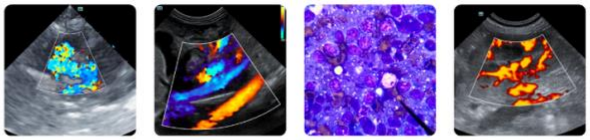

PATIENT

Wimsey Clark

SPECIES

Feline

BREED

Siamese X

SEX

Neutered Male

AGE

10 Years

WEIGHT

5.45 kg

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP

IMAGING PERFORMED BY

Carlie Koltek RVT

HOSPITAL NAME

Tuxedo Animal Hospital

REFERRING VET

Dr. Lameg (Corydon AH)

INVOICE

12445

DATE

11/24/25

PRESENTING CLINICAL SIGNS

Vomiting/Diarrhea X-rays confirm thickened bowel wall, no obvious masses, no obstructive pattern

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. No evidence of pelvic dilation was present. The left kidney measured 3.9 cm in length. The right kidney measured 4.1 cm in length.

Adrenal Glands

No obvious pathology in the area of the left adrenal gland.

The right adrenal gland was mildly prominent in size (not consistent with neoplastic criteria). The right adrenal gland measured 0.52 cm width.

Spleen

The spleen presented mildly enlarged with splenic folding, maintained homogenous parenchyma and overall symmetrical capsule contour. The spleen measured 1.1 cm width level of the mid spleen.

Liver

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 with regional intact mildly thickened wall. Thickened stomach wall measured 0.60 cm width. No evidence of obstruction to pyloric outflow. Pylorus wall measured 0.35 cm width. Overall maintained intact stomach wall layering. The stomach was nondistended containing mild lumen gas.

The intestinal walls demonstrated generalized thickened wall exhibiting altered to inverted wall. layer ratio owing to thickened muscularis layer. The duodenum wall measured 0.32 cm width. The jejunum wall measured 0.40 cm to 0.43 cm width. The ileocolic wall measured 0.36 cm width.

Normal intact colon wall layering. The colon exhibited generalized mild distention with soft fecal matter in lumen.

Pancreas

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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 visualized significant omental lymphadenopathy, omental masses or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

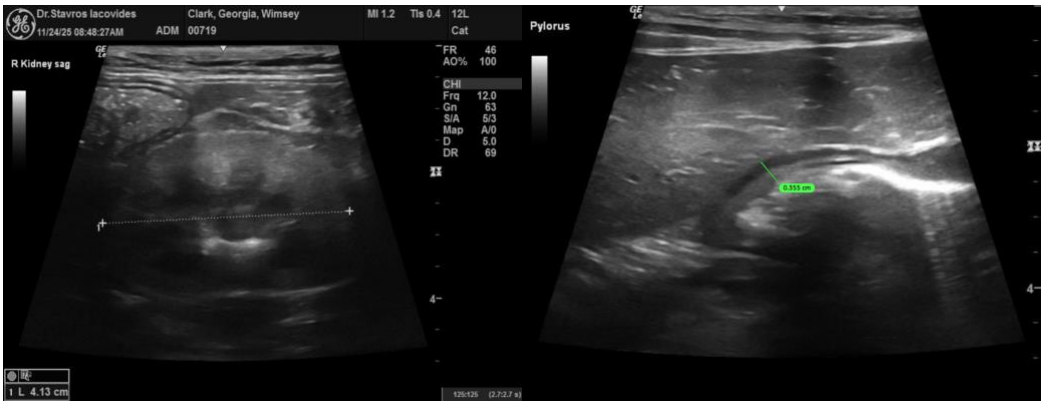
- Intact mildly thickened stomach wall.
- Diffuse thickened intact small intestine exhibiting altered to inverted wall layering.
- Mild generalized distended colon containing soft fecal matter.
- Normal area of pancreas.
- Mildly enlarged folded spleen.

Secondary Findings

- Age-related renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Primary differentials for the enteropathy include IBD, eosinophilic enteritis or other inflammatory enteropathy or intestinal round cell neoplasia such as lymphoma. Likewise, the regional intact mild thickened stomach may suggest inflammatory versus emerging neoplastic criteria. A definitive diagnosis would require gastrointestinal biopsies for histopathology. A GI panel to include PLI, TLI, cobalamin and folate is recommended. Gastrointestinal support and empirical IBD protocol with clinical and as needed sonographic monitoring of continued or progressive gastrointestinal signs or weight loss if biopsies are not possible, and pending GI panel, would be reasonable.



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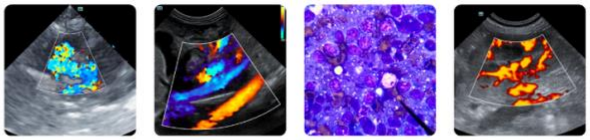

Clinical Sonography & Telecytology
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SonoPath.com info@sonopath.com 1.800.838.4268

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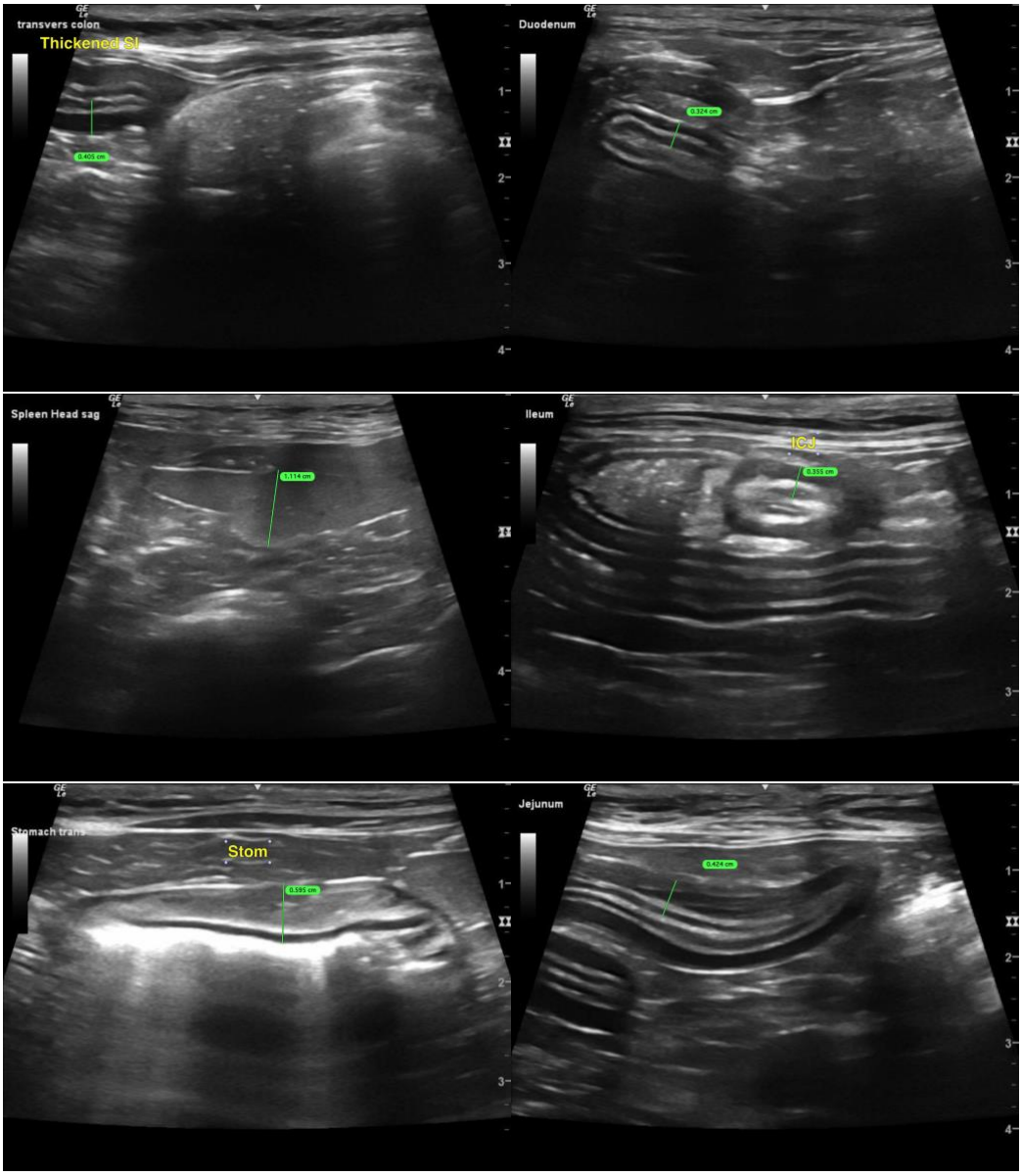

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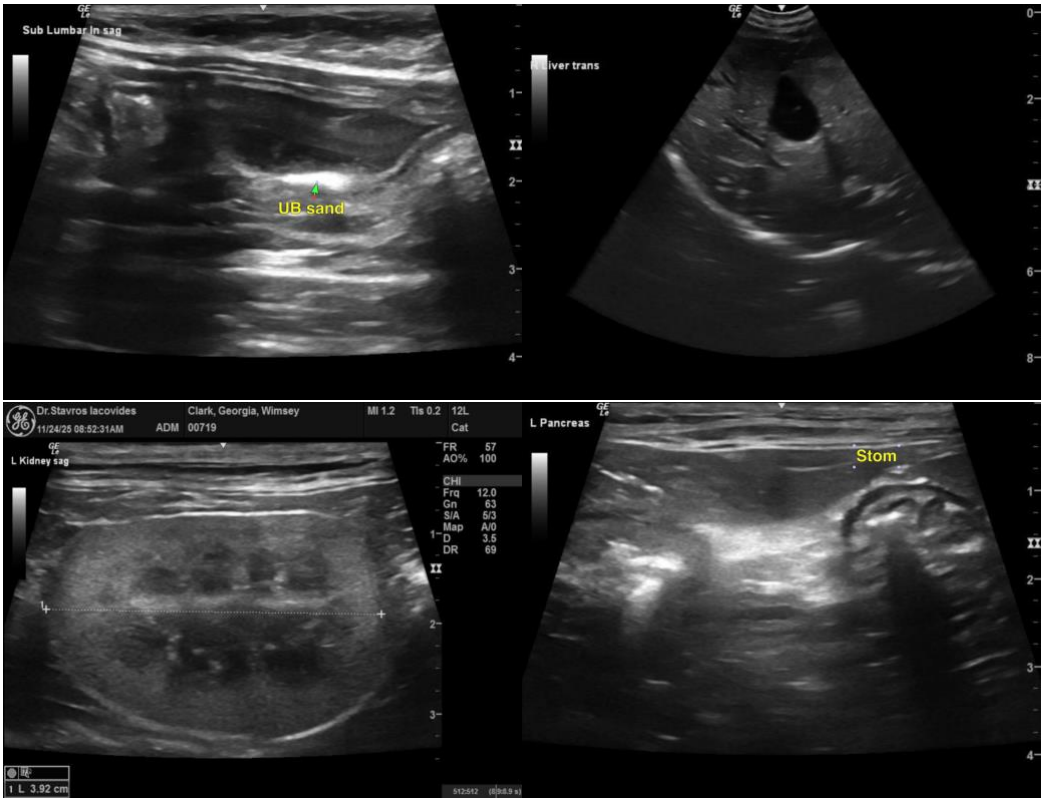

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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