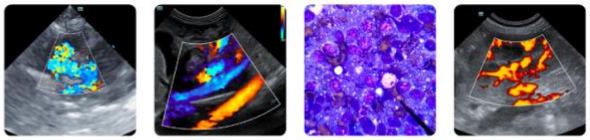


PATIENT

Pixie

SPECIES

Feline

BREED

Persian

SEX

Spayed Female

AGE

12 Years

WEIGHT

2.7 kg

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP

IMAGING PERFORMED BY

Michelle DeMelo RVT

HOSPITAL NAME

Woodstock Veterinary Hospital

REFERRING VET

Dr. Esther Duschinsky

INVOICE

12219

DATE

11/11/25

PRESENTING CLINICAL SIGNS

Pixie our clinic cat has had a long hx of pica, intermittent vomiting and anorexia - Currently on Dexamethasone and Cerenia injections EOD, Mirtaz TDG daily, Fluoxetine daily, Vitamin B12monthly and Sementra daily - Was recently switched from Hill's Z/D wet and dry food to Royal Canin Renal+Hypo HP - about 1.5 years ago she acutely became anorexic, had vomiting and was pyrexic and painful - Exploratory was performed and revealed multiple adhesions with entrapped omentum/SIT and evidence of hemorrhagic lesions on the tail of spleen with multiple adhesions of omentum balled up at the tail - spleen itself had 10% of tail with nodular, multilobulated area with evidence of bleeding previously and adhesions - also noted were multiple hemorrhagic areas with adhesions noted in the omentum - unfortunately no LN or GIT biopsies were taken - Kidneys appeared normal at that time and liver showed a prominent yellow zonal appearance - Spleen was removed - P recovered slow from this sx and ended up needing a feeding tube for an extended period of time - Since then has been up and down with appetite and vomiting episodes - ultrasound submission for QC memo (submitted separately) and to evaluate the kidneys and urinary bladder for urolithiasis and overall check for underlying cause for poor doing

Abnormal PE/Chem/CBC/UA Results: Recent bloodwork, overall surprisingly good for Pixie. Mild (Chronic) anemia at 26. Mild decreased ALT (not likely significant), Largest and likely most significant is a UPCR of 0.5, SG is 1.020, so worried about some early renal disease and protein losing nephropathy. Rec. Start Semintra meds and when asked about diet, discussed that previously there was concern or possible IBD or food sensitivity, rec. stick with Hypo diets, Rec. Hypo/Renal diet as a higher calorie diet option.

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 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. No evidence of pelvic dilation was present. The left kidney measured 3.5 cm in length. The right kidney measured 3.7 cm in length.

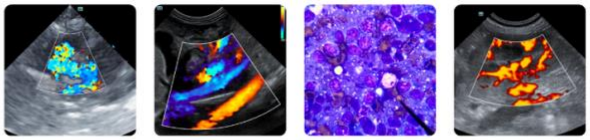
Adrenal Glands

The left and right adrenal glands were not definitively visualized with no obvious pathology.

Spleen

The spleen was not visualized owing to previous splenectomy.

Liver



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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. A solitary well demarcated nondisruptive hyperechoic intraparenchymal nodule was visualized measuring 0.71 cm in diameter.

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

Gastrointestinal

The stomach presented with regional mild thickened wall layering exhibiting intact to regional indistinct mural detail. The stomach was nondistended containing a mild amount of retained anechoic fluid and lumen gas. Mildly thickened gastric wall measured 0.37 cm wall width.

The visualized segments of small intestine exhibited intact wall layering and normal wall layer ratio with empty lumen. The duodenum wall measured 0.21 cm width. The jejunum wall measured 0.22 cm width.

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

Pancreas

Subjective mild prominent pancreas exhibiting mild capsule asymmetry and nonhomogenous remodeled to mildly hypoechoic parenchyma compared to adjacent omentum.

Free Abdomen

Mild perigastric hyperechoic omentum and intermittent mild homogenous gastric lymph nodes were visualized with an example measuring 0.46 cm in diameter. No overt peritoneal effusion. No evidence of omental masses.

ULTRASONOGRAPHIC FINDINGS

- Normal to mildly thickened stomach wall with mild retained gastric fluid.
- Mild perigastric hyperechoic omentum and mild gastric lymphadenopathy.
- Sonographically unremarkable visualized small intestine.
- Prominent nonhomogenous mildly hypoechoic pancreas.
- Nonspecific mild chronic renal changes.
- Nonvisualized spleen- previous splenectomy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The mildly thickened hypomotile stomach may indicate inflammatory, infectious or potential emerging neoplastic etiologies. Chronic to chronic active pancreatitis would be suspected if cranial abdomen/subxiphoid discomfort on palpation. Correlation with a spec fPL or a full GI panel to include PLI, TLI, cobalamin and folate to assess for nonstructural small intestinal disease as a contributing factor. Gastric +/- pancreatic biopsies are required for a definitive diagnosis. Empirical therapy for gastritis which may include dietary therapy, as needed gastroprotectants +/- empirical coverage for helicobacter with clinical and as needed sonographic monitoring would be reasonable. Monitoring of urinalysis +/- UPC level if evidence of proteinuria is recommended.

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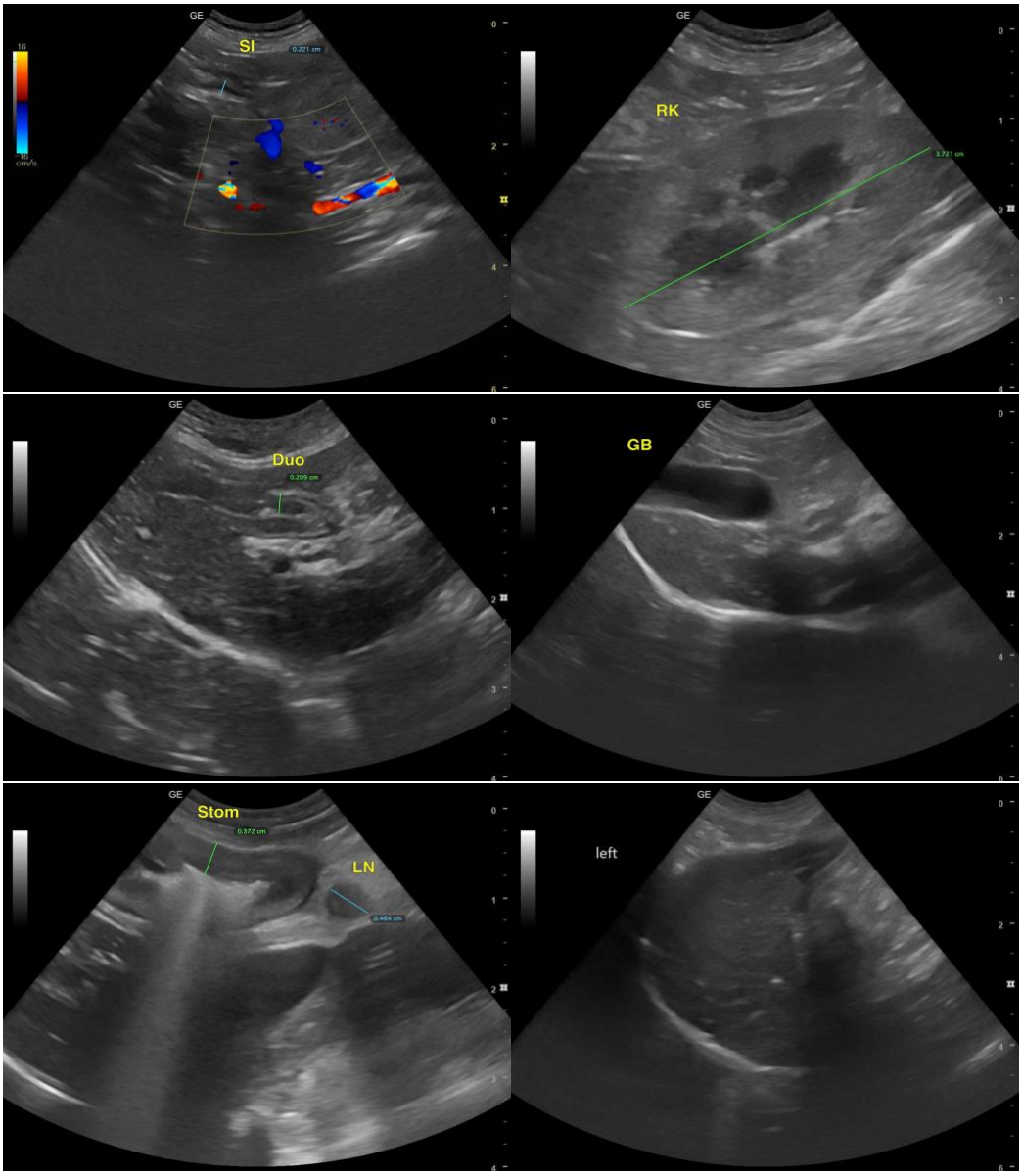

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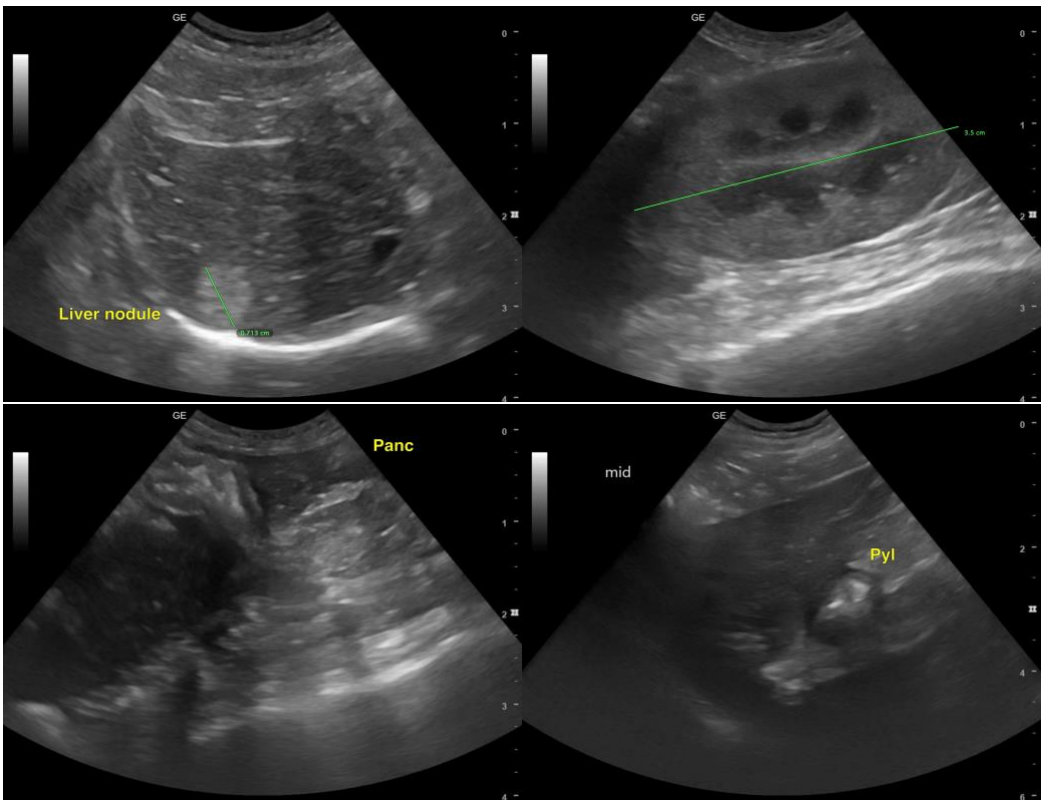

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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