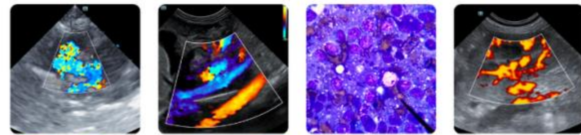


PATIENT

Eku Spencer

SPECIES

Feline

BREED

Brown Tabby

SEX

Neutered Male

AGE

12 Years 11 Months

WEIGHT

3.15 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Jill Rankin

HOSPITAL NAME

Cambrian Animal Hospital

REFERRING VET

Dr. Kathryn Barr

INVOICE

14599

DATE

03/24/26

PRESENTING CLINICAL SIGNS

Originally from Puerto Rico. Several years ago was diagnosed with IBD via biopsies at Western. Presented Feb 2025 for weight loss, lethargy, fragility, and mobility issues. Was found to be hypokalemic and started treatment of hydrolyzed protein diet, steroids, vitamin B12, and potassium supplementation. Did really well on treatment and improved drastically. Potassium returned to normal and no longer required supplementation. Presented for recheck today, and had lost weight again, appeared weak, appetite was high, and was moderately dehydrated. Steroid dose is 2.5mg PO EOD, however hydrolyzed diet and Vitamin B12 were stopped by O. Bloodwork showed mild non-regenerative anemia (worse, but masked by dehydration?), mild stress leukogram (Steroids), mildly increased BUN (dehydration/perforation?), but little other abnormalities. Radiographs showed massive amount of gas present in intestines, and loss of serosal detail, particularly in the cranial abdomen. Restarted hydrolyzed diet and vitamin B12 treatment.

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. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic change were noted.

Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Loss of corticomedullary distinction was also present. The left kidney measured 4.3 cm in length. The right kidney measured 4.2 cm in length. Areas of medullary mineral and mild left kidney hydronephrosis were present with mild right kidney pyelectasia.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.43 cm width at the caudal pole.

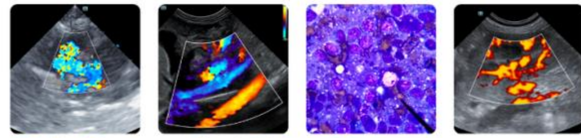
The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.28 cm width at the caudal pole.

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 presented subjective normal in size. The parenchyma of the liver was subjectively increased in echogenicity compared to the spleen and renal cortices. The echotexture of the liver parenchyma was uniform with a mild coarse echotexture. The capsule of the liver was symmetrical in margination.



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The hepatic and portal vasculature were normal in appearance without signs of congestion. A mild mid liver asymmetrical cyst was present measuring 1.6 cm in diameter.

The gallbladder was non-distended in size with mildly thickened walls and primarily anechoic luminal content. The cystic and common bile ducts were dilated and tortuous without overt post hepatic obstruction.

Gastrointestinal

The stomach presented intact wall layering exhibiting regional prominent rugal folds. The stomach contained a moderate amount of retained echogenic fluid and nonshadowing chyme. Intact pylorus wall without overt obstruction to pyloric outflow. The pylorus wall measured 0.33 cm wall width.

The small intestine presented intact wall layering with overall maintained wall layer ratio. Thickened small intestinal wall measuring up to 0.36 cm wall width. Variable fluid distended intestinal segments with concurrent empty intestinal segments to the level of the ileocolic junction and colon.

Normal visible colon wall layers were present with soft fecal matter.

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 overt visualized swollen mesenteric lymphadenopathy was present. Mild volume of peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Echogenic liver with intraparenchymal cyst.
- Mildly inflamed gallbladder and nonobstructive cystic/common bile duct dilation.
- Hypomotile stomach.
- Chronic enteropathy pattern exhibiting segmental variable fluid distended and concurrent empty intestinal segments.
- Heterogeneous pancreas.
- Chronic renal changes exhibiting medullary mineral, mild left kidney hydronephrosis and right kidney pyelectasia.
- Mild volume peritoneal effusion.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Metabolic, gastric and segmental to variable intestinal ileus owing to underlying chronic intestinal disease, potential chronic pancreatitis and triaditis are possible. A definitive area of mechanical intestinal obstruction was not obvious yet given concurrent empty intestinal segments is not definitively excluded. Chronic IBD or other inflammatory enteropathy given patient's history with potential suppression of intestinal mural changes or emerging intestinal round cell neoplasia, i.e. lymphoma are all potentials.

A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Correlation with effusion analysis +/- assuming normal clotting status and using 25-gauge needle, hepatic FNA cytology is recommended. Hospitalization with gastrointestinal support, documented 12 to 18-hour fast and

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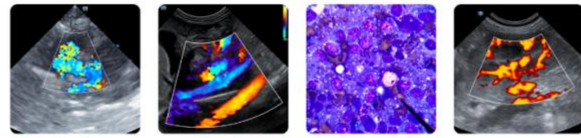
sonographic reassessment of gastrointestinal motility is recommended. If persistent hypomotile gastrointestinal tract in conjunction with gastrointestinal signs, exploratory laparotomy with biopsies may be indicated.



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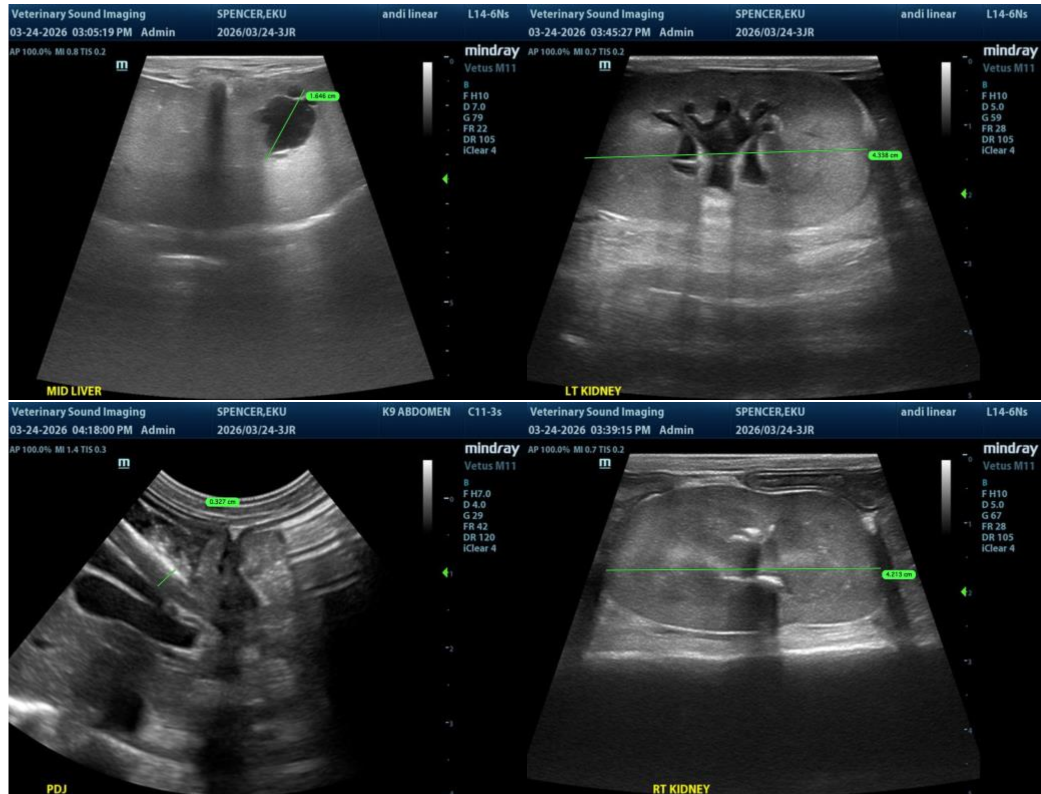

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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