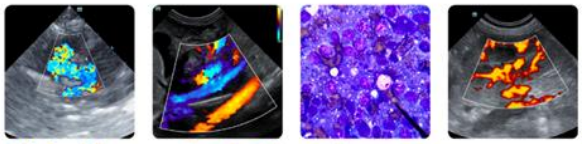


PATIENT

Paul Winsor

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

9yr

WEIGHT

6.2kg

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Dr. Jill Rankin

HOSPITAL NAME

Fish Creek Pet Hospital

REFERRING VET

Dr. Kevin and Charlotte

INVOICE
23837

DATE
02/09/2026

PRESENTING CLINICAL SIGNS

- Paul presents with a history of intermittent vomiting and inappetence,
- Paul was admitted the day prior to the scan due to persistent inappetence and abdominal pain on palpation, following a history of intermittent vomiting. Initial diagnostics at that time included bloodwork, which revealed a creatinine of 179 and a urine specific gravity of 1.036 with other results being unremarkable, and abdominal x-rays that showed no obvious obstructive pattern. An initial ultrasound performed by the attending veterinarian suggested possible thickening of the intestinal tract and potential inflammation around the pancreas.
- Overnight, Paul was treated with Gabapentin and was reported to be eating, comfortable, and happy by the morning of the scan. However, this morning he spiked a fever of 40.6 was noted to be heavily sedated from his medication, which was subsequently reduced.
- Overall:
- History of vomiting & inappetence for about a week.
- BW - CBC unremarkable, creatinine high, urine concentrated
- Xray - no obvious obstructions
- POCUS - Possible thickening of intestines

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Anechoic urine was present in the lumen with no evidence of urine/lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

Normal size and margination were 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 3.8 cm in length. The right kidney measured 4.0 cm in length.

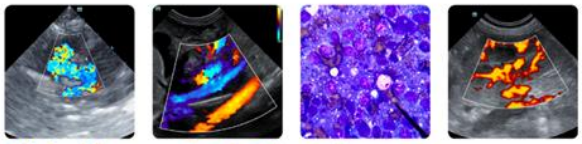
The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.52 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.

Spleen

The spleen exhibited overall normal size and primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Intermittent subtle nodules were present throughout the cranial to caudal 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 or neoplastic changes were not noted. The echogenic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas.



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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. Normal vascular volume. 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 mild variably echogenic non-shadowing ingesta sonographically suggestive of food echogenicity with no signs of 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 measured 0.36 cm width. The jejunum wall measured 0.32 cm width. The ileocolic wall measured 0.41 cm width.

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

Pancreas

The 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 evidence of peritoneal effusion was present.

Focally enlarged mid abdominal 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 present. An example of lymph node size was 1.5 cm x 0.37 cm.

ULTRASONOGRAPHIC FINDINGS

Primary

- Intact mildly thickened small intestine with associated mild mesenteric lymphadenopathy- IBD or other inflammatory enteropathy with mild reactive lymphatic hyperplasia or lymphadenitis favored, minor potential for emerging to low grade intestinal neoplasia such as lymphoma and early metastatic lymphadenopathy
- Mild heterogeneous pancreas - patient variant or mild chronic to chronic active pancreatitis +/- remodeling possible.
- Sonographically normal kidneys

Secondary

- Subtle hyperechoic splenic nodules-most consistent with benign criteria i.e. Myelolipomas

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of mechanical gastrointestinal obstruction, i.e. mass, foreign body, or stricture. A GI panel

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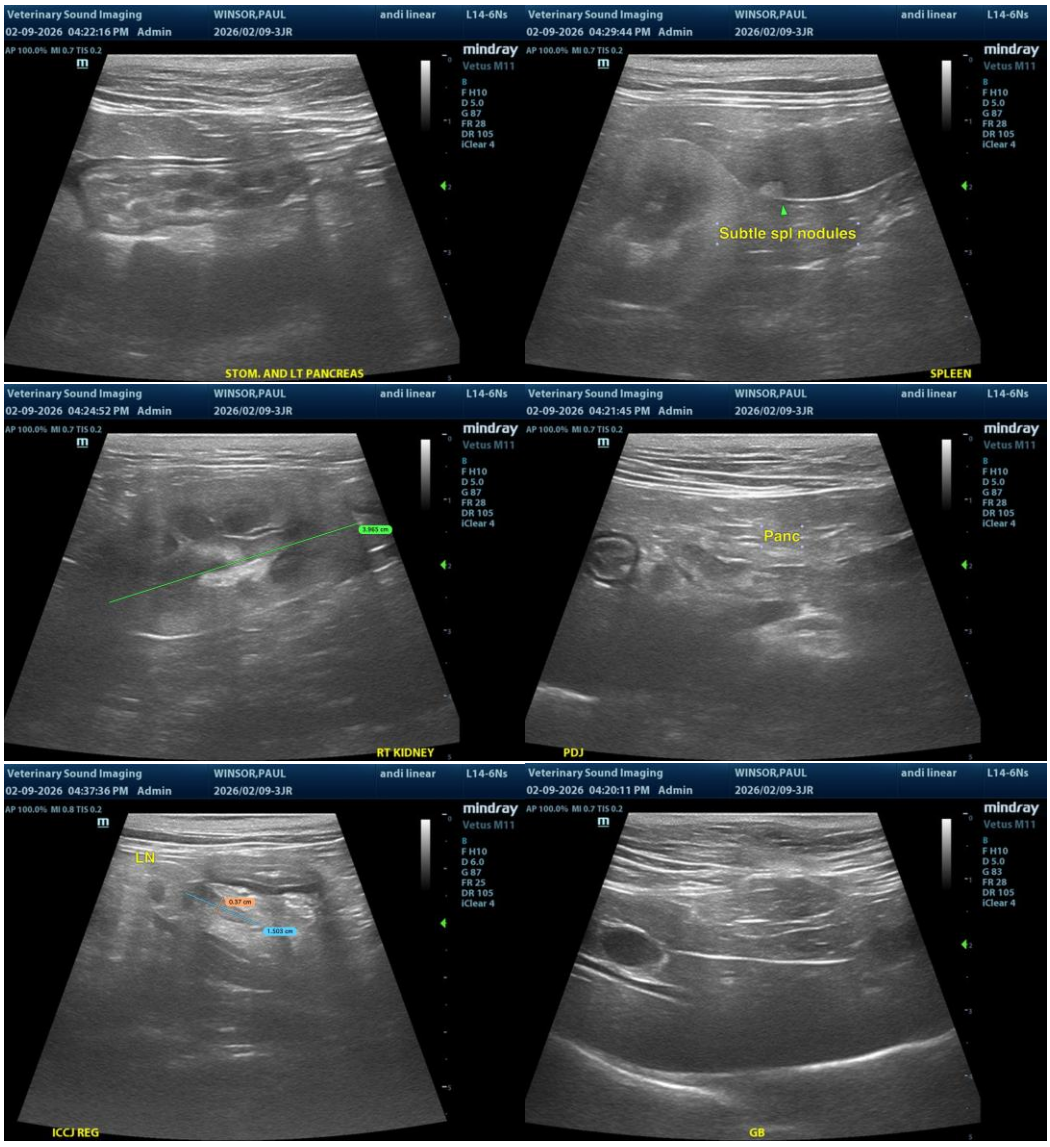
to include PLI/TLI/Cobalamin/Folate is recommended. A definitive diagnosis would require biopsies for histopathology.

Gastrointestinal support, which may include dietary trial, as needed gastric protectants, cobalamin supplementation pending assessment of cobalamin level, +/- empirical IBD protocol with clinical and as needed sonographic monitoring would be reasonable if biopsies are not elected or possible.



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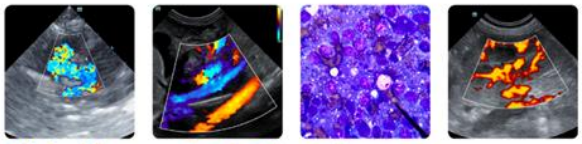

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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