



## PATIENT

Pinky Kampstra

## SPECIES

Feline

## BREED

DSH

## SEX

Spayed Female

## AGE

12.5 Years

## WEIGHT

9.75 pounds

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Dr. Chrissy Krell DVM

## HOSPITAL NAME

Companion Animal  
Hospital

## REFERRING VET

Dr. Skylar Brenden  
DVM

## INVOICE

13595

## DATE

02/04/26

## PRESENTING CLINICAL SIGNS

- Pinky is a 12 year old spayed female feline with 1 year history of diarrhea. Primary DVM had managed on prednisolone and client reported this worked well. They were able to drop down to EOD dosing and would increase to SID during flares. Pinky presented in Jan because she was having a diarrhea episode that was not responding well to prednisolone. Appetite slightly decreased, drinking more than usual, no vomiting. Her exam was normal other than 2lb weight loss since Sept 2025. We discussed CKD stage 2/4 may or may not be contributing to GI signs, alternatively would consider IBD/GI lymphoma with historical response to prednisolone. Treated with SQ fluids, SQ vitamin B12. Sent with Forti Flora SA. Client reached out on 1/30 because diarrhea has not changed, inquired about intestinal biopsies and I recommended we start with AUS to avoid anesthesia and exacerbation of CKD unless further indicated. She is still on prednisolone EOD. Concern for early CKD and GI disease (IBD, lymphoma, secondary to another underlying cause, open).

PE: BCS 5/9 however lost 2lb since Sept 2025 and mild muscle wasting along dorsum. Pink MM, CRT < 2 sec. OU clear. AU clean. Nice skin and haircoat. Normal heart and lung sounds, tachycardic. Abdomen soft and non-painful. Lymph nodes small. Ortho/Neuro appear normal. Sept 2025 Labs-Chem CRE 2.0 (H), AMY 1788 (H); T4 WNL; USG (cystocentesis) 1.012. Jan 26, 2026: Chem: Creat 2.0, BUN 21, otherwise wnl. USG: 1.012. TT4 - wnl

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra 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 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 3.3 cm in length. The right kidney measured 3.2 cm in length.

### Adrenal Glands

The bilateral adrenal glands were indistinctly visualized likely secondary to steroid therapy with no obvious pathology. The left adrenal gland subjectively measured 0.29 cm width. The right adrenal gland subjectively measured 0.28 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 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 was empty with no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The small intestine wall measured 0.20 cm wall width. The ileum wall measured 0.32 cm wall width. The duodenum wall measured 0.22 cm wall width.

The colon presented intact borderline prominent wall in the descending colon. The colon was nondistended containing soft fecal matter. The descending colon wall measured 0.20 cm wall width.

### **Pancreas**

The area of the pancreas was sonographically normal.

### **Free Abdomen**

Minor prominent colic lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Mild perilymphatic hyperechoic omentum. An example of lymph node size was 0.50 cm in diameter.

## **ULTRASONOGRAPHIC FINDINGS**

### **Primary Findings**

- Sonographically unremarkable stomach/small intestine.
- Possible mild chronic colitis pattern with soft fecal matter.
- Mild colic lymphadenopathy- consistent with benign criteria i.e. mild reactive hyperplasia or lymphadenitis, nondependent colitis.

### **Secondary Findings**

- Age-related renal changes.
- Mild urine sediment.

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

No evidence of significant gastroenterocolic mural pathology or lymphadenopathy, although suppression of gastrointestinal wall changes or lymphadenopathy secondary to prednisolone therapy are possible. A GI panel to include PLI/TLI/Cobalamin/Folate and Diarrhea PCR panel are recommended.



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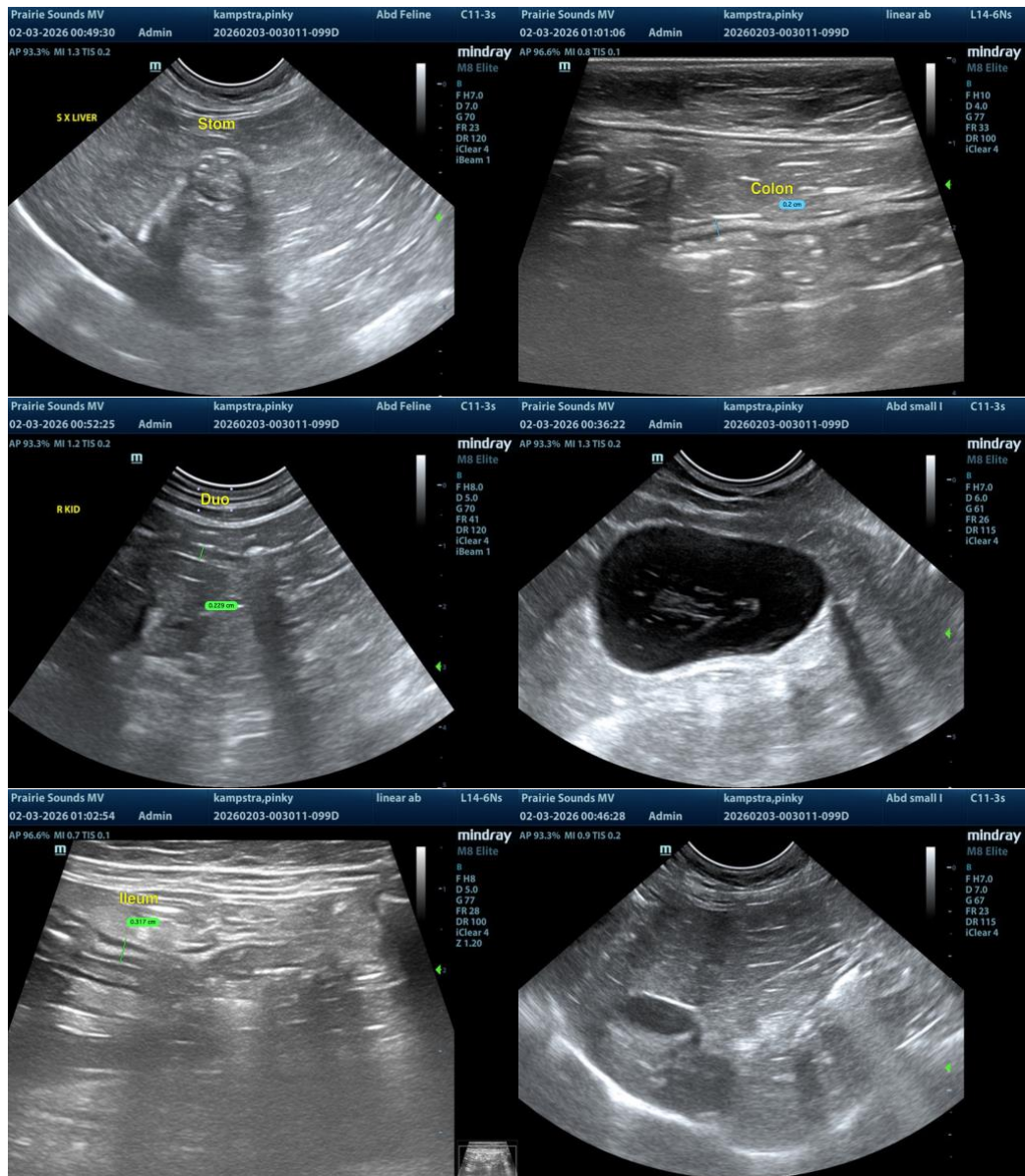
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Pending additional diagnostics, dietary trial such as higher fiber diet, i.e. WD or similar, or hydrolyzed diet with fiber supplementation, high colony count probiotics such as proviable, cobalamin supplementation pending assessment of cobalamin level, and if clinically indicated, deworming Panacur SID for seven to ten days with assessment of clinical response in conjunction with current empirical gastrointestinal support/therapy may prove beneficial.





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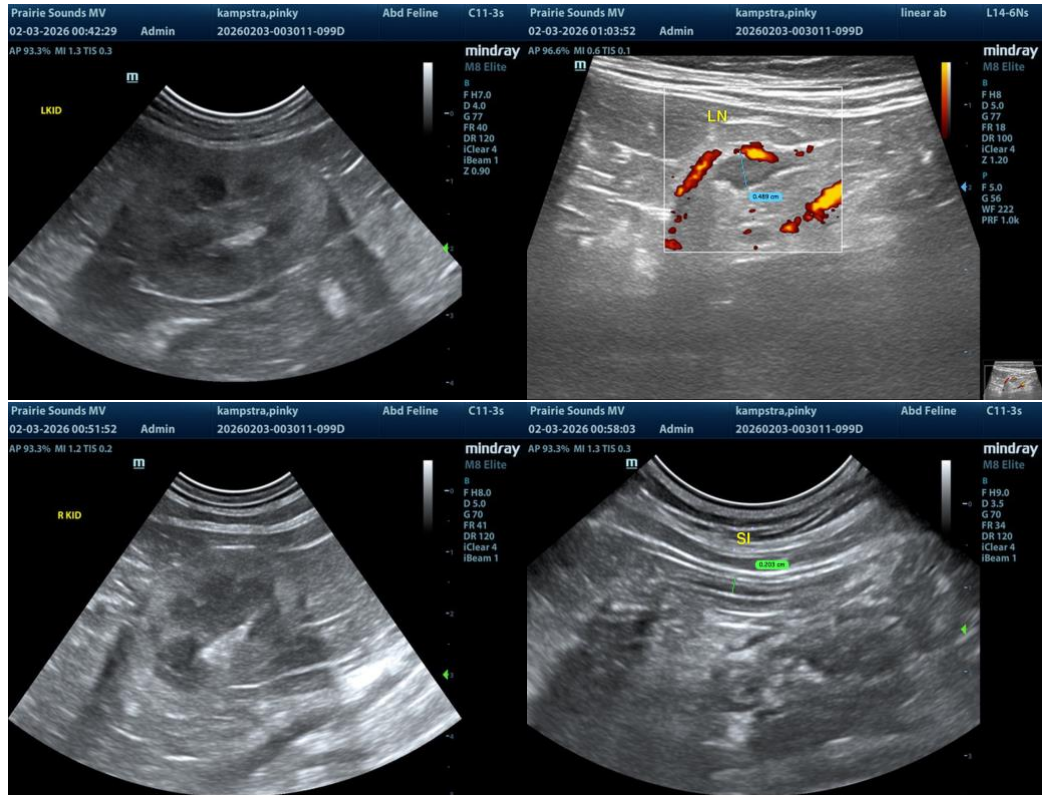
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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