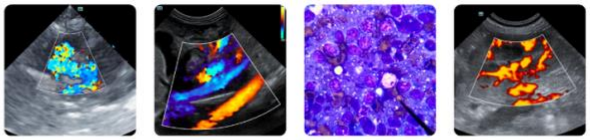


PATIENT

Korra Farley

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

6 Years 8 Months

WEIGHT

9.3 pounds

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP

IMAGING PERFORMED BY

Dr. Lucas Budden

HOSPITAL NAME

Frontier Veterinary Hospital

REFERRING VET

Dr. Lucas Budden

INVOICE

13129

DATE

01/12/26

PRESENTING CLINICAL SIGNS

Clinical signs: Chronic vomiting and weight loss History: Chronic vomiter entire life. Past few weeks has been vomiting every other day. 4-5 days ago was vomiting and not eating. This resolved and has been eating normally and no vomiting has been noted over the past few days. Ultrasound to assess for cause of chronic vomiting. Current medications: Gabapentin to facilitate ultrasound Dexdomitor/Butorphanol sedation for ultrasound

Abnormal PE/Chem/CBC/UA Results: Physical exam: no pain on abdominal palpation, no organomegaly, further weight loss (12/16/25 was 9.78#, now 9.3#), mild dental tartar, no thyroid slip, normal exam otherwise Lab work: GI panel pending Senior panel 12/16/25 Creatinine high 1.6 Glucose high 180 Remainder of chemistry normal CBC normal Thyroid normal 2.3 FEL V/FIV negative/negative Heartworm test negative USG 1.062 Protein 2+ RBC 2-3 Quiet sediment otherwise Fecal negative

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic change were noted.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex. Indistinct fluid in the caudal aspect of the pelvis or potential atypical caudal right kidney cyst. The left kidney measured 3.5 cm in length. The right kidney measured 3.6 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.38 cm width.

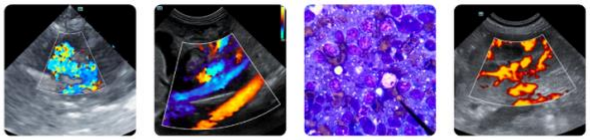
The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.35 cm width.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver & Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion.



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The gallbladder was non-distended in size. The gallbladder wall was mildly thickened in appearance consisting of an echogenic double rim corresponding to the inner and outer portions of the wall. This is consistent with gallbladder wall edema. Possible causes may include acute inflammation, edema and anaphylaxis. The gallbladder contained anechoic bile without evidence of bile sediment. The common bile duct was not visualized. No evidence of posthepatic obstruction. The gallbladder wall measured 0.17 cm wall width.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild nonshadowing ingesta/chyme without evidence of obstruction to pyloric outflow. The pylorus wall measured 0.22 cm.

The intestinal walls demonstrated generalized intact segmentally thickened wall most notable in the jejunum with mild altered jejunal wall layer ratio owing to propensity for a mildly thickened muscularis layer. The duodenum wall measured 0.24 cm width. The jejunum wall measured 0.26 cm to 0.27 cm width. The ileocolic wall measured 0.36 cm width.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The pancreas was normal in size with mild capsule asymmetry and isoechoic mildly heterogeneous left pancreatic limb parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia. Minor prominent left limb pancreatic duct.

Free Abdomen

A solitary and mildly prominent pancreatic duodenal and intermittent colic lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). Mild increased peri-ileocolic omental echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Normal stomach with mild nonshadowing ingesta/chyme.
- Intact borderline to mild segmental thickened small intestine wall.
- Mild heterogeneous left pancreas.
- Mild edematous gallbladder.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although possible small intestinal variants, mild mural changes in the intestinal tract are present, which suggests mild enteropathy with mild IBD, or other inflammatory enteropathy favored. Minor potential for emerging to low-grade intestinal round cell neoplasia thought less likely. Concurrent mild chronic pancreatitis may be suspected if cranial abdomen/subxiphoid discomfort on palpation. Correlation with pending GI panel as well as screening three view chest radiographs are suggested.

Dietary trial, empirical deworming, if clinically indicated, as needed gastroprotectants with clinical and sonographic monitoring would be reasonable. Intestinal biopsies may be considered if persistent or progressive gastrointestinal signs or a weight loss. UPC level may be considered if persistent proteinuria given quiet urine sediment.

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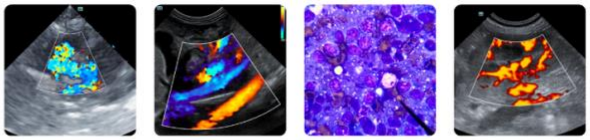

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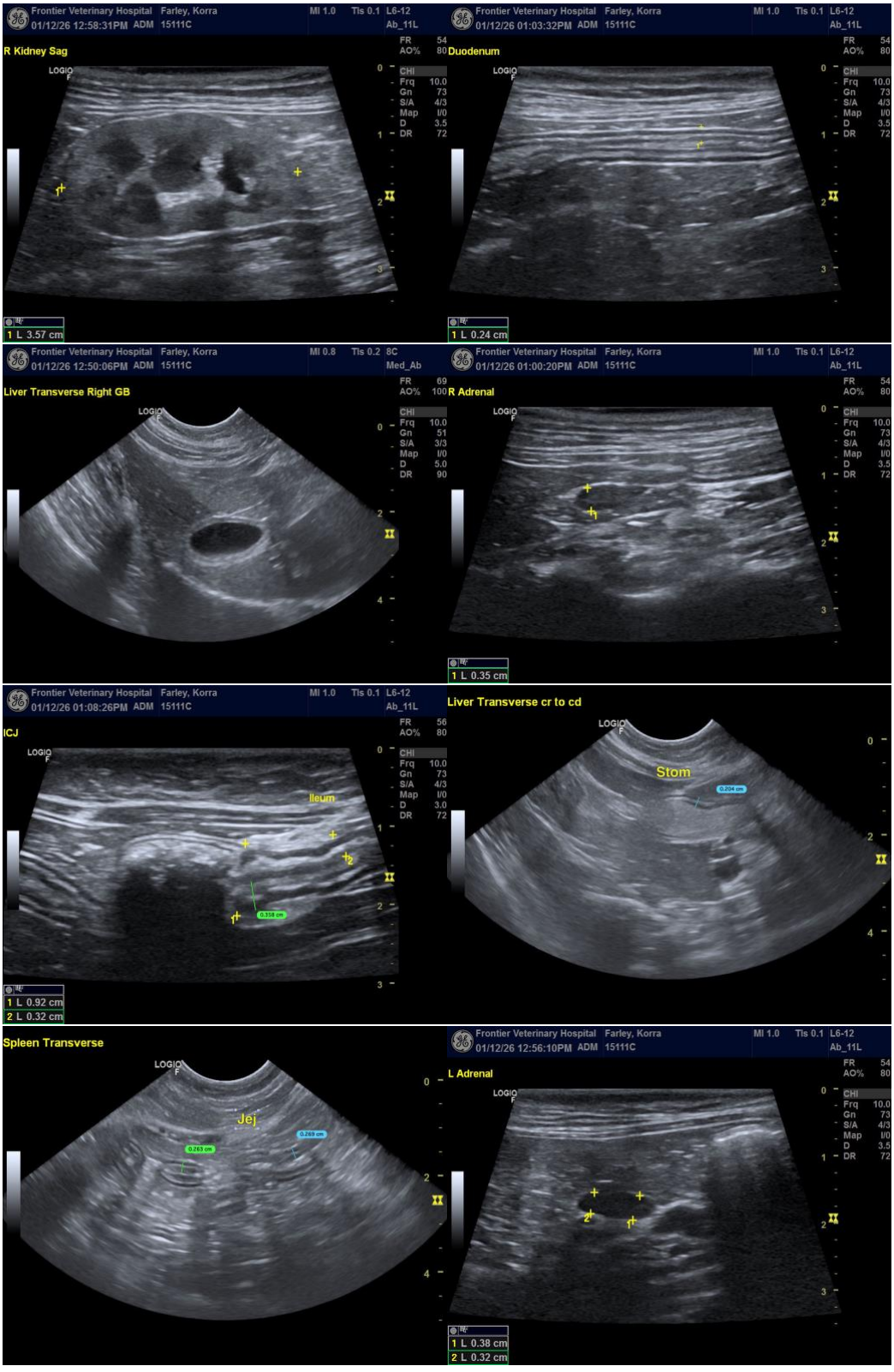

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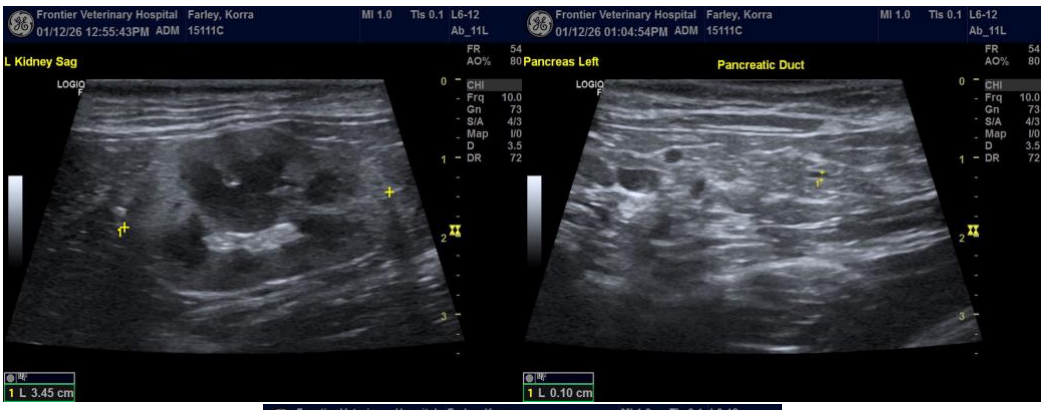

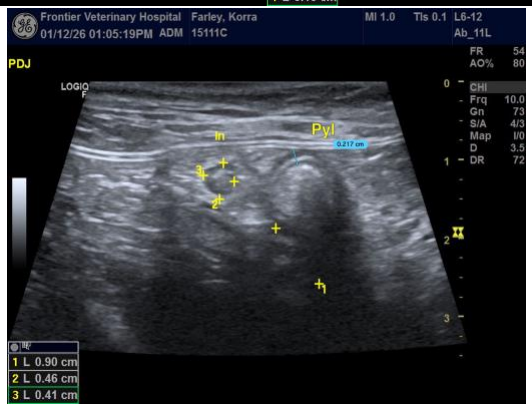

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

info@SonoPath.com