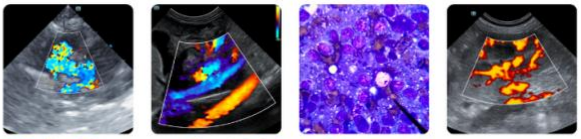


PATIENT

Dusty Lingle

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

8 Years

WEIGHT

6.33 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Lindsay Powell CVT

HOSPITAL NAME

Hershey Animal Emergency Center

REFERRING VET

Dr. Kimberly Davidson

INVOICE

13419

DATE

01/27/26

PRESENTING CLINICAL SIGNS

- Chronic vomiting. History of FBO 10/26/25 resolved with surgery. Increased vomiting frequency, lethargy and inappetence over past couple days.

Abnormal PE/Chem/CBC/UA Results: Fractious, sedated exam done. thickened caudal intestines on palpation. otherwise unremarkable PE CBC: eosinopenia (0.02), otherwise WNL Chem: hyperglycemia (239), hypercholesterolemia (259) EPOC: hypokalemia (3.3), hyperglycemia (237) fPL: WNL Radiographs Conclusions: -Findings are most supportive of enteritis +/- and gastritis. –Mild-moderate volume of desiccated fecal content. –Chronic degenerative renal disease (likely right sided) with bilateral nephrolithiasis. –Generalized bronchial pulmonary pattern with a nodular component

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.

The area of the aortic trifurcation was free of pathology.

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 with no evidence of pelvic dilation. A hyperechoic corticomedullary band, consistent with a medullary rim sign, was present. This is a nonspecific finding seen in both normal and abnormal kidneys. It may be associated interstitial renal disease, hypercalcemia, tubular necrosis, lymphoma, and FIP. However, it is a nonspecific finding. The left kidney measured 3.9 cm in length. The right kidney measured 4.1 cm in length.

Adrenal Glands

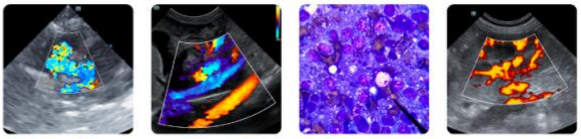
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.38 cm width.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.44 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



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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.

The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild retained pyloric fluid. No evidence of obstruction to pyloric outflow. The pylorus wall measured 0.35 cm wall width.

The small intestine presented intact wall layering with overall maintained wall layer ratio. Borderline mild thickened intestinal wall without evidence of loss of intestinal wall layering or mechanical/metabolic ileus to the level of the colon. The duodenum wall measured 0.29 cm wall width. The jejunum wall measured 0.28 cm wall width. The ileocolic wall measured 0.39 cm wall width.

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

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

Minor colic lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Mild perilymphatic hyperechoic omentum. An example of lymph node size was 1.0 cm x 0.53 cm. No evidence of peritoneal effusion.

ULTRASONOGRAPHIC FINDINGS

- Sonographically normal mild hypomotile stomach.
- Intact borderline mild thickened small intestinal wall with maintained wall layer ratio.
- Bilateral nonspecific renal medullary rim sign.
- Minor colic lymphadenopathy-suspect mild reactive lymphadenitis or hyperplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of significant visceral pathology, specifically significant gastrointestinal mural pathology, pancreatitis, gastrointestinal obstructive pattern or foreign material. Mild metabolic gastric stasis, potentially secondary to recurrent non-specific gastroenteritis or possible low-grade chronic gastroenteropathy, which may present essentially sonographically normal is possible.

Gastrointestinal support is indicated, which may include long-term dietary trial and as needed gastroprotectants with clinical monitoring is recommended. Empirical deworming may be considered if clinically indicated. Sonographic reassessment or monitoring is suggested if continued or progressive gastrointestinal signs or weight loss. Urinalysis is recommended if not recently done.

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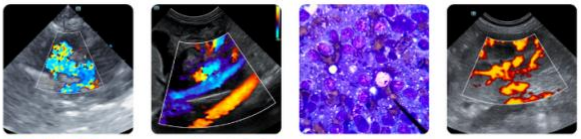

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Educational Teleconsultation Services™

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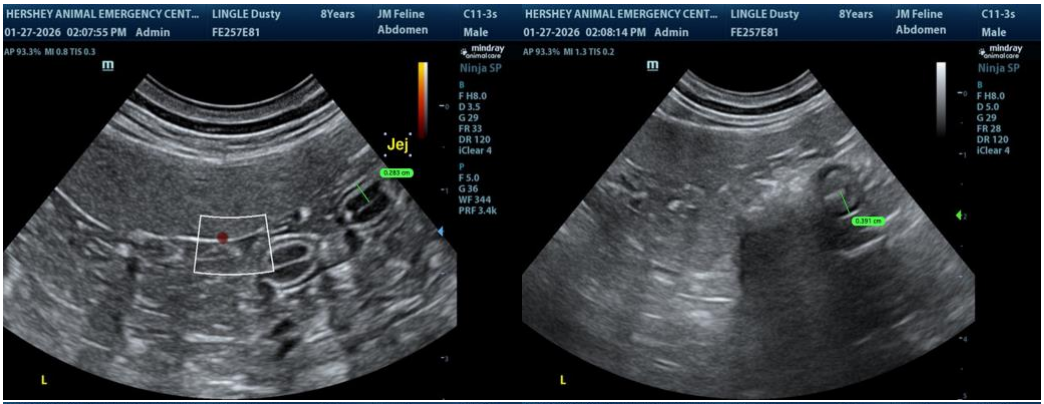

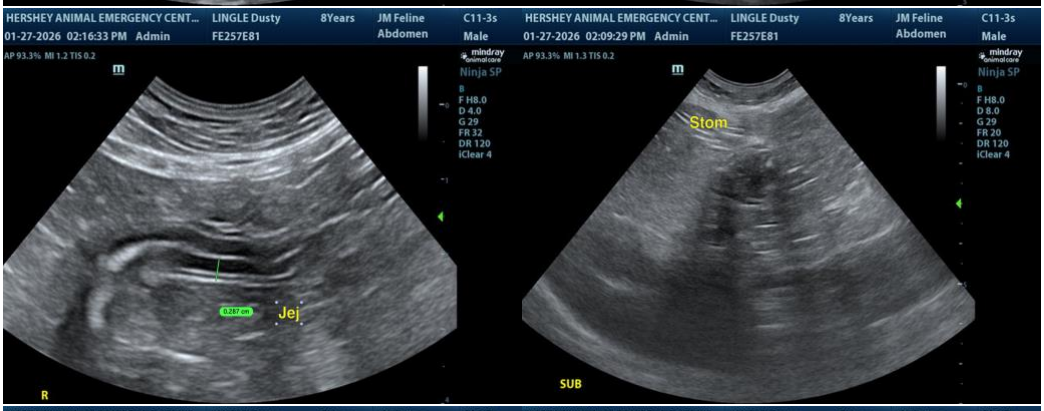

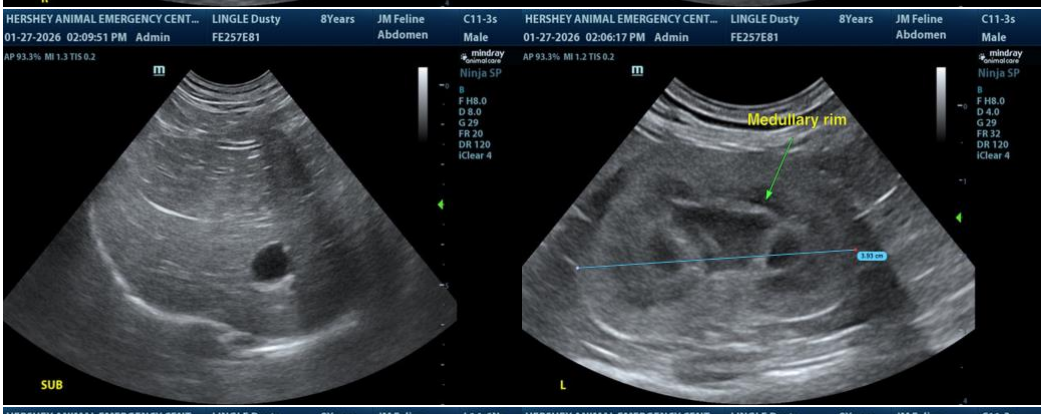

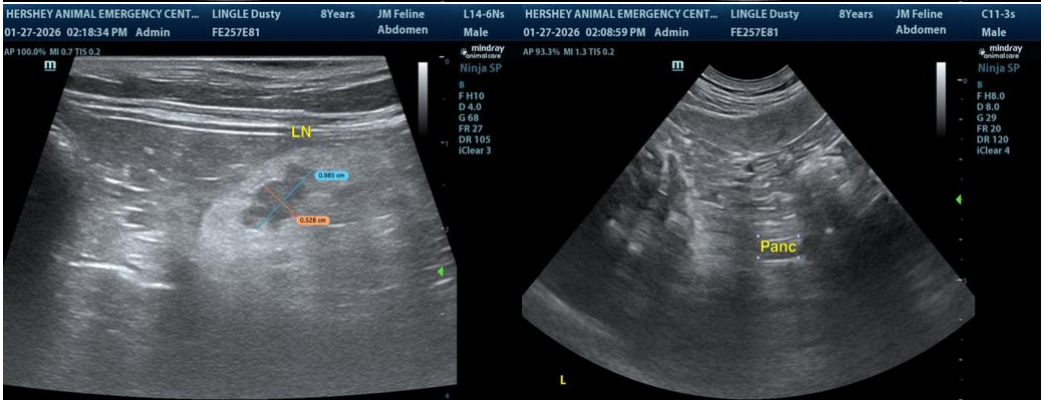

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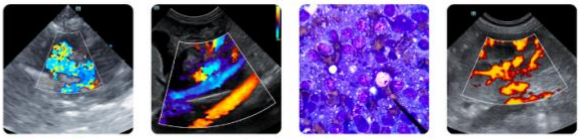

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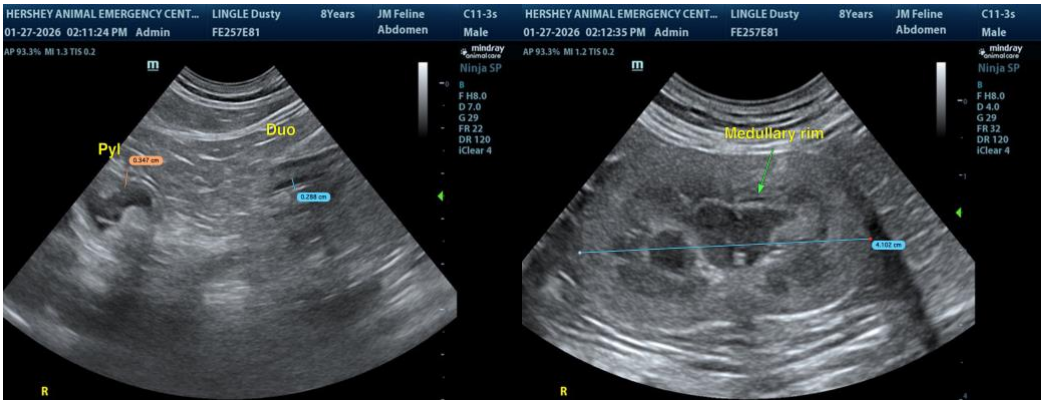

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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