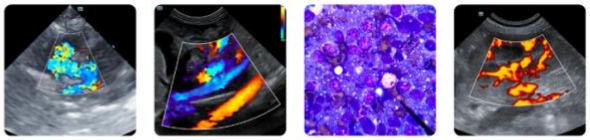


PATIENT

Daisy Daniels

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

6 Years

WEIGHT

6.4 kg

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP

IMAGING PERFORMED BY

Dr. Anna Wepprich

HOSPITAL NAME

Wilvet Salem

REFERRING VET

Dr. Anna Wepprich

INVOICE

13027

DATE

01/09/2026

PRESENTING CLINICAL SIGNS

Anorexic since 1/5/26, vomiting, diarrhea, elevated tbili at rDVM. Urinating outside the box.

Abnormal PE/Chem/CBC/UA Results: Was at Orchardview with Dr. Crawford 1/8/26. Had history of vomiting and diarrhea. Also had been anorexic since Monday. Had not been wrestling with dogs in household like she normally does. Orchard View 1/8/26 RDW 28.3% (H) Lymphopenia 0.81 K/uL Thrombocytopenia 135 K/uL (Platelecrit low normal) Hypochloremia 108 mmol/L ALT 340 U/L ALP < 10 Bilirubin 5.3 mg/dL Urinalysis- cystocentesis, USG > 1.050, bilirubin 6, urobilinogen 12, suspect presence of rods with urine bacterial confirmation was none detected on rods or cocci.

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 with no evidence of pelvic dilation. The left kidney measured 4.3 cm in length. The right kidney measured 4.6 cm in length.

Adrenal Glands

The areas of the left and right adrenal glands were free of pathology.

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.

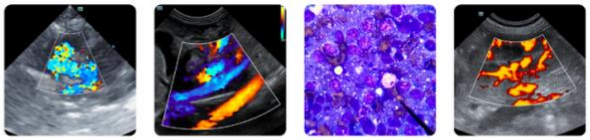
Liver & Gallbladder

The liver revealed mild hepatomegaly with symmetrical contour and homogenous mild increased hepatic parenchyma compared to adjacent omentum. Mild coarse hepatic parenchyma echotexture without evidence of mass or nodules. Normal vascular volume was maintained.

The gallbladder was non distended in size with mild biliary sludge. The common bile duct was not visualized.

Gastrointestinal

The stomach presented intact wall layering with subjective mild prominent pylorus wall. The stomach lumen contained minor retained anechoic fluid with no evidence of obstruction to pyloric outflow. The pylorus wall measured 0.38 cm wall width.



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The small intestine exhibited primarily intact borderline to mild thickened wall layering with mild altered wall layer ratio as well as concurrent segmental indistinct mural detail involving the mid abdomen intestinal segments consistent with jejunum. The ileocolic wall measured 0.35 cm wall width. The small intestine wall measured 0.26 cm to 0.27 cm wall width. AN area of thickened to mildly proliferative mid abdomen jejunum to emerging mass was visualized measuring approximately 1.0 cm in diameter with mild surrounding hyperechoic omentum.

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

Pancreas

The area of the pancreas was sonographically normal.

Free Abdomen

No visualized significant omental lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Hepatopathy.
- Mild gallbladder debris with sonographically normal common bile duct.
- Primarily intact segmental to mild thickened intestinal wall with segmental indistinct to loss of jejunal mural detail/emerging jejunal mass.
- Intact mildly thickened pylorus with minor retained gastric fluid.
- Normal urinary bladder.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of mechanical gastrointestinal or posthepatic obstruction. Inflammatory or neoplastic hepatointestinal etiologies are possible with granulomatous disease/FIP thought less likely. Further assessment may include (assuming normal clotting status and using 25-gauge needle) hepatic FNA cytology, intestinal biopsies with potential resection and anastomosis of segmental jejunum with histopathology likely required for a definitive diagnosis. Urine culture and sensitivity is recommended if not done.

ADDENDUM

Additional 20 images were submitted for review.

Similar appearing hepatomegaly exhibiting homogenous parenchyma and normal hepatic vascular volume and nondilated cranial abdomen cranial abdomen caudal vena cava. Gallbladder wall edema is now present with anechoic bile. The common bile duct was not definitively visualized. A mild volume of perihepatic to cranial abdomen free fluid was visualized.

The visualized intestinal segments exhibited similar appearing intact ti mildly thickened wall with small intestine wall measuring 0.28 cm wall width. The previously noted segmental indistinct loss of jejunal wall layering to emerging jejunal mass was not definitively visualized in limited addendum series.

Addendum Findings

- Possible progressive hepatopathy.
- Edematous gallbladder.
- Perihepatic/cranial abdomen mild volume effusion.
- Similar appearing segmental intact thickened small intestinal wall.

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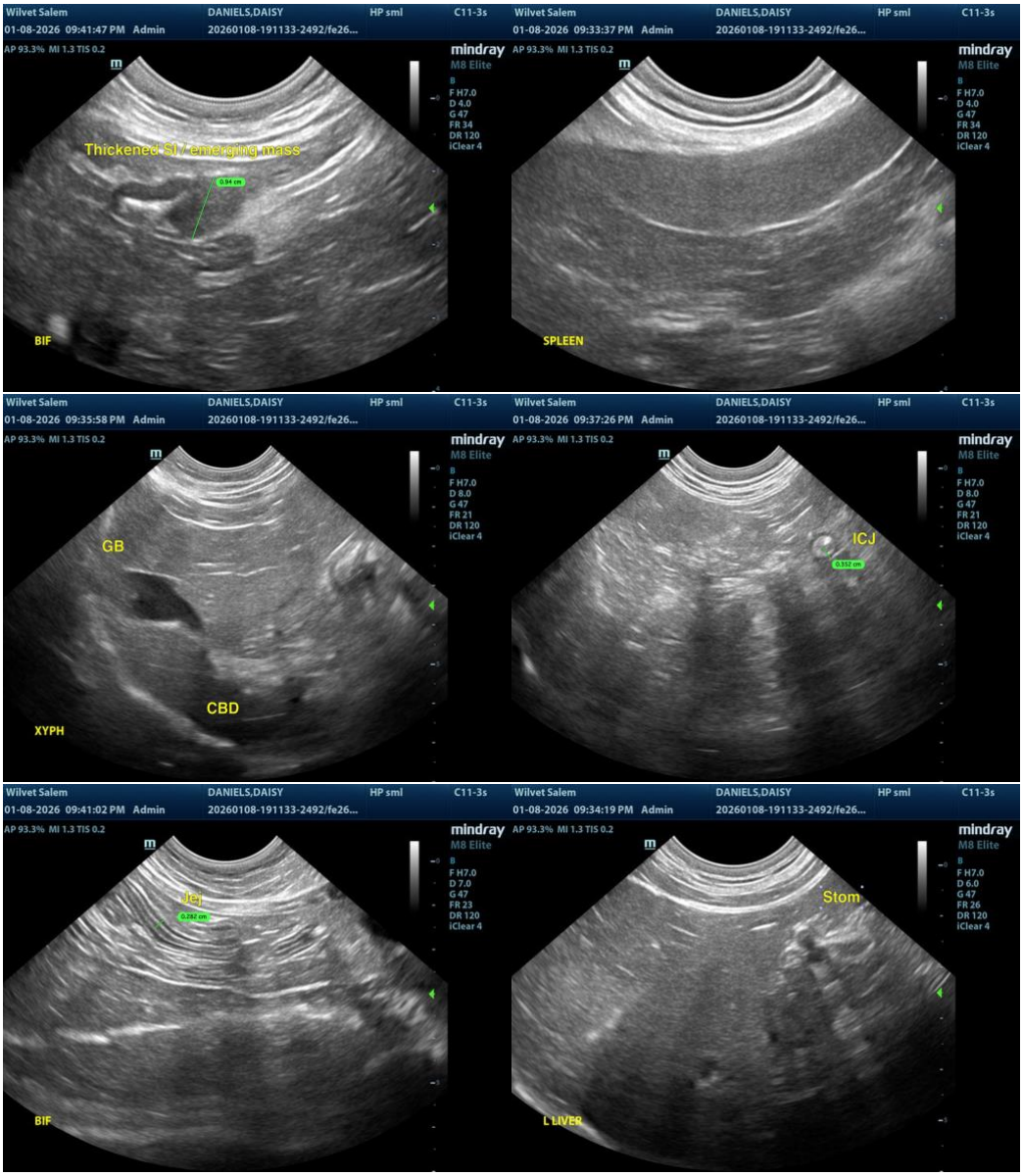
Addendum Interpretations

Given potential progressive hepatopathy and assuming normal clotting status, hepatic FNA cytology is warranted for further clarification primarily to assess for inflammatory or occult neoplastic criteria prior to consideration for previously mentioned potential surgical considerations.



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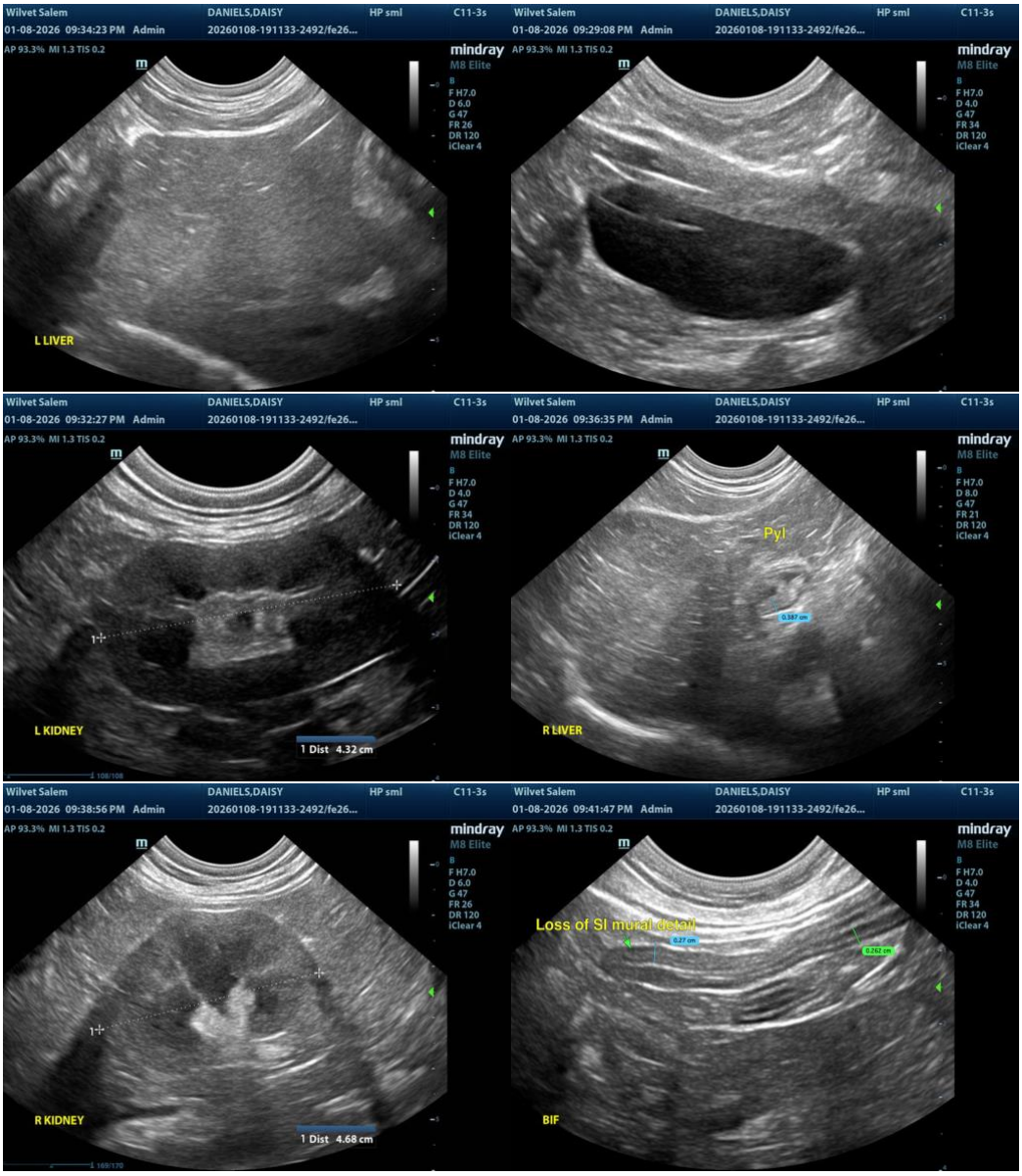

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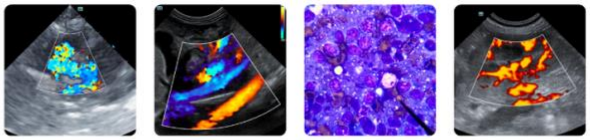

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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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