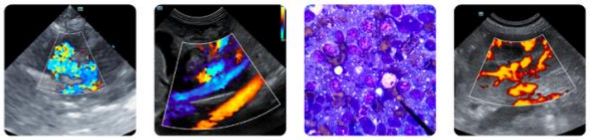

PATIENT

Jasmine Lindsay

SPECIES

Feline

BREED

Persian Mix

SEX

Spayed Female

AGE

11 Years 11 Months

WEIGHT

4.7 kg

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP

IMAGING PERFORMED BY

Dr. Jill Rankin

HOSPITAL NAME

Southwood Vet Hospital

REFERRING VET

Dr. Harris

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PRESENTING CLINICAL SIGNS

Jasmine has severe allergies, suspected hyper cardiomyopathy, suspected herpes carrier, suspected asthma, periodic collapsing events, possible seizures, renal insufficiency, hypertensive, and early arthritis. All above listed medical concerns have been being managed at home with a diet of RC renal/hypo dry, amlodipine and gabapentin. Over the last month she was on again off again eating (originally believed to be related to an allergy flare) since Christmas she has not been eating, super lethargic, clingy, non-vocal, drinking more, urinating more, soft BM with blood and possible vomiting with blood. Blood work was run. Had a slight elevation in her kidney values, otherwise everything else was within normal limits. She was placed on 200ml nacl SQ every other day, mirtazapine as needed, Cerenia daily. She declined further over the weekend and came in on Saturday jan 3, 2026 for further diagnostics. Exam showed mild dehydration, doughy abdomen with some discomfort, larger caudal abdomen. Radiographs were performed and showed moderately thickened stomach and intestinal walls, possible mass, nephrocalcinosis in the right kidney, right kidney elongation with possible renal pelvic dilation, area of concern in right dorsal anterior quadrant (unable to determine exactly what it is). Was put on metronidazole and an ASAP ultrasound was booked.

Abnormal PE/Chem/CBC/UA Results: Previous diagnostics from October 10 included bloodwork that showed a low sodium-to-potassium ratio, elevated cholesterol (5.8), and a markedly elevated CPK (5,152), with a normal T4. A urinalysis performed around the same time showed a USG of 1.020, 1+ protein, and a normal UPC ratio of 0.2. Bloodwork from December 30 showed an elevated BUN (12.3) and creatinine (190)

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 was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. Mild medullary mineral and mild pyelectasia was present in the left kidney, Nonobstructive medullary renoliths were visualized in the right kidney. The left kidney measured 3.2 cm in length. The right kidney measured 3.5 cm in length.

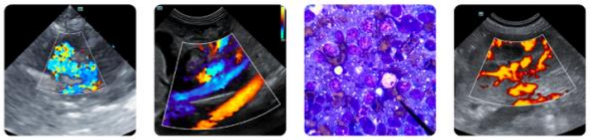
Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.33 cm width.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.32 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



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thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted. The spleen measured 0.87 cm width level of the mid spleen.

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.

The gallbladder was non distended in size with mild nonorganized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The small intestine exhibited generalized intact wall layering and segmental to generalized thickened intestinal wall primarily visualized in the jejunum. Empty intestinal lumen without mechanical/metabolic ileus to the level of the colon. The duodenum wall measured 0.27 cm width. The jejunum wall measured up to 0.28 cm width. The ileocolic wall measured 0.34 cm width.

Generalized normal colon wall with primarily formed fecal matter in lumen. A subjective nonobstructive descending colon mass was present extending mildly into the descending colon lumen measuring 1.5 cm x 0.73 cm.

Pancreas

The left pancreas presented mildly prominent in size with mild capsule asymmetry and subtle nonhomogenous hypoechoic parenchyma compared to adjacent nonreactive or inflamed omentum.

Free Abdomen

Intermittent mildly prominent jejunocolic 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). No evidence of peritoneal effusion.

ULTRASONOGRAPHIC FINDINGS

- Chronic renal changes exhibiting nonobstructive right kidney renolithiasis and left kidney mild medullary mineral/pyelectasia.
- Normal bilateral adrenal glands.
- Segmental to generalized intact mildly thickened small intestine.
- Suspect nonobstructive descending colon mass.
- Intermittent mild jejunocolic lymphadenopathy.
- Possibly mild pancreatitis.
- Sonographically normal empty stomach.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Mild IBD intestinal pattern with mild associated jejunocolic lymphadenopathy are possible concurrent mild pancreatitis. Possible potential for emerging to low-grade intestinal round cell neoplasia in conjunction with suspect descending colon mass may present in a similar sonographic manner. No evidence of gastroenterocolic obstruction. A GI panel to include PLI, TLI, cobalamin and folate is

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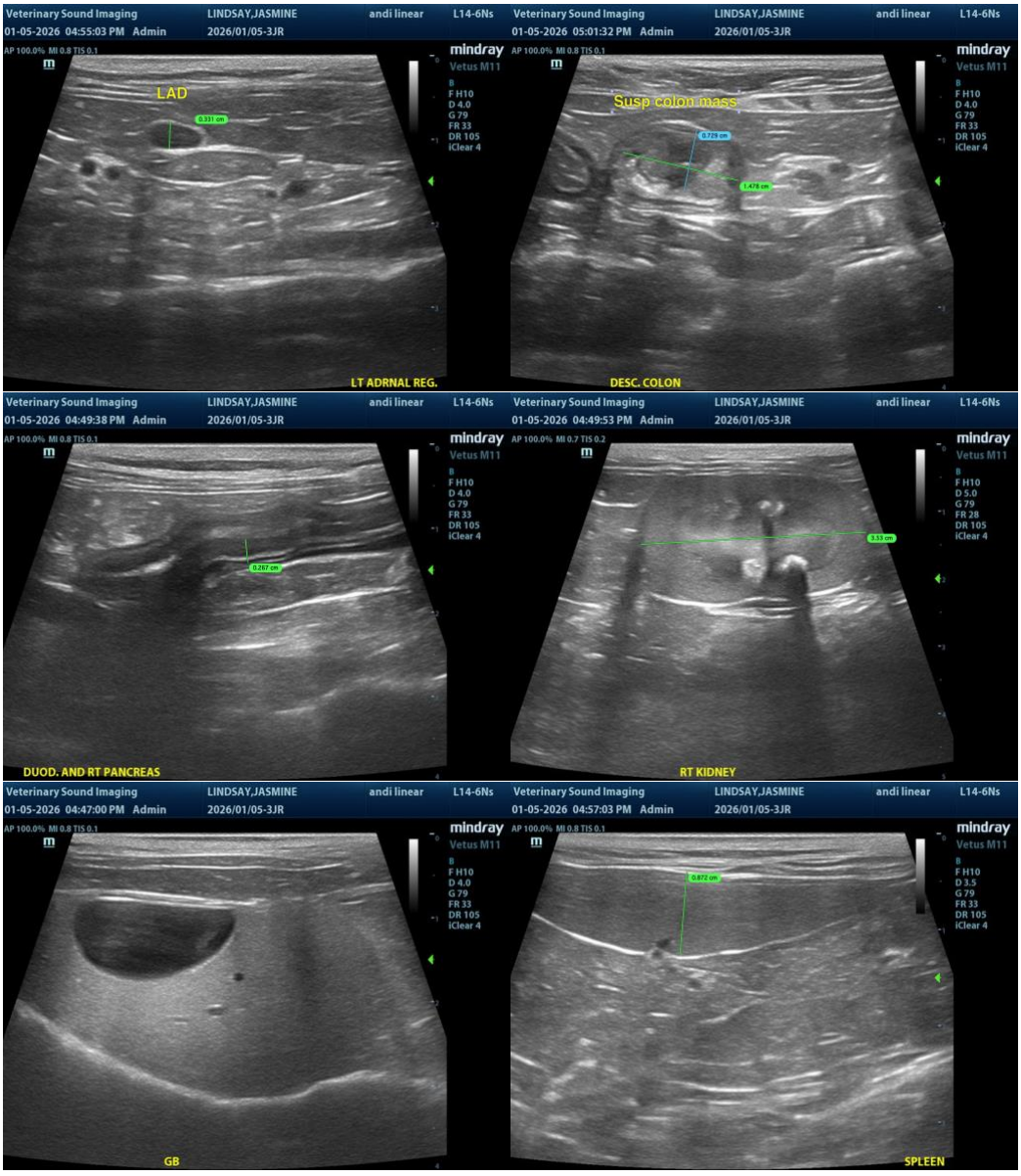
recommended. Gastrointestinal and renal support with monitoring of renal parameters, gastrointestinal signs and body condition with sonographic monitoring of the small intestine and suspect descending colon mass would be reasonable. A definitive diagnosis would likely require intestinal and colon biopsies for histopathology.



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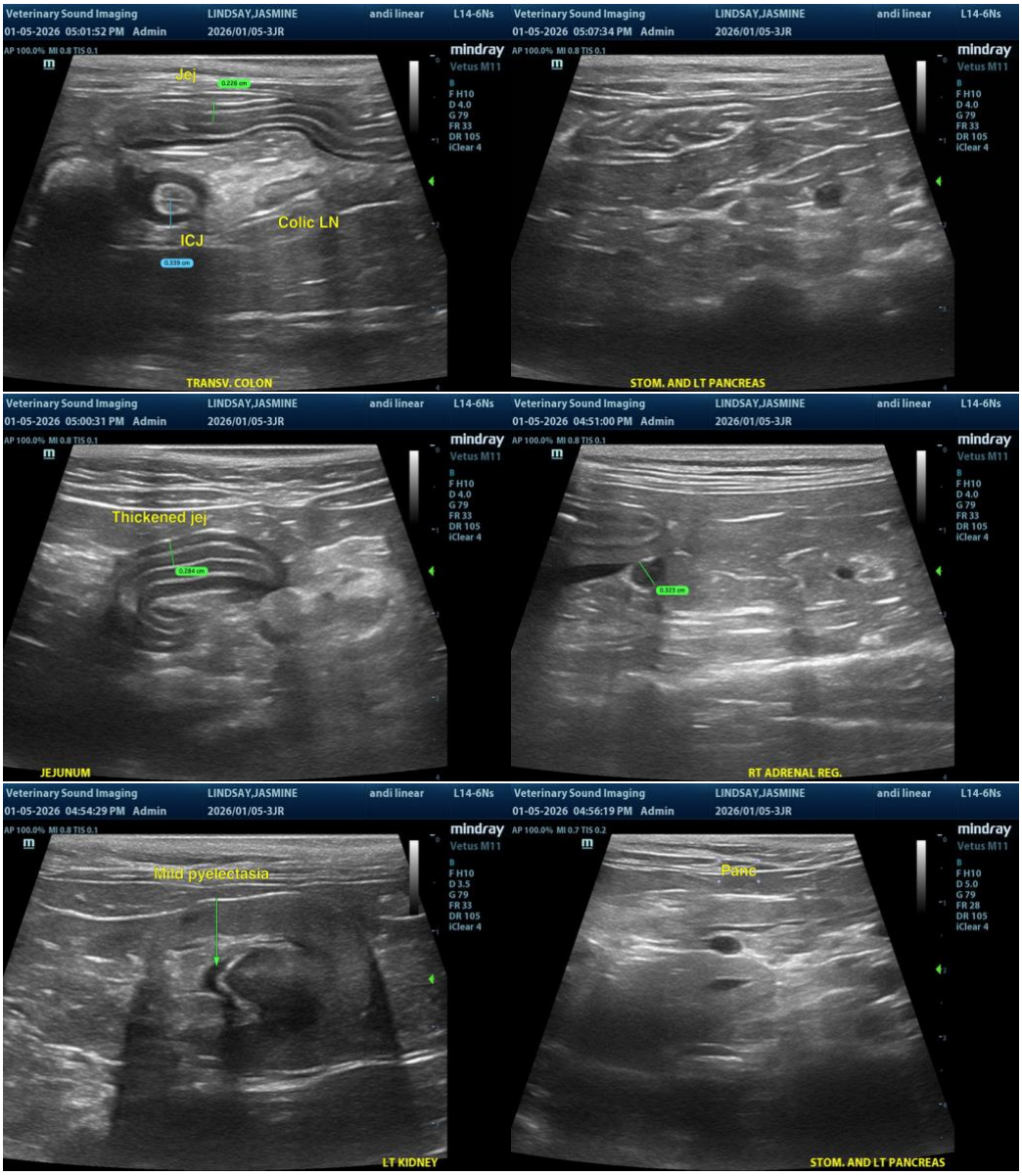

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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