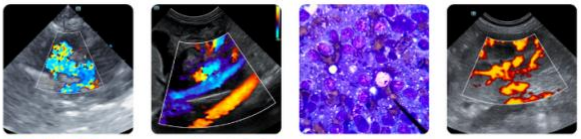

PATIENT

Bane Braham

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

13 Years 8 Months

WEIGHT

4.5 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Patti Mayfield DVM

HOSPITAL NAME

Ridgeview Veterinary Clinic

REFERRING VET

Dr. Caelli Edmonds DVM

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14107

DATE

03/05/26

PRESENTING CLINICAL SIGNS

- Relevant History: Bane has a >1-year history of intermittent vomiting, consisting of bile or partially digested food. Frequency has decreased with dietary modification but continues to occur several times per month. He has a known prior history of ingesting foreign material (rubber bands, string, wire) before adoption. No current history of diarrhea. Appetite and body weight have remained stable. He is indoor-only. Medical history is significant for hyperthyroidism, currently controlled on methimazole, as well as urinary crystal history, eosinophilia with overgrooming/alopecia, and cutaneous/subcutaneous masses. He also has a complicated crown fracture of the right maxillary canine (tooth 104) planned for future extraction.
- Current Medications/Supplements: Methimazole (Felimazole) 5 mg PO once daily. Dasuquin. Enteric support supplement. Whole body supplement. Maropitant (Cerenia) as needed for vomiting

Abnormal PE/Chem/CBC/UA Results: Physical Examination: Patient is bright, alert, and responsive with stable body condition. Abdomen is soft and non-painful with no palpable masses. No dehydration noted. Small dermal/subdermal nodules noted previously; ventral alopecia consistent with overgrooming. - Previous Diagnostics: - CBC/Chemistry/SDMA/T4: Hyperthyroidism now controlled (T4 3.4 µg/dL). - Mild persistent eosinophilia and lymphocytosis. - Mildly elevated BUN with increased BUN/Creatinine ratio; creatinine and SDMA within normal limits. - ALT and ALP within reference range. - Urinalysis: concentrated urine; no active sediment abnormalities. - KeyScreen GI parasite PCR: negative. - No prior abdominal imaging performed.

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 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. Mild loss of corticomedullary border demarcation was also present. The left kidney measured 4.1 cm in length. The right kidney measured 4.1 cm in length.

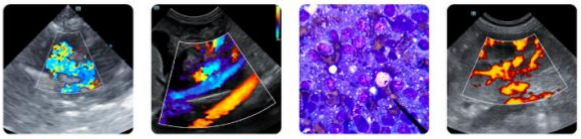
Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.45 cm width.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.33 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.



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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 mild 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 cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate ingesta exhibiting mild near field hyperechogenicity with distal acoustic shadowing. No evidence of mechanical pyloric outflow obstruction.

The small intestine presented intact borderline mild thickened wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine contained intestinal ingesta with no signs of ileus, obstruction or foreign material. The duodenum wall measured 0.29 cm wall width. The jejunum wall measured 0.29 cm wall width. The ileocolic wall measured 0.40 cm wall width.

Normal visible colon wall layers were present with formed 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

Minor colic 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). No evidence of peritoneal effusion.

ULTRASONOGRAPHIC FINDINGS

- Moderate shadowing gastric ingesta.
- Intact borderline mild thickened small intestine wall with intestinal ingesta.
- Mild heterogeneous pancreas.
- Chronic renal changes.
- Mild gallbladder debris.
- Mild urine sediment.
- Minor colic lymphadenopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The shadowing gastric ingesta is nonspecific and may indicate post-prandial presentation with dense ingesta, retained ingesta owing to metabolic or non-obstructive delayed gastric emptying, foreign material or combination. The small intestine exhibited mild mural changes which may indicate patient

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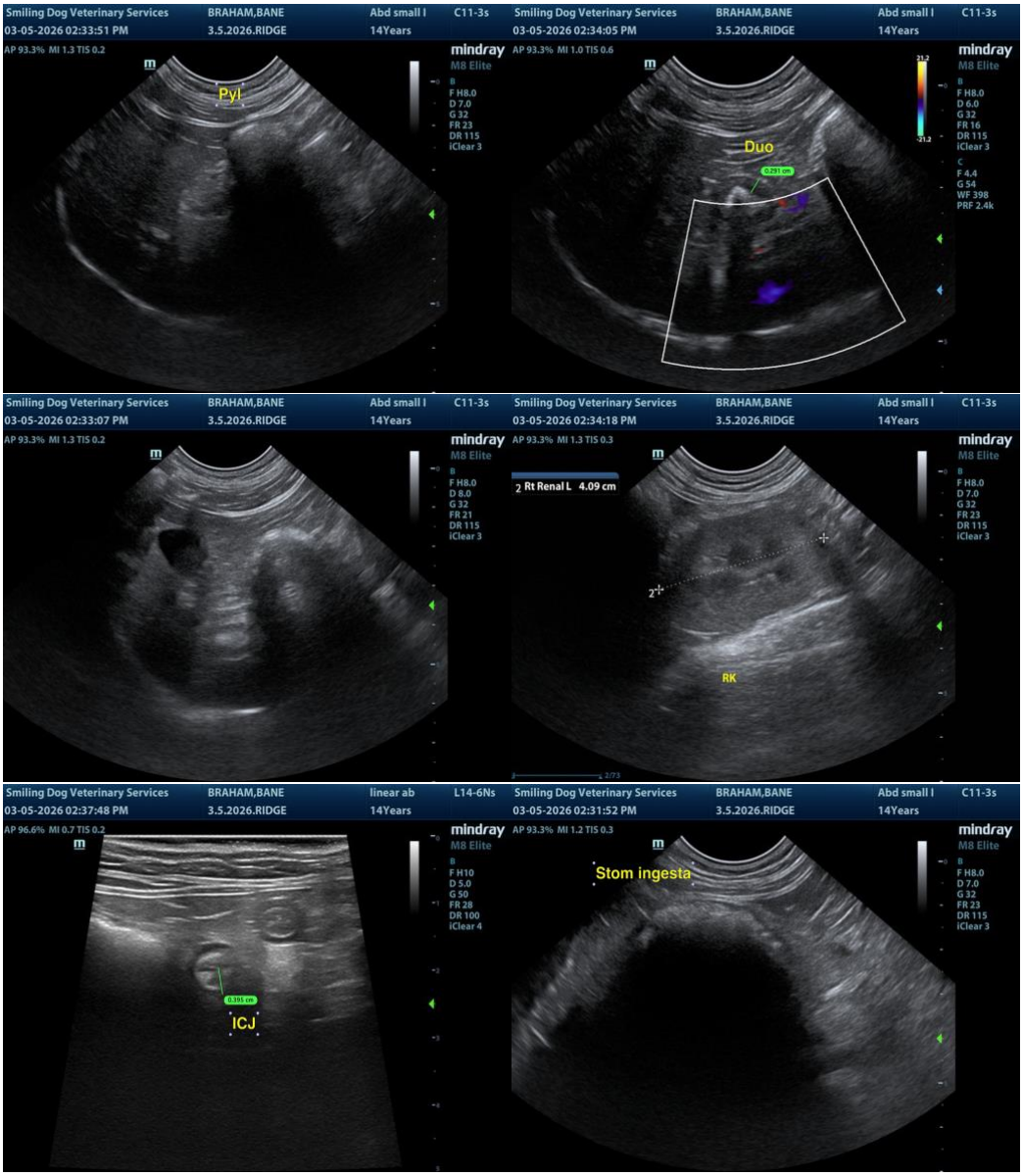
variant or in conjunction with eosinophilia inflammatory bowel disease. No obvious evidence of neoplastic criteria.

If documented NPO, 12-hour fast and sonographic reassessment of the gastrointestinal tract is recommended. If persistent gastric ingesta, laparotomy with gastric evacuation and intestinal biopsies is indicated. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Chronic pancreatitis may be suspected If cranial abdomen/subxiphoid discomfort on palpation. The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S if evidence of inflammatory cells is recommended.



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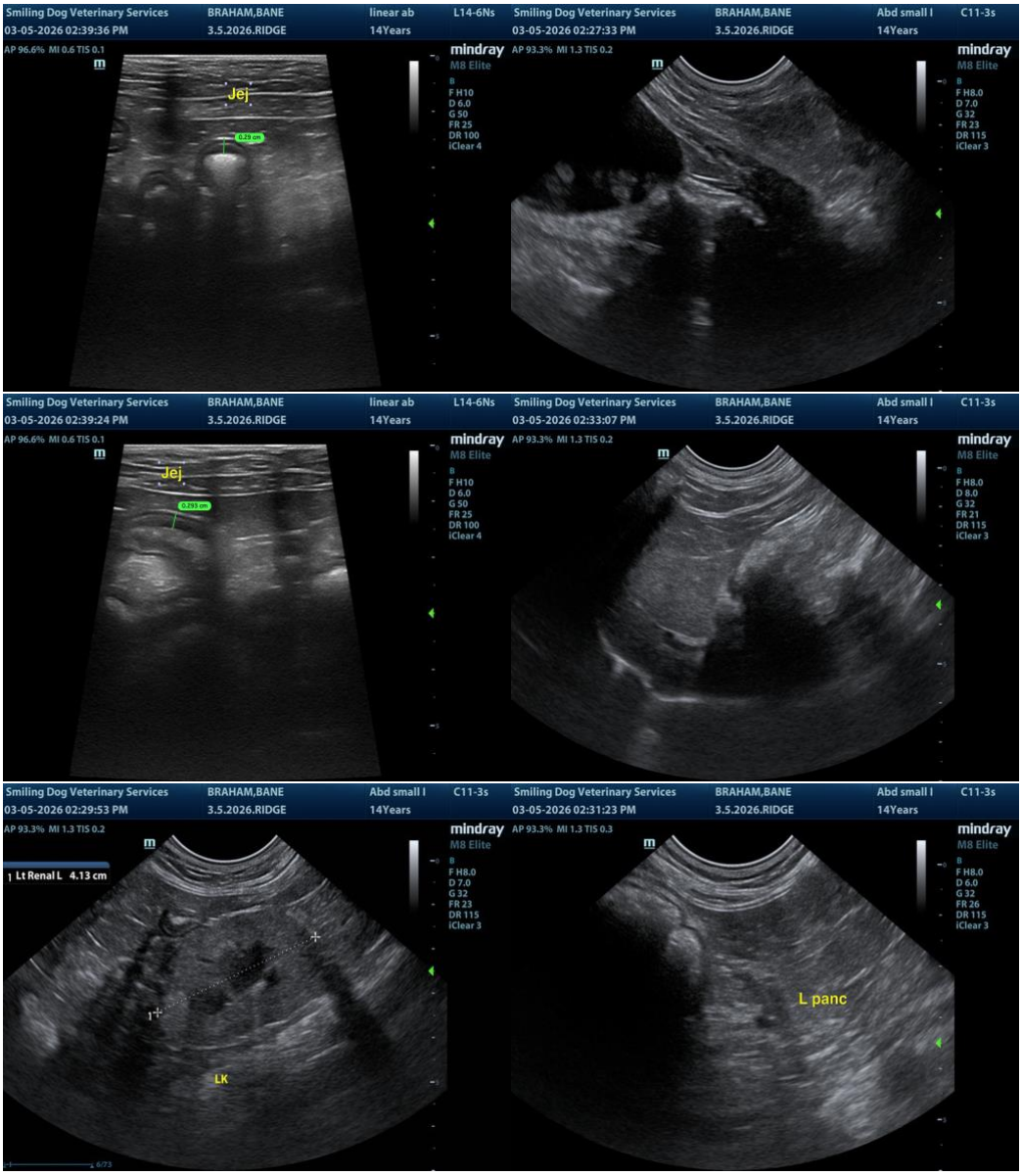

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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