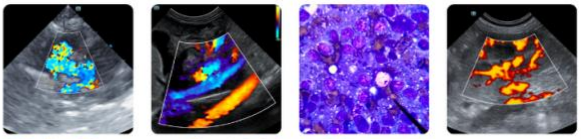


PATIENT

Princess Kender

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

13 Years

WEIGHT

4.24 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Lindsay Powell CVT

HOSPITAL NAME

Hershey Animal Emergency Center

REFERRING VET

Dr. Kimberly Davidson

INVOICE

13987

DATE

02/27/26

PRESENTING CLINICAL SIGNS

- v/d started early this morning
- seems more hungry than typical

Abnormal PE/Chem/CBC/UA Results: 10-12% dehydrated, obtunded mentation. Mildly uncomfortable on abdominal palpation but hard to evaluate due to obtunded mentation. increased RR/RE EPOC: pCO2 (30.4), BE (-8), hypokalemia (3.2), mild hyperchloremia (129), hyperlactatemia (4), hypoglycemia (24) BG: 38, dextrose 1 ml/kg bolus then 272 PCV/TP: 47/8.4 BP: 88 (tail) on doppler, then 62 (front leg) after IVF bolus, 80 after second IVF bolus T4: 1.4 CBC: leukopenia (2.71), neutropenia (1.3), monocytopenia (0.04), eosinopenia (0.01) Chem: hypoglycemia (26), hyperglobulinemia (5.4), ALT (460), ALP (294), GGT (16), Tbili (1.8) fPL: 5.3 (equivocal range) Radiographs: gastroenterocolitis, poor left/mid abdominal serosal detail (pancreaticomegaly (acute pancreatitis vs. mass) vs. peritonitis), mild bronchial 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. Primarily anechoic urine was present in the lumen. Echogenic to particulate nondependent 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 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. A hyperechoic corticomedullary band, consistent with a medullary rim sign, was present. This is a nonspecific finding seen in both normal and abnormal kidneys. It may be associated interstitial renal disease, hypercalcemia, tubular necrosis, lymphoma, and FIP. However, it is a nonspecific finding. The left kidney measured 3.9 cm in length. The right kidney measured 4.2 cm in length.

Adrenal Glands

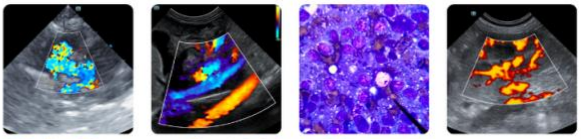
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.46 cm width.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.44 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 & Gallbladder



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The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mild / moderate nonuniform and hypoechoic to the spleen with a mild/ moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non distended in size with mild nonorganized biliary sludge. The proximal common bile duct was dilated and mild tortuous without overt post hepatic obstruction.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained minor retained fluid with no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with overall maintained wall layer ratio. Borderline to mild thickened jejunum wall with empty intestinal lumen to the level of the colon. The jejunum wall measured 0.27 cm wall width. The ileocolic wall measured 0.43 cm wall width.

The colon walls presented intact yet mild thickened wall layering exhibiting mildly prominent to hyperechoic submucosa layer. Generalized nonformed fecal matter was present in the colon lumen. The colon wall measured 0.39 cm wall width.

Pancreas

The left and right pancreas presented mildly prominent in size with capsule asymmetry exhibiting mild nonhomogenous hypoechoic parenchyma with mild surrounding peripancreatic hyperechoic omentum.

Free Abdomen

Intermittent mesenteric nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). No evidence of peritoneal effusion.

ULTRASONOGRAPHIC FINDINGS

- Normal mildly hypomotile stomach.
- Enterocolonopathy.
- Chronic/chronic active pancreatitis pattern with regional peripancreatic hyperechoic/reactive omentum.
- Hepatopathy.
- Thickened gallbladder with mild bile sediment.
- Nonobstructive proximal common bile duct dilation.
- Intermittent mild mesenteric lymphadenopathy.
- Nonspecific bilateral renal medullary rim sign.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Cholangiohepatitis pattern for the hepatobiliary presentation is probable in conjunction with evidence of chronic/chronic active pancreatitis and non-specific enterocolic disease. Triaditis is a potential in this patient. Emerging occult to multi-centric neoplasia is thought less likely yet not definitively excluded.

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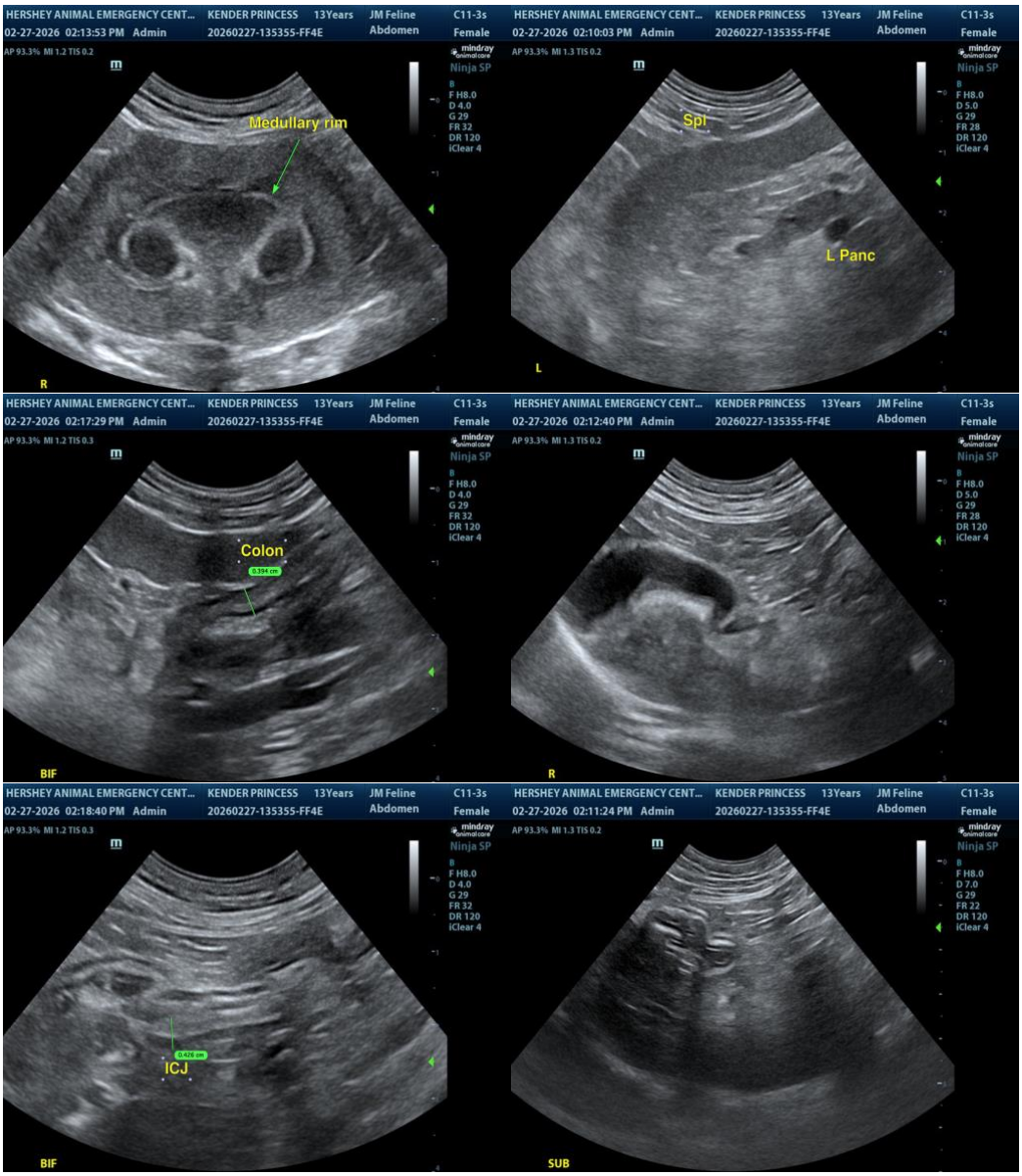
Further assessment may include (assuming normal clotting status and using a 25-gauge needle, hepatic FNA cytology primarily to assess for inflammatory criteria and a GI panel to include PLI, TLI, cobalamin and folate.

Empirical therapy for chronic/chronic active pancreatitis or triaditis with clinical monitoring and as needed sonographic reassessment if non-responsive clinical signs or evidence of progressive hepatopathy is recommended. Urinary workup is suggested if not recently done.



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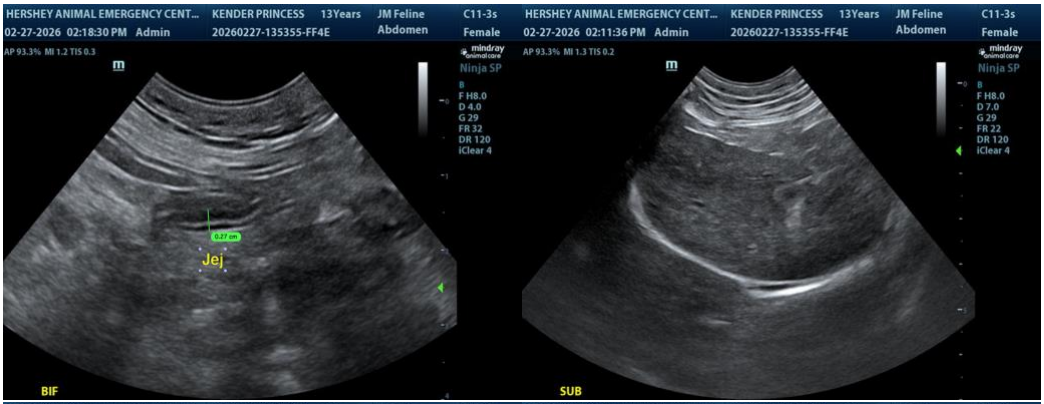

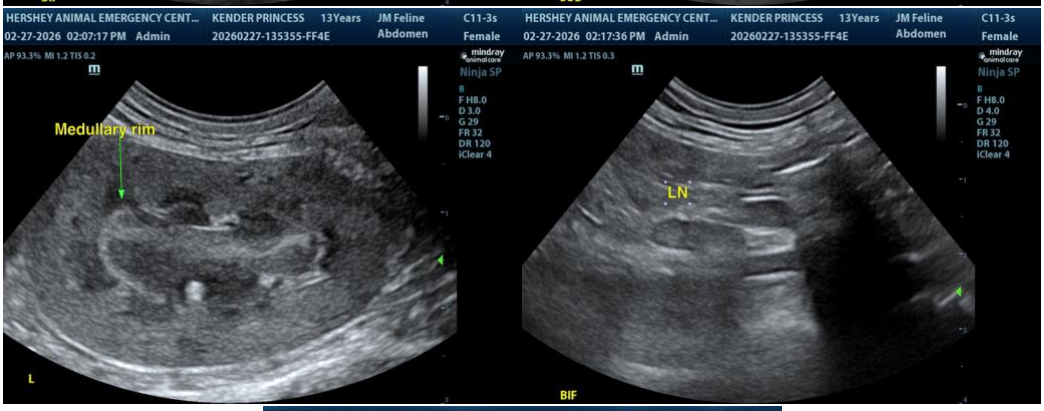

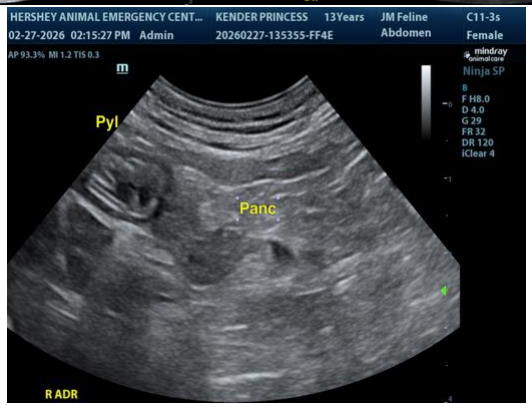

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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