PATIENT

Toby Baker

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

18 Years 7 Months

WEIGHT

9.5 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

VCA Feline Animal Hospital

REFERRING VET

Dr. Vincent Fleming

INVOICE

12567

DATE

12/04/25

PRESENTING CLINICAL SIGNS

History - Patient unwilling to eat for past day, not drinking either, no V/D noted, believe defecating normally, receiving medications as usual, no significant rhinitis signs noted, breathing fine. Seems painful and moving more slowly to owner. Constipation, Abdominal pain, Anorexia Diabetic Diet: maint wet primarily. Med: Marbofloxacin 12.5mg q24 Clavamox 62.5mg q12 lantus 1.5u q12- Diabetic Pred 2.5mg q24 B12 q48 Methimazole 2.5mg AM 1.25mg PM Cerenia 4mg q24 cypro 1 mg q24 Cobalequin q48 amlodipine 0.625mg q24 Miralax slurry q24 1.5 ml gabapentin when Solensia appears to wear off at end of month.

Abnormal PE/Chem/CBC/UA Results: LABS attached Radiographic findings - Abdomen: adequate serosal detail no overt organomegaly or mass effect significant amounts stool in transverse/descending colon.; Ultrasonographic findings - Brief AFAST: no free fluid 0/4 suspect mesenteric inflammation +/- pancreatitis.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Nondependent particulate mild sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes 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 to moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Pinpoint to focal medullary mineral and small cortical cysts were visualized. Left kidney cortical cyst measured 0.55 cm. The left kidney measured 3.9 cm in length. The right kidney measured 3.8 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 0.40 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.46 cm width.

Spleen

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Intermittent well demarcated nondisruptive hyperechoic nodules were present throughout the cranial to caudal parenchyma. Mild medial capsule asymmetrical contour. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory or neoplastic changes were not noted. The hyperechoic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas. The nodules measured 0.32 cm. The spleen measured 0.93 cm width level of the mid spleen.

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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.

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

Gastrointestinal

The stomach presented with intact mildly thickened wall with subjective variably thickened hyperechoic gastric submucosa layer. Empty lumen with mild lumen gas. Gastric body wall measured 0.45 cm wall width.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was primarily empty with mild segmental nonshadowing chyme. The ileocolic junction was normal measuring 0.35 cm wall width. Small intestine wall measured 0.2 cm wall width. The duodenum wall measured 0.24 cm width. Minor segmental jejunal corrugation and subtle mucosal speckling was present.

The colon was subjective mildly distended with semi formed fecal matter in lumen.

Pancreas

The pancreas was normal in size and asymmetrical capsule contour with heterogeneous remodeled parenchyma compared to adjacent omentum. Intermittent small left limb pancreatic cysts were visualized.

Free Abdomen

Intermittent mild mesenteric lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. An example of lymph node size was 1.0 cm in diameter. No evidence of peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Chronic pancreatitis with remodeling and small pancreatic cysts.
- Probable gastroenteritis exhibiting intact mildly thickened stomach wall.
- Suspect intermittent mild mesenteric lymphadenitis- secondary to inflammatory bowel episode.
- Mild gallbladder debris.
- Bilateral chronic renal changes exhibiting cortical cysts.
- Mild distended colon containing semi formed fecal matter.

Secondary Findings

- Probable benign splenic nodules- suggestive of myelolipomas.
- Urine sediment.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Minor potential for emerging to occult gastrointestinal and lymphatic neoplasia thought less likely in favor of inflammatory criteria in conjunction with chronic pancreatitis. Supportive care is indicated with clinical monitoring. Sonographic reassessment or monitoring is recommended if continued or progressive clinical signs nonresponsive to empirical therapy. The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S if evidence of inflammatory cells is recommended.

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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