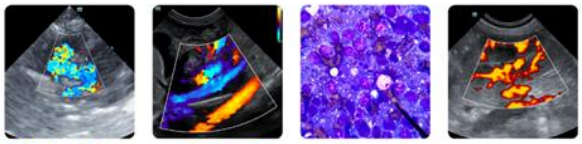


PATIENT

Mocha Turnbill

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

8yr

WEIGHT

5.06kg

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 Dani

INVOICE
24291

DATE
03/25/2026

PRESENTING CLINICAL SIGNS

- Mocha is a cat with a one-month history of vomiting, which has progressed to include intermittent vomiting, hyporexia, and weight loss over the past three weeks.
- One month prior to presentation, Mocha was seen at Little Creek for hematemesis. Blood work at that time revealed a high basophil count, mild stress hyperglycemia, and mild hypokalemia. A urinalysis showed glucosuria, but a subsequent fructosamine test was normal. Abdominal x-rays were also normal.
- Over the last three weeks, Mocha has experienced intermittent vomiting, hyporexia, and weight loss, with her weight decreasing from 5.2 kg to 5.06 kg. Repeat blood work showed marked basophilia, stress hyperglycemia, a potassium level of 3, and mildly low chloride. A thyroid panel and viral (FIV/FeLV) test were both normal. Mocha is originally from Panama, has been in Canada since October, and is reportedly fully vaccinated.

Abnormal PE/Chem/CBC/UA Results: Chronic intermitent vomiting +/- hematemesis 1 month duration. Weight loss. Hyporexia. Feb 2025 diagnostics: - Mild reticulocytosis (64.4 K/uL), a mild neutrophilia (11.8 x 10^9/L), and a mild basophilia (0.41 x 10^9/L).- Serum Chemistry: Revealed hyperglycemia (14.7 mmol/L), hypokalemia (2.8 mmol/L), and hypochloremia (111 mmol/L). Urinalysis: Specific gravity was 1.032, pH was 7. Results showed 30 mg/dL protein and 100 mg/dL glucose. - Abdominal Radiographs (3 views): The radiographs were unremarkable. There is food present in the stomach and feces in the colon, with no evidence of a masseffect or free fluid. Fructosamine: 232

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

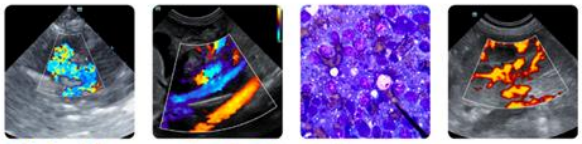
The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no evidence of urine/lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible 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 4.0 cm in length. The right kidney measured 4.4 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 0.31 cm width at the caudal pole and. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.34 cm width at the caudal pole.



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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. 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 was empty with no signs of ileus, obstruction or foreign material.

The intestinal walls demonstrated intact wall layers with diffusely thickened walls and altered 1:3 muscularis / mucosa ratio primarily involving the jejunum and ileum, owing to propensity for thickened jejunoileal muscularis layer.

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

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

No omental masses or peritoneal effusion was present.

Intermittent minor prominent to enlarged jejunocolic lymph 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).

ULTRASONOGRAPHIC FINDINGS

Primary

- Normal empty stomach
- Intact thickened small intestinal wall
- Intermittent mild jejunocolic lymphadenopathy
- Normal area of pancreas

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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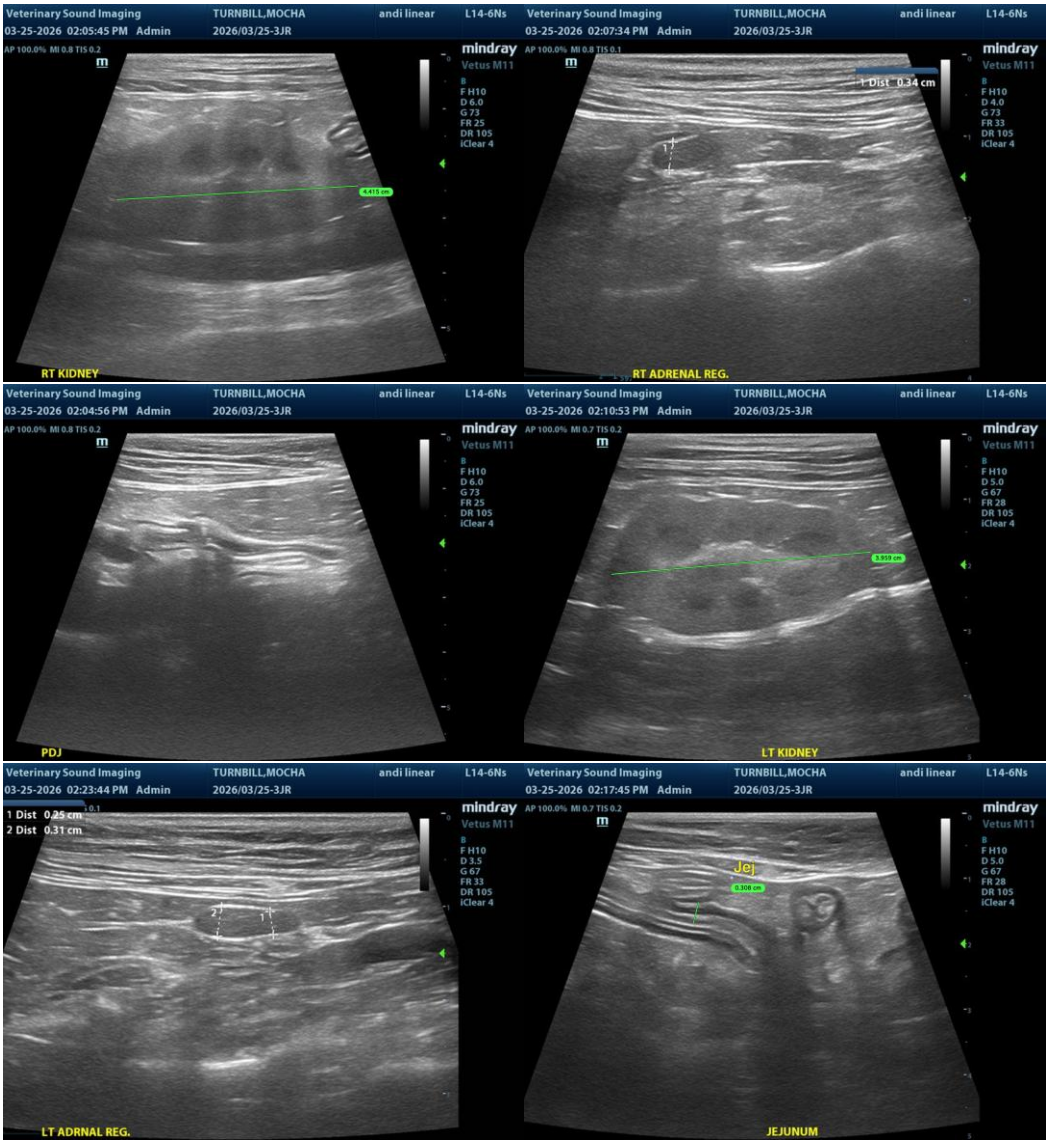
The appearance of the small intestine is compatible with infiltrative enteropathy. Primary considerations may include inflammatory infiltrative enteropathy such as IBD or neoplastic infiltrative enteropathy with round cells such as lymphoma or mast cell disease among potential etiologies. Dry form FIP may also present in this manner yet is considered unlikely. Diagnosis would require biopsies for histology, obtained either via endoscopy or, ideally, full thickness biopsies via laparotomy. A GI Panel to include PLI/TLI/Cobalamin/Folate is recommended. If additional diagnostics are not elected, empirical medical therapy for IBD which may include dietary therapy, cobalamin supplementation, probiotics +/- steroids trial with assessment of clinical response and monitoring of body weight could be considered.



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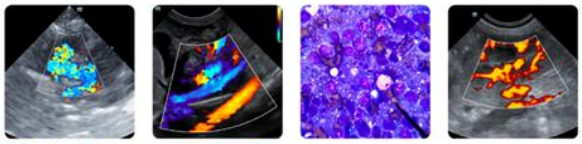

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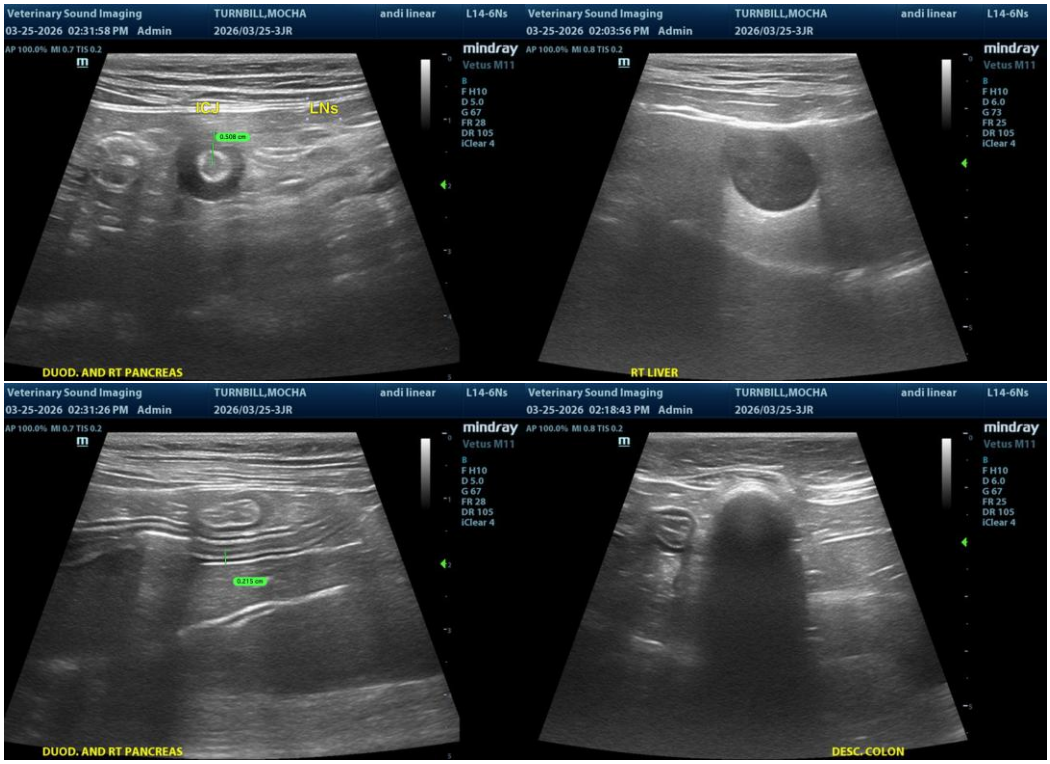

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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