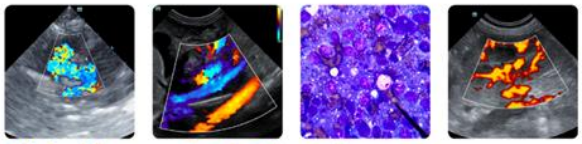


PATIENT

Louie IsaacsonVet

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

9yr

WEIGHT

16.3lb

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Chrissy Krell, DVM

HOSPITAL NAME

Isaacson Veterinary Hospita

REFERRING VET

Barb Lester, DVM

INVOICE
23720

DATE
01/30/2026

PRESENTING CLINICAL SIGNS

- Louie is a clinic cat, noted some weight loss recently (unintentional). No other clinical symptoms. He has some arthritis in his left hind leg from previous injury(femoral fracture) and injury to his stifle, receives Adequan injections, cold laser therapy, and is on fluoxetine for inappropriate urination. Screening for a cause of the weight loss.

Abnormal PE/Chem/CBC/UA Results: PE: dental disease, overall unremarkable. CBC: wnl Chem: wnl TT4: wnl XR Consult CONCLUSIONS: 1. Functional ileus versus less likely aerophagia. Consider infiltrative disease (inflammatory bowel disease, round cell neoplasia) versus non-specific enteritis (irritant, metabolic, infectious, or vascular etiologies). 2. Possible pulmonary nodule versus artifact of superimposed normal anatomy. Broncholithiasis is possible. In the case of a pulmonary nodule, consider primary pulmonary neoplasia such as bronchoalveolar carcinoma, metastatic neoplasia, or granuloma. 3. Chronic healed left distal femoral fracture. The proliferative new bone likely corresponds to periosteal stripping from previous trauma. 4. Chronic L7-S1 degenerative intervertebral disk disease.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with mild non-dependent particulate sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was 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 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 with interstitial renal disease, hypercalcemia, tubular necrosis, lymphoma, and FIP. However, it is a nonspecific finding. The left kidney measured 4.5 cm in length. The right kidney measured 5.1 cm in length.

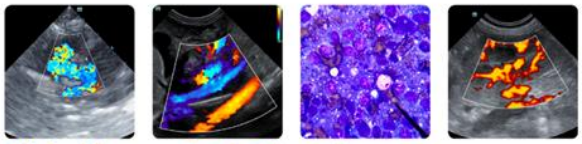
The area of the aortic trifurcation was free of pathology.

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 0.43 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.



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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. Normal vascular volume. 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 moderate variably echogenic non-shadowing ingesta sonographically suggestive of food echogenicity with no signs of obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine contained similar appearing non-shadowing ingesta/chyme with no signs of obstruction or foreign material. The duodenum wall measured 0.26 cm width. The jejunum wall measured 0.25 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 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

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Sonographically unremarkable gastrointestinal tract with non-shadowing gastrointestinal ingesta- consistent with food echogenicity
- Non-specific bilateral renal medullary rim sign
- Mild urinary bladder sediment

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of significant visceral pathology as a definitive cause of the patient's weight loss. Correlation with most recent meal ingestion is recommended. If documented NPO some degree of non-obstructive metabolic or functional gastrointestinal ileus could be possible. A GI panel to include PLI/TLI/cobalamin and folate to assess for non-structural or occult intestinal or pancreatic disease is recommended. Consideration for potential extra-abdominal contributing factors such as thoracic or musculoskeletal disease potentially indicated.

The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S if evidence of inflammatory cells is recommended.

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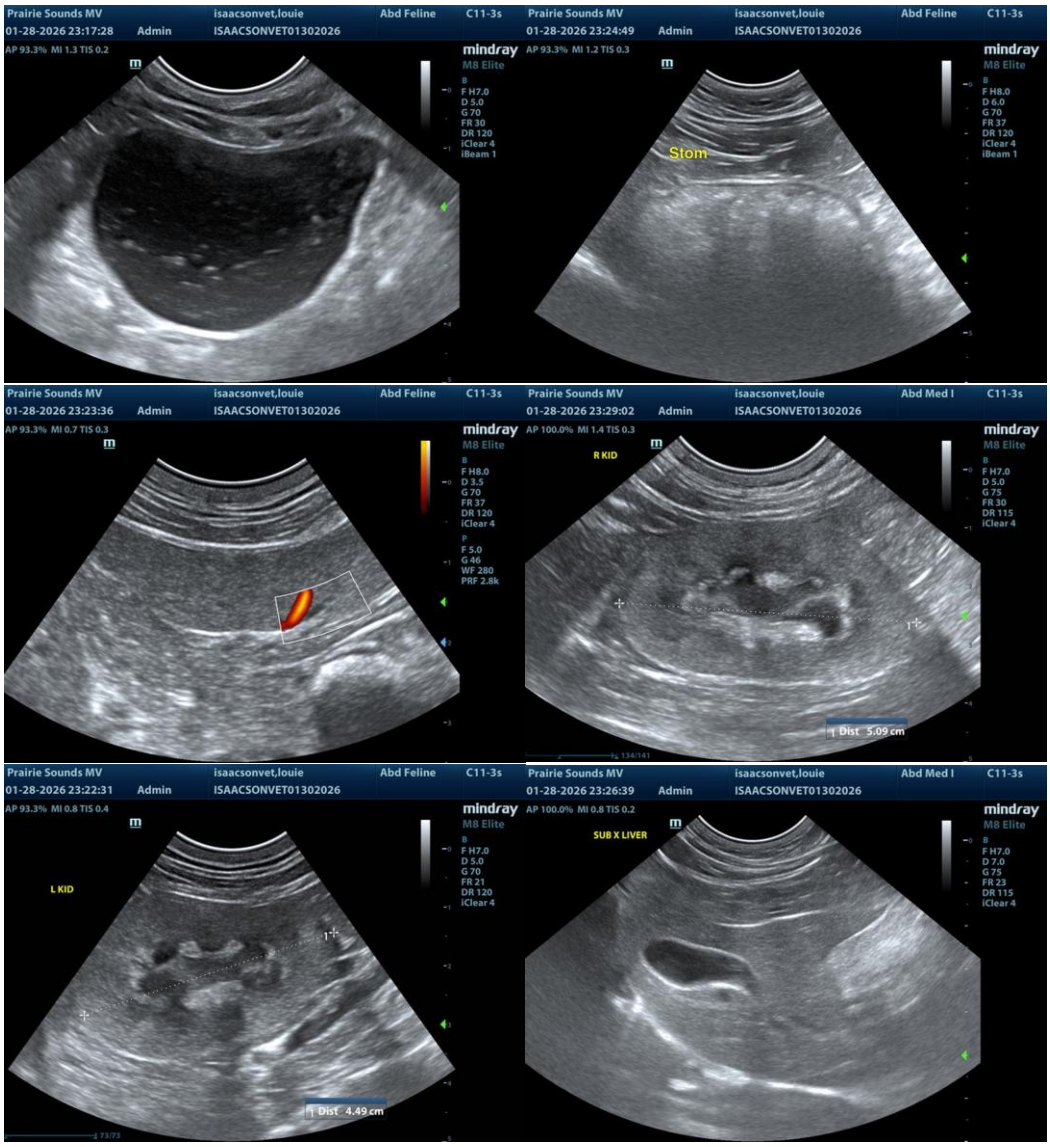

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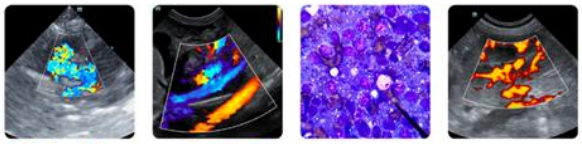

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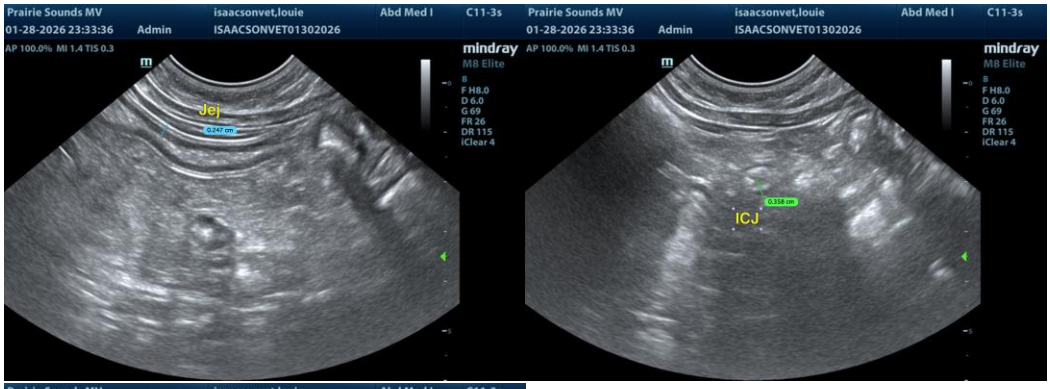

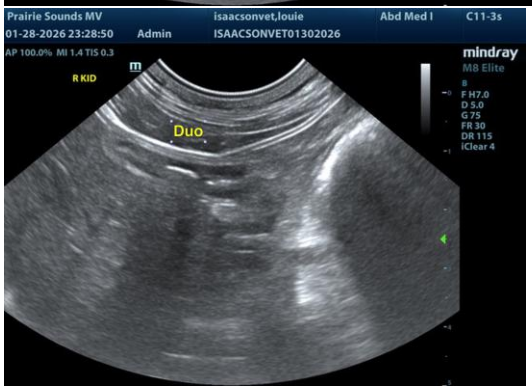

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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