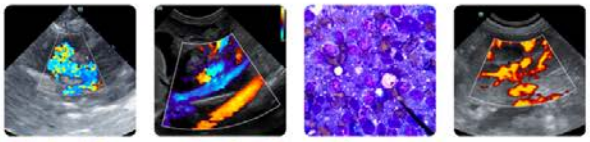


PATIENT

Fig Scott

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

10 Years

WEIGHT

13.42 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Lucas Budden

HOSPITAL NAME

Frontier Veterinary Hospital

REFERRING VET

Dr. Lucas Budden

INVOICE

74473

DATE

4/15/26

PRESENTING CLINICAL SIGNS

Vomiting daily to multiple times per day. Maintaining weight (weights at last 3 visits: 11.8# on 5/30/25, 13.7# on 3/31/26, 13.42# today). Frequency of vomiting has increased over the past year. Appetite normal. No diarrhea.

Current medications: Gabapentin, Butorphanol, Dexdomitor to facilitate imaging

Abnormal PE/Chem/CBC/UA Results: Physical exam: BCS 7/9, no thyroid slip, moderate flaking over dorsum, comfortable on abdominal palpation and no organomegaly, minimal dental tartar Lab work: senior panel 3/31/26 Glucose high 198 Creatinine high 1.7 Cholesterol high 250 Triglyceride high 276 Lipemia 1+ CBC and remainder of chemistry normal Thyroid high normal 3 FEL V/FIV negative/negative Heartworm test negative USG 1.058 Protein 2+ White blood cell 01 RBC 21-50 Struvite 0-1 Collected via cystocentesis GI panel pending

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 (3.9 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.

The right kidney has a normal shape and size (4.05 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.

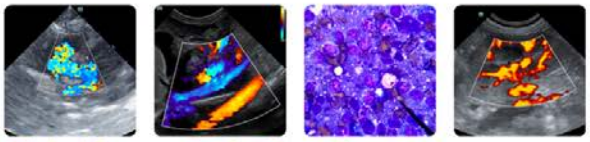
Adrenal Glands

The left adrenal gland is normal in size measuring 0.27 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 0.29 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 (0.77 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.



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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.

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. Duodenum wall measures 0.23 cm. Jejunum wall measures 0.15 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 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

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is no evidence of a significant lymphadenopathy. The pancreaticoduodenal lymph node is prominent measuring 0.57 cm. There are occasional visible/mildly prominent lymph nodes near the ileocecal junction. Examples measure 0.13 cm and 0.21 cm. The omentum is generally normal in echogenicity.

PRIMARY FINDINGS

- Pancreatic changes consistent with chronic pancreatic remodeling +/- chronic pancreatitis.
- Occasional visible/mildly prominent, likely reactive lymph nodes.

SECONDARY 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.
- Age related changes visualized associated with both kidneys.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

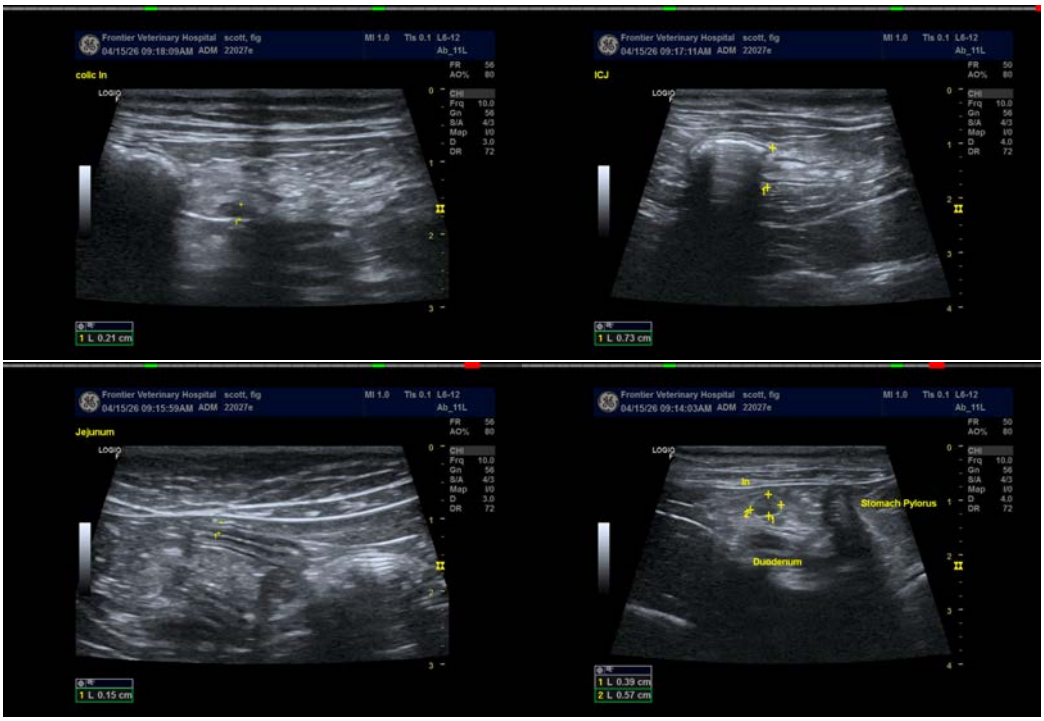
The changes observed on today's scan are mild. No focal lesions are visualized associated with the gastrointestinal tract to explain the chronic vomiting reported.

The pancreas is prominent and visible in both limbs. Correlate findings with a PLI level. If this is significantly elevated, consider empirical treatment for chronic pancreatitis.

There are many causes for chronic vomiting that do not always cause significant ultrasonographic changes. These tend to be inflammatory type issues such as dietary intolerance, IBD, etc. Consider the following:

- 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 despite this, ultimately biopsies of the GI tract may be warranted. Additionally, you could consider repeat imaging, looking for progression of today's changes or a small focal lesion note visualized on today's exam.



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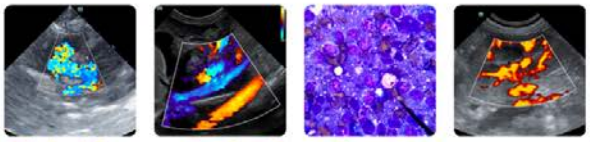

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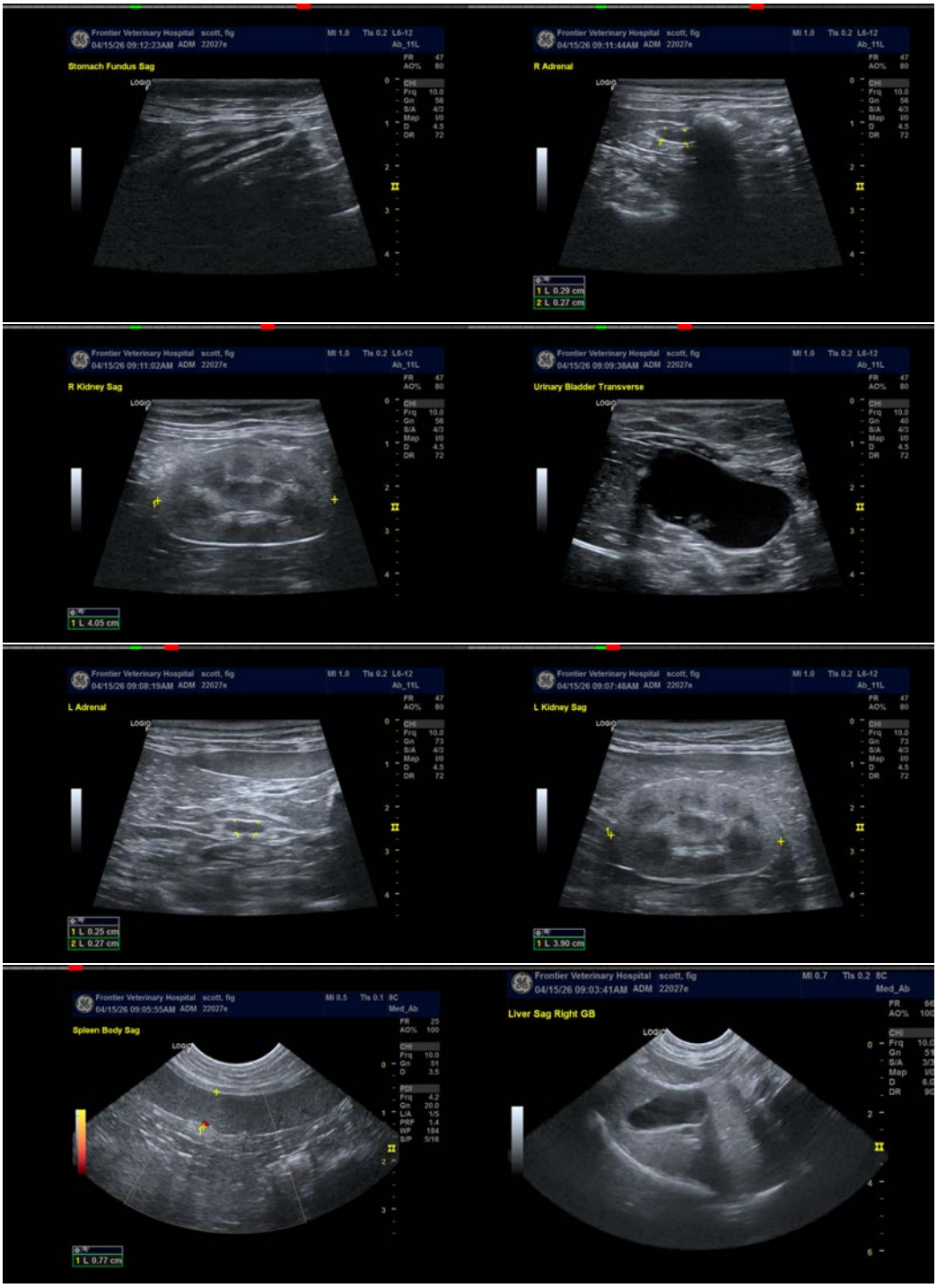

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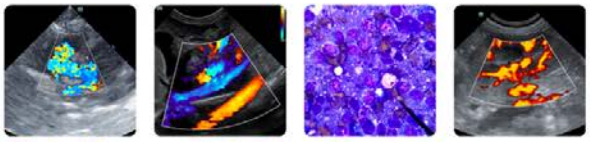

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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