



PATIENT

Cherry Obrecker

SPECIES

Feline

BREED

Ragdoll

SEX

Spayed Female

AGE

2013

WEIGHT

16.4

INTERPRETED BY

R. McKenzie Daniel,
DVM, DABVP (Canine
/ Feline Practice)

**IMAGING
PERFORMED BY**

Rebekah Jakum, CVT,
ARDMS/RVT

HOSPITAL NAME

Alburtis AH

REFERRING VET

Dr. Klemp

INVOICE

12091

DATE

11/04/25

PRESENTING CLINICAL SIGNS

Chronic, intermittent diarrhea, vomiting for 1-month, elevated spec fPL, mild weight loss, occasional increased urgency, tenesmus

Medication: fiber

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 pyelectasia and mild increased renal sinus echogenicity was present. The left kidney measured 4.1 cm in length. The right kidney measured 4.5 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 0.34 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.38 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.

Liver

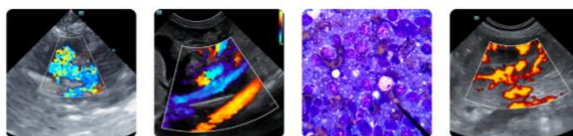
The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. A nondisruptive mildly complex ventral intraparenchymal cyst was visualized measuring 1.5 cm in diameter.

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 was empty with no signs of ileus, obstruction or foreign material.

The intestinal walls demonstrated intact wall layers with diffusely thickened walls and altered 1:3 muscularis / mucosa ratio primarily consisting of muscularis hypertrophy. The duodenum wall



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measured 0.33 cm width. The jejunum wall measured 0.34 cm width. The ileocolic wall measured 0.36 cm width.

Normal visible colon wall layers were present with semi formed fecal matter in lumen. The descending colon wall measured 0.28 cm wall width.

Pancreas

The left pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

No visualized significant omental lymphadenopathy or peritoneal effusion was present. Mild peri-ileocolic hyperechoic reactive omentum.

ULTRASONOGRAPHIC FINDINGS

- IBD intestinal pattern with suspect low-grade colitis.
- Mild heterogeneous left pancreas.
- Normal empty stomach.
- Mild chronic renal changes exhibiting mild pyelectasia.
- Hepatic cyst, potential for biliary cystadenoma- subjective benign.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Potential for emerging to low-grade intestinal round cell neoplasia such as lymphoma which may present sonographically similar to IBD (thought less likely yet cannot be excluded). Concurrent chronic pancreatitis is suspected given elevated spec fPL and if evidence of cranial abdomen/subxiphoid discomfort on palpation. A definitive diagnosis would require intestinal biopsies for histopathology. Gastrointestinal support and empirical IBD therapy protocol with clinical and as needed sonographic monitoring if continued gastrointestinal signs or weight loss would be reasonable. The bilateral pyelectasia may be owing to chronic renal changes, potential pelvic scarring possibly owing to previous calculi passage, IV fluid therapy (if applicable). Urine C/S and protein: creatinine ratio on sterile urine sample is recommended.





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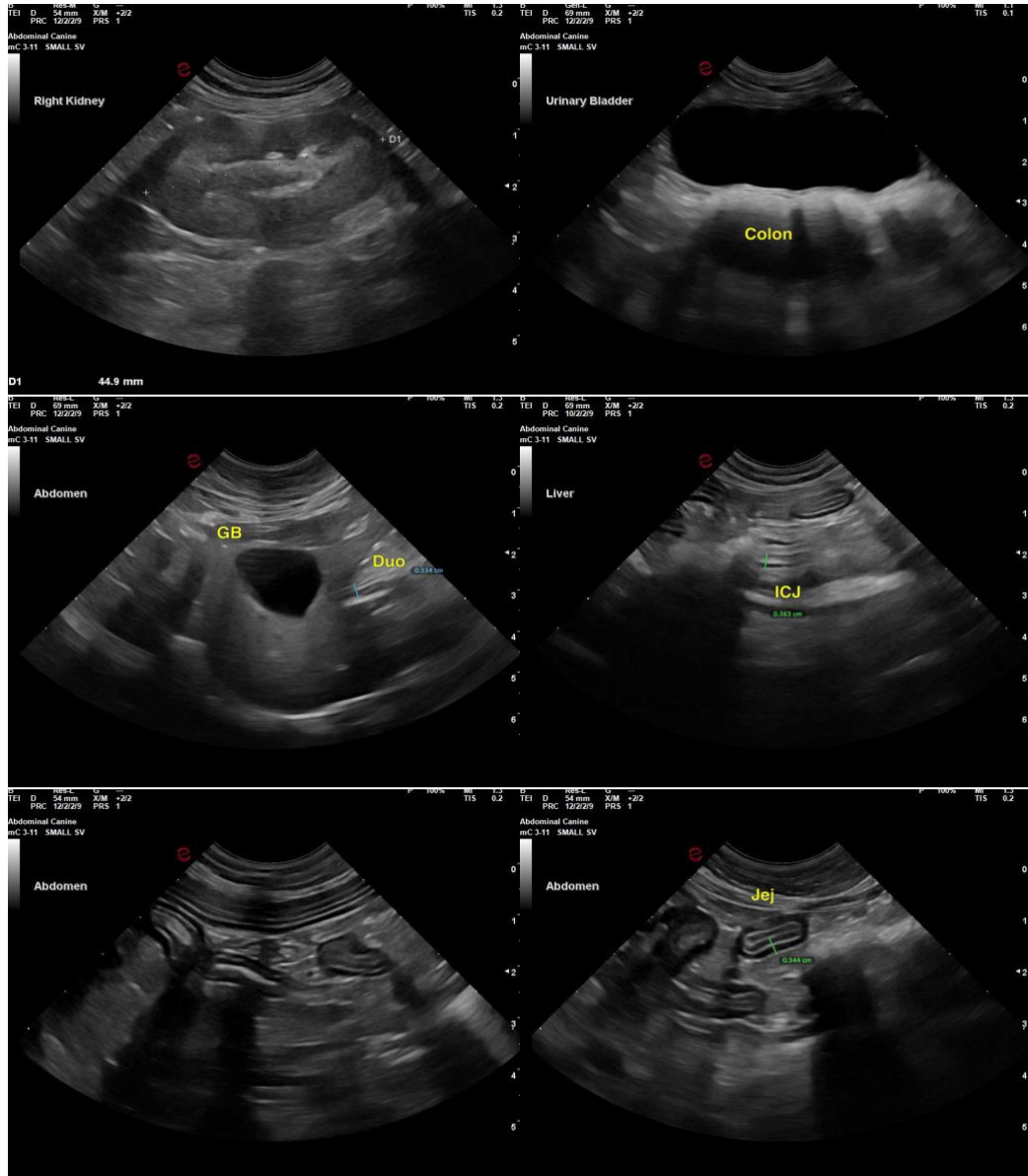
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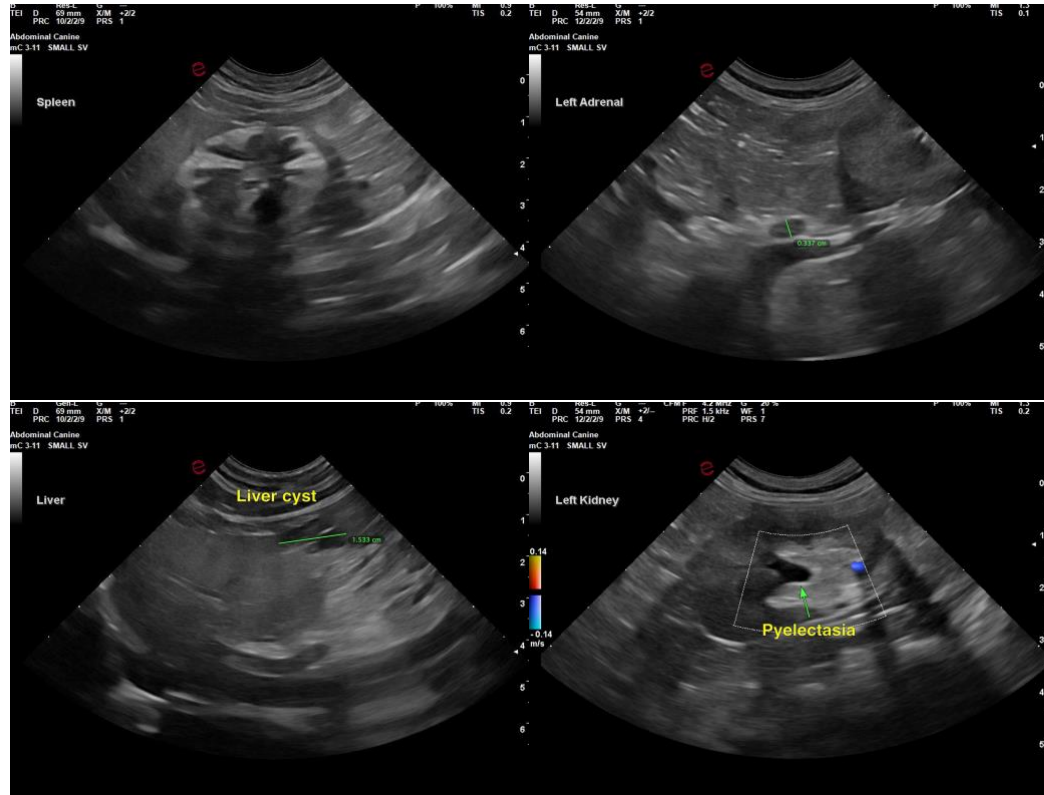
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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