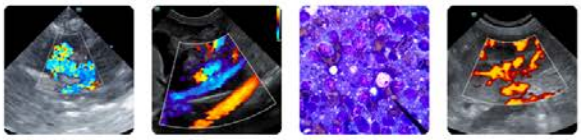


DATE

5/26/26

PATIENT

Sasha Wilkes

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

8/10/12

WEIGHT

10 lbs

INTERPRETED BY

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

HOSPITAL NAME

Fallston Veterinary Clinic

REFERRING VET

Dr. Gates

INVOICE

75438

PRESENTING CLINICAL SIGNS

Patient History: Needs echo for pre-anesthetic workup of heart murmur as well as abdominal ultrasound to recheck vomiting. Vomiting has returned, occurring 2-3 times weekly for past two weeks, consisting of food and bilious material. History of chronic diarrhea that has resolved on the GI biome diet. No table food or treats given. Previous abdominal ultrasound (from previous vet) showed normal intestinal thickness and layering, pancreatic remodeling but no signs of active pancreatitis

Current Medications: Currently on prednisolone 2.5mg (increased from every third day to every other day a few weeks ago due to increased vomiting), fluticasone inhaler once daily, and cobalamin injections
Labwork Results: Labwork not attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Stephanie Warga RDCS, RVT.

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 (3.94 cm) with too numerous to count pinpoint hyperechoic foci most consistent with dystrophic mineralization. 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, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.43 cm) with too numerous to count pinpoint hyperechoic foci most consistent with dystrophic mineralization. Additionally there is a small, slightly irregular anechoic structure in the cortex most consistent with a cortical cyst measuring 0.57 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, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.21 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 0.39 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 (0.74 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.

Gastrointestinal
The stomach contains minimal luminal contents. It measures at a normal thickness of 0.19 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 0.29 cm. Jejunum wall measures 0.25 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 non-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 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. There is a mild mesenteric lymphadenopathy present with prominent hypoechoic lymph nodes. Examples measure 0.48 cm and 0.57 cm. The omentum is mildly hyperechoic in the cranial abdomen and around the lymph nodes.

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.
- Age related changes visualized associated with both kidneys.
- Changes consistent with a mild reactive lymphadenopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the GI tract to explain the vomiting reported. This does not exclude the possibility of a primary enteropathy, and current steroid use can reduce visible changes.

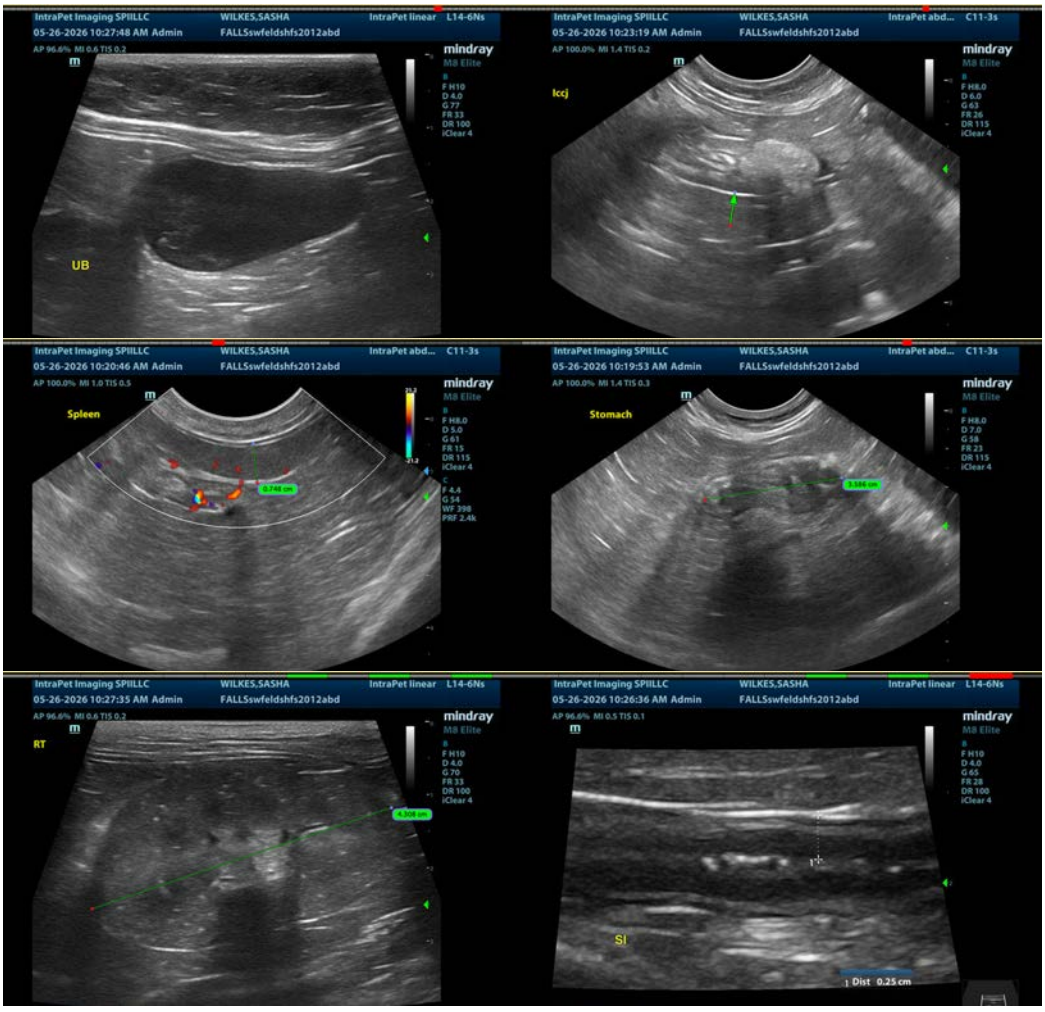
The area of pancreas visualized do not appear overtly inflamed. Correlate with PLI level, looking for any evidence of mild chronic pancreatitis. Additionally, you could consider a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate to perform the aforementioned pancreatic evaluation and look for

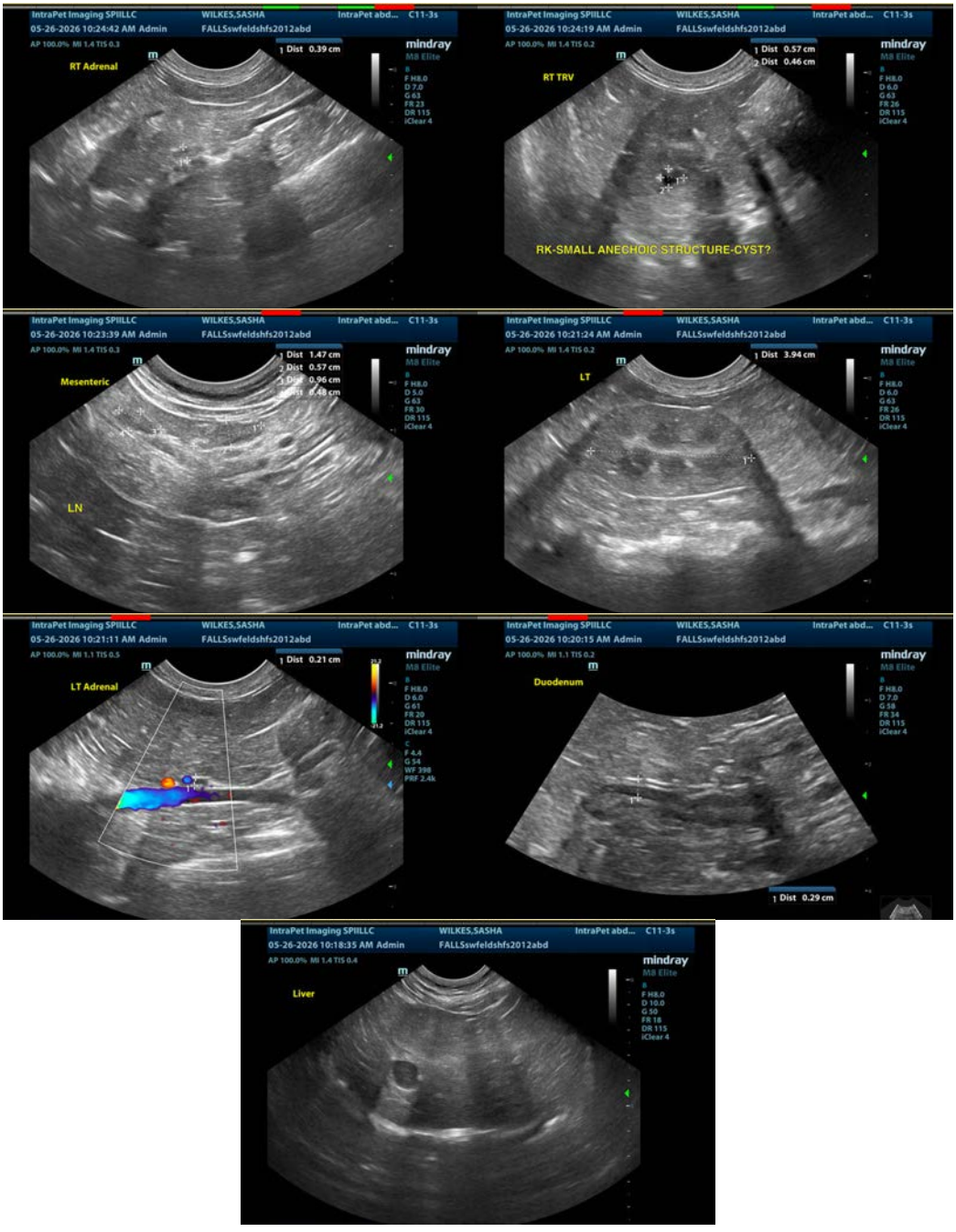
additional evidence of an ongoing enteropathy.

There are mild age related changes visualized associated with both kidneys. Correlate with urine concentrating ability and renal values.

Mesenteric lymph nodes are somewhat prominent with an appearance most consistent with mildly reactive lymph nodes, although metastatic change cannot be definitively ruled out, as steroid therapy can mask these changes.

If symptoms are persistent, ultimately biopsies of the GI tract may be warranted.

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WILKES,SASHA
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RT Adrenal
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mindray
M8 Elite
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WILKES,SASHA
IntraPet abd... C11-3s
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RK-SMALL ANECHOIC STRUCTURE-CYST?
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Mesenteric
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Dist 0.96 cm
LN
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mindray
M8 Elite
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WILKES,SASHA
IntraPet abd... C11-3s
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Duodenum
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WILKES,SASHA
IntraPet abd... C11-3s
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FALLSswfeldshfs2012abd
Liver
mindray
M8 Elite

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.

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