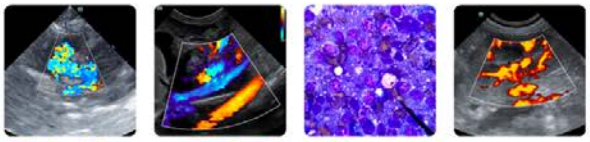


PATIENT

Moon Light Keith

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

7 Years 10 Months

WEIGHT

12.96 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

74649

DATE

4/21/26

PRESENTING CLINICAL SIGNS

Intermittent hematochezia noted since November of 2022. Had recently moved from New Mexico at that time. Hill's i/d diet has improved symptoms, but they have not resolved. Per owner will eat grass intermittently and vomit. Otherwise appetite normal and maintaining weight. No other history of vomiting. History of FIV positive and chronic/recurrent herpes conjunctivitis. Ultrasound to assess GI tract for cause of hematochezia. Current medications: Hill's i/d diet

Abnormal PE/Chem/CBC/UA Results:Physical exam: BCS 7/9, potential FORL 207, left eye mild serous discharge and very mild intermittent blepharospasm, mild crusted eye discharge medial canthus OU, normal exam otherwise Lab work: Senior panel 4/19/26 Chemistry panel normal Complete blood count normal Thyroid normal FIV positive FeLV negative Heartworm test pending Fecal test pending USG 1.066 Protein 1+ Quiet sediment otherwise

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 (3.98 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 (3.83 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.

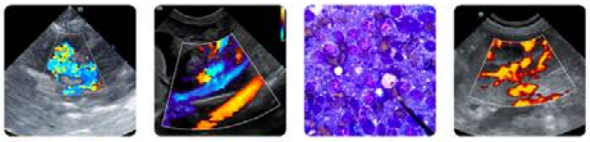
Adrenal Glands

The left adrenal gland is normal in size measuring 0.26 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 0.27 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 (0.89 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 0.36 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. 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 0.26 cm. Jejunum wall measures 0.26 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. Descending colon wall measures 0.18 cm.

Pancreas

The pancreas is visible and mildly mottled in both limbs. 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 significant lymphadenopathy. A visible/slightly prominent lymph node is visualized near the ileocecal junction measuring 0.26 cm.

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.
- Pancreatic changes most consistent with mild pancreatic remodeling.
- Reactive lymph nodes near the ileocecal junction.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes observed on today's scan are relatively mild. No focal lesions are visualized associated with the GI tract to explain the large bowel symptoms described. Unfortunately, you can still have significant large bowel disease with relatively minimal ultrasonographic findings. Consider the following for further evaluation:

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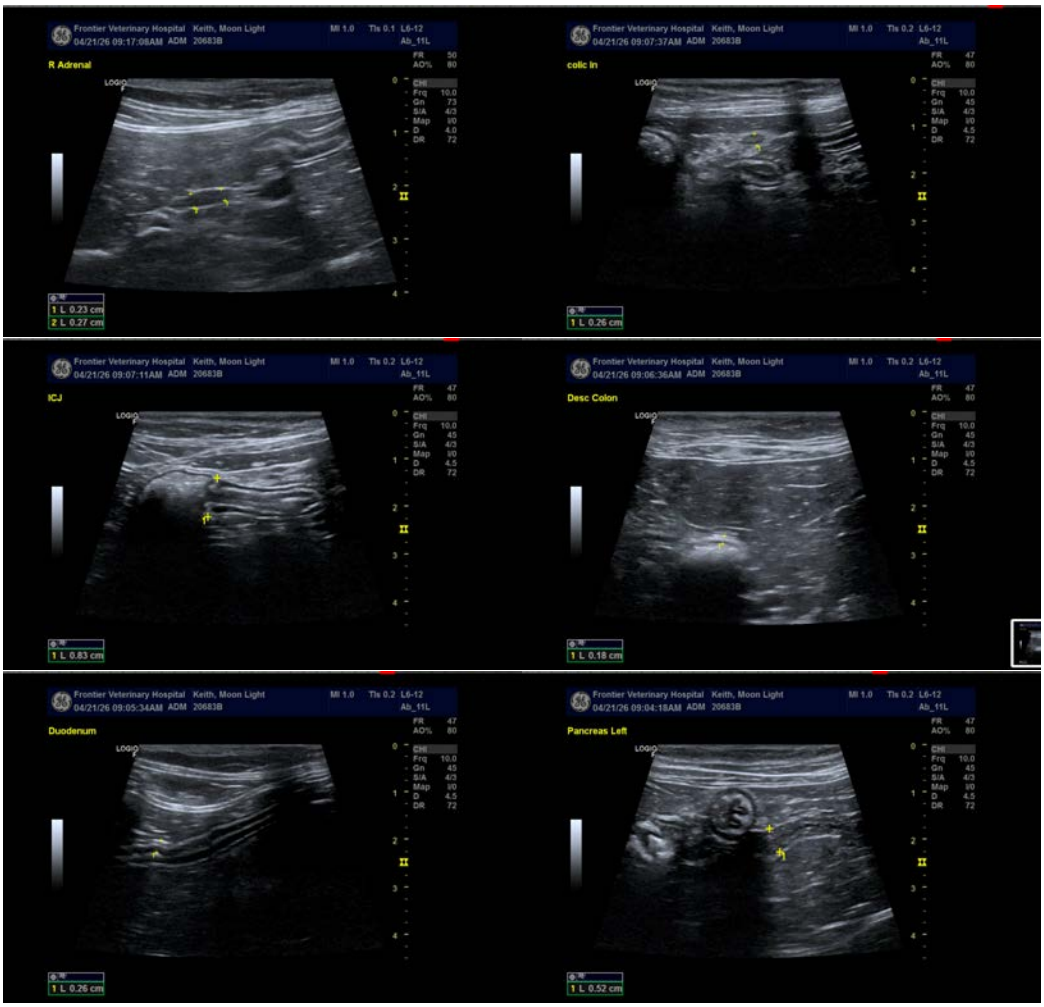
- If not already done, recommend parasite screening and deworming for large bowel parasites.
- Consider screening for diarrhea pathogens (clostridium, etc.).
- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- You could experiment with the addition of fiber to the diet. This can be of benefit to some patients with large bowel disease, but can cause softer stool in other.
- 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. This will look for exocrine pancreatic insufficiency.
- If not already done, recommend probiotic therapy.

If these steps are taken and symptoms are persistent, consider a colonoscopy for further evaluation and to obtain biopsies of the lower GI tract.



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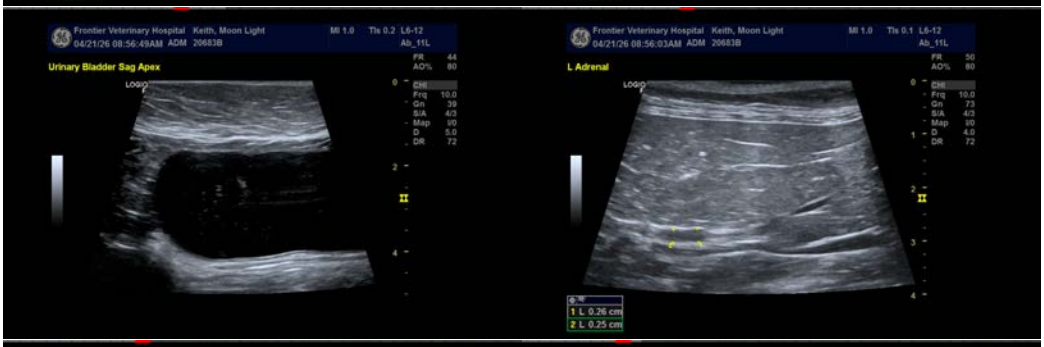

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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