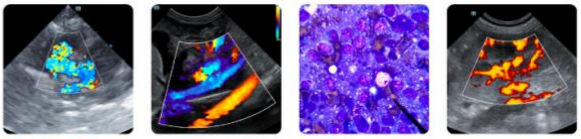


PATIENT

Polly Crow

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

4 Years 10 Months

WEIGHT

6.45 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Patti Mayfield DVM

HOSPITAL NAME

Sunriver Vet Clinic

REFERRING VET

Dr. Emily Kent DVM

INVOICE

13872

DATE

02/19/26

PRESENTING CLINICAL SIGNS

- Patient presents for evaluation of chronic recurrent episodes of inappetence, vomiting, and lethargy. No diarrhea
- Patient first seen in April 2024 for acute on chronic vomiting for 1.5 weeks. Treated with Cerenia and fluids. Recovered uneventfully
- Patient seen by ER in Jan 2025 for vomiting and lethargy- treatment for pancreatitis after
- an elevated fPL was found.
- Patient seen in Dec 2025 for inappetent and lethargic, gagging but not vomiting.
- Labwork unremarkable. Treated with a change in diet (RC GI low fat) and mirtazapine transdermal SID PRN
- Jan 2026- O reported inappetence and vomiting throughout the month, but was not seen
- Feb 2026: Seen for vomiting and
- inappetence, no improvement with mirtazapine. Sent home with Maropitant and Hill's GI biome and recommend continued use of Miratz as needed. If no improvement is recommended, if improved but signs redevelop in a couple of months, recommend a novel protein diet.

Abnormal PE/Chem/CBC/UA Results: April 2024: Radiographs taken for acute on chronic vomiting: Faint soft tissue opacity, cranial ventral abdomen. Rule out steatitis secondary to current or prior pancreatitis, splenic tail (indicating splenomegaly), or a poorly defined fluid-filled small intestinal segment. Soft tissue opacity medial to the spleen. This finding is supportive for steatitis (prior/concurrent pancreatitis). Gas within the stomach and small intestine is nonspecific, possibly indicating gastroenteritis - Jan 2025 cbc, chem, UA WNL fPL abnormal - Dec 2025 BAR-fractious, hissing and swatting, BCS 7/9, moderate dental calculus, tense on abdominal palpation- attributed to stress CBC: WNL Chem 27: WNL T4: WNL FeLV/FIV/HWT: WNL UA: pH 8.5 with 2+ crystals, Neg crystals, neg protein, inactive sediment FPL: wnl

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

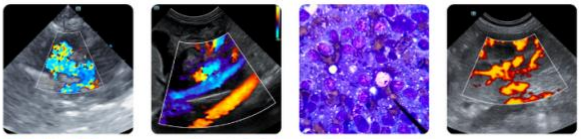
The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Echogenic to particulate nondependent mild to moderate sediment was present without evidence of calculus formation. 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 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 4.6 cm in length. The right kidney measured 4.6 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 0.55 cm width.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.47 cm width.



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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 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 intact wall layering with a normal wall layer ratio. The lumen of the stomach contained echogenic, mild primarily nonshadowing ingesta. No evidence of gastric mural pathology or obstruction to pyloric outflow. The pylorus wall measured 0.25 cm wall width.

The intestinal walls demonstrated intact wall layers with diffusely thickened walls and altered 1:3 muscularis / mucosa ratio primarily consisting of muscularis hypertrophy. Significant to primarily generalized mild nonshadowing intestinal ingesta to the level of the colon. The duodenum wall measured 0.30 cm wall width. The jejunum wall measured 0.34 to 0.35 cm wall width.

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

Pancreas

The pancreas presented normal in size and contour with minor nonhomogenous hypoechoic parenchyma compared to adjacent nonreactive omentum.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- IBD intestinal pattern wit gastrointestinal ingesta- ingesta consistent with food echogenicity.
- Possible mild chronic/chronic active pancreatitis.

Secondary Findings

- Urine sediment.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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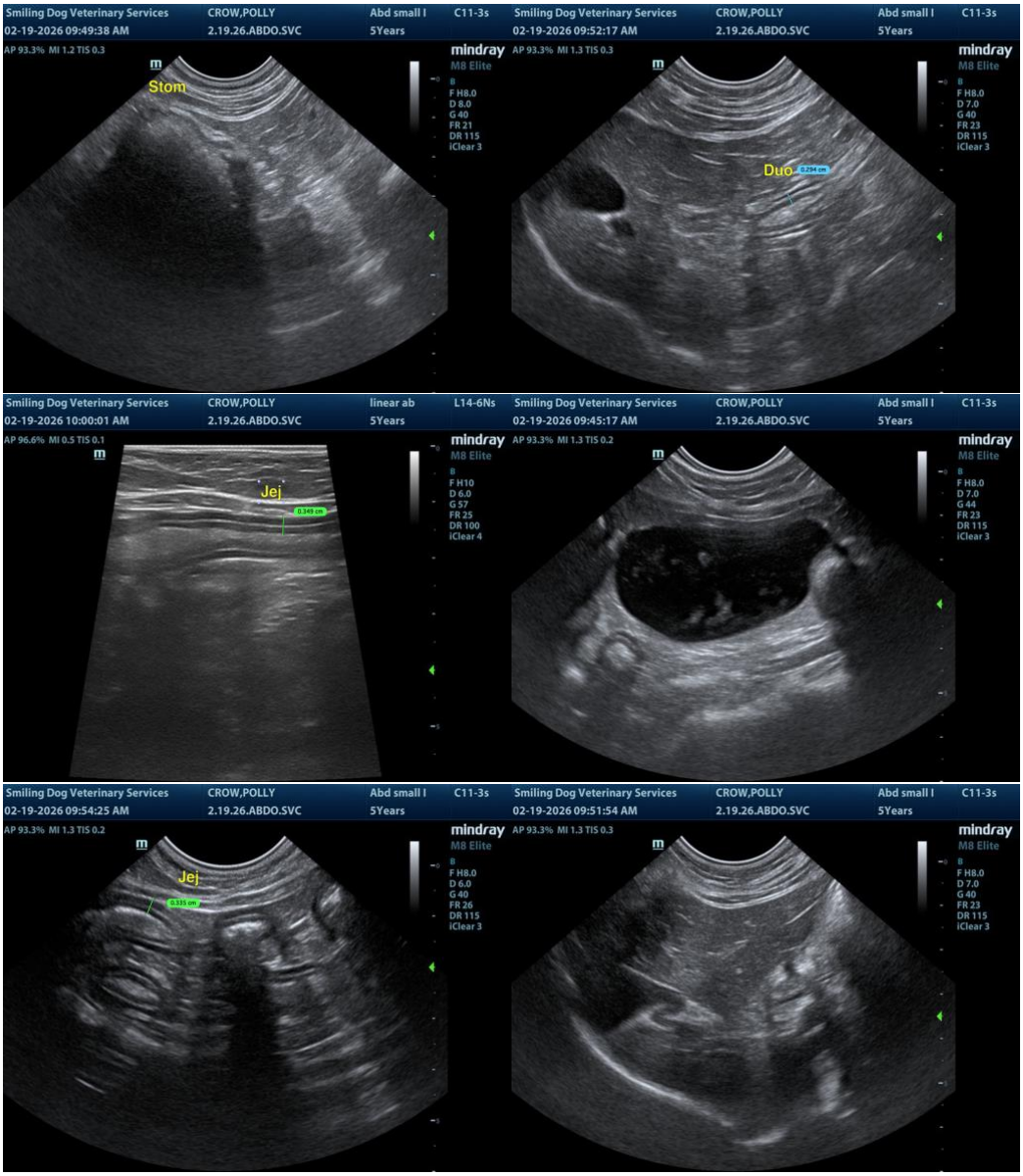
Potential for emerging to low-grade intestinal round cell neoplasia, which may present similarly to IBD criteria is not definitively excluded yet thought less likely. A GI panel to include PLI, TLI, cobalamin and folate is recommended.

Gastrointestinal support, which may include dietary trial, as needed gastroprotectants, empirical deworming if clinically indicated and cobalamin supplementation pending assessment of cobalamin level may prove beneficial. Intestinal biopsies are required for definitive diagnosis. IBD protocol, including steroid trial, could be considered if continued gastrointestinal signs or evidence of weight loss.



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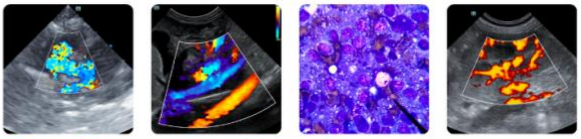

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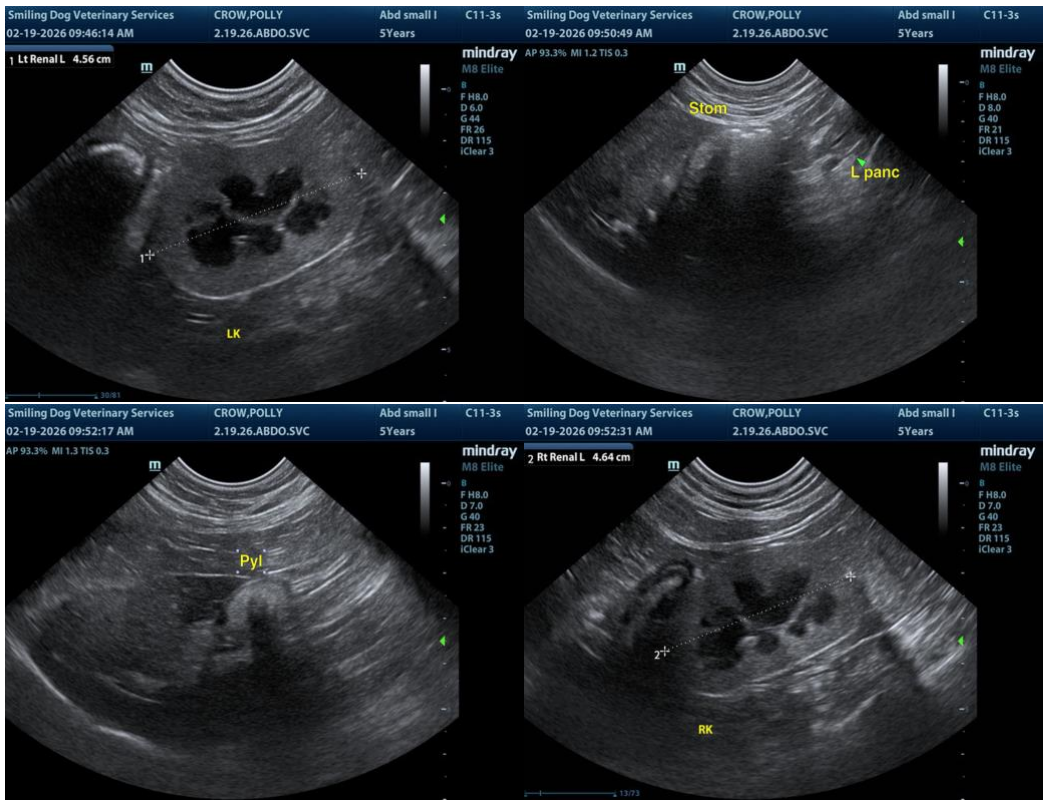

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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