



PATIENT

Callie Lyter

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

14 Years

WEIGHT

2.85 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary
Emergency Center

REFERRING VET

Dr. Logan Law

INVOICE

14769

DATE

04/01/26

PRESENTING CLINICAL SIGNS

History from 3/9/26: P has been vomiting for 5-6 months. average is 2-3 times a day. vomit is mostly fluid bile to an orange color fluid, sometimes with food. Owner notes weight loss. November 2025 was about 8 pounds. P had blood work done in 11/2025 which was unremarkable per owner. weight on 3/9: 3.16 kg (6.95 pounds). 3/9 outpatient treatment of sq fluids and Cerenia injection. rx'd Cerenia tablets and amoxi/clav. 4/1: P did well on Cerenia for the 5 days. P did not have any vomiting. Then P again vomiting 2-3 times a day. P did vomit 2 times today. continued weight loss; today 2.85 kg. concern for chronic vomiting - Primary GI disease (IBD vs Neoplasia), Azotemia, other

PE: soft on abdominal palpation, thickened loops of small intestine; BCS 4/9 3/9: CBC: WBC 20.45 H, NEU 16.91 H, Mono 1.08 H Blood Gas: BE, ECF -8 L, Lactate 4.14 H, BUN 34 H, Creatinine 2.59 H Chemistry: BUN 38.1 H, Creatinine 2.0 H, Total protein 5.9 L, Glucose 134 H T4: 1.9 WNL fpL: 3.3 normal radiographs: possible enlarged kidney

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 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.

The area of the aortic trifurcation was free of pathology.

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 3.1 cm in length. The right kidney measured 3.2 cm in length.

Adrenal Glands

The left adrenal gland was indistinctly visualized yet overtly normal in size, position and shape. The left adrenal gland measured 0.36 cm width.

The area of the right adrenal gland was free of overt pathology although not definitively visualized.

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. The hepatic and portal vasculature were normal in appearance without signs of congestion.



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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 exhibited regional intact nonthickened wall with concurrent variably thickened wall exhibiting indistinct loss of gastric mural detail. The stomach contained a mild amount of retained fluid without overt obstruction to pyloric outflow. Intact normal stomach wall measured 0.22 cm wall width. Thickened stomach wall measured 0.59 cm wall width. Thickened pylorus wall measured 0.64 cm wall width.

The small intestine presented overall intact wall layering with mild altered wall layer ratio owing to propensity for segmental to generalized prominent intestinal mucosa layer. The duodenum wall measured 0.28 cm wall width. The jejunum wall measured 0.28 cm wall width. The ileocolic wall measured 0.37 cm wall width.

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

Pancreas

The left pancreas was mildly prominent in size with mild capsule asymmetry and isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia. Mild prominent pancreatic duct was present.

Free Abdomen

Intermittent minor to mildly prominent mesenteric 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

- Mild hypomotile stomach exhibiting regional variably thickened stomach wall with indistinct to loss of mural detail.
- Generalized intact thickened small intestine.
- Suspect mild chronic pancreatitis.
- Intermittent minor to mild mesenteric lymphadenopathy.
- Bilateral chronic renal changes- no evidence of renomegaly.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Primary concern for emerging gastric neoplasia such as lymphoma or other in light of thickened stomach wall exhibiting indistinct to loss of stomach mural detail is warranted with potential for combined neoplastic and inflammatory gastroenteropathy.

A definitive diagnosis would require gastrointestinal biopsies for histopathology. Continued gastrointestinal support including dietary trial and gastroprotectant Omeprazole 1.0 mg/kg SID with continued as needed antiemetic medication with clinical and sonographic monitoring would be a more conservative approach. Uremic gastritis is considered less likely given current degree of azotemia. Correlation of azotemia with urinary workup including screening culture/sensitivity and UPC level may be considered.



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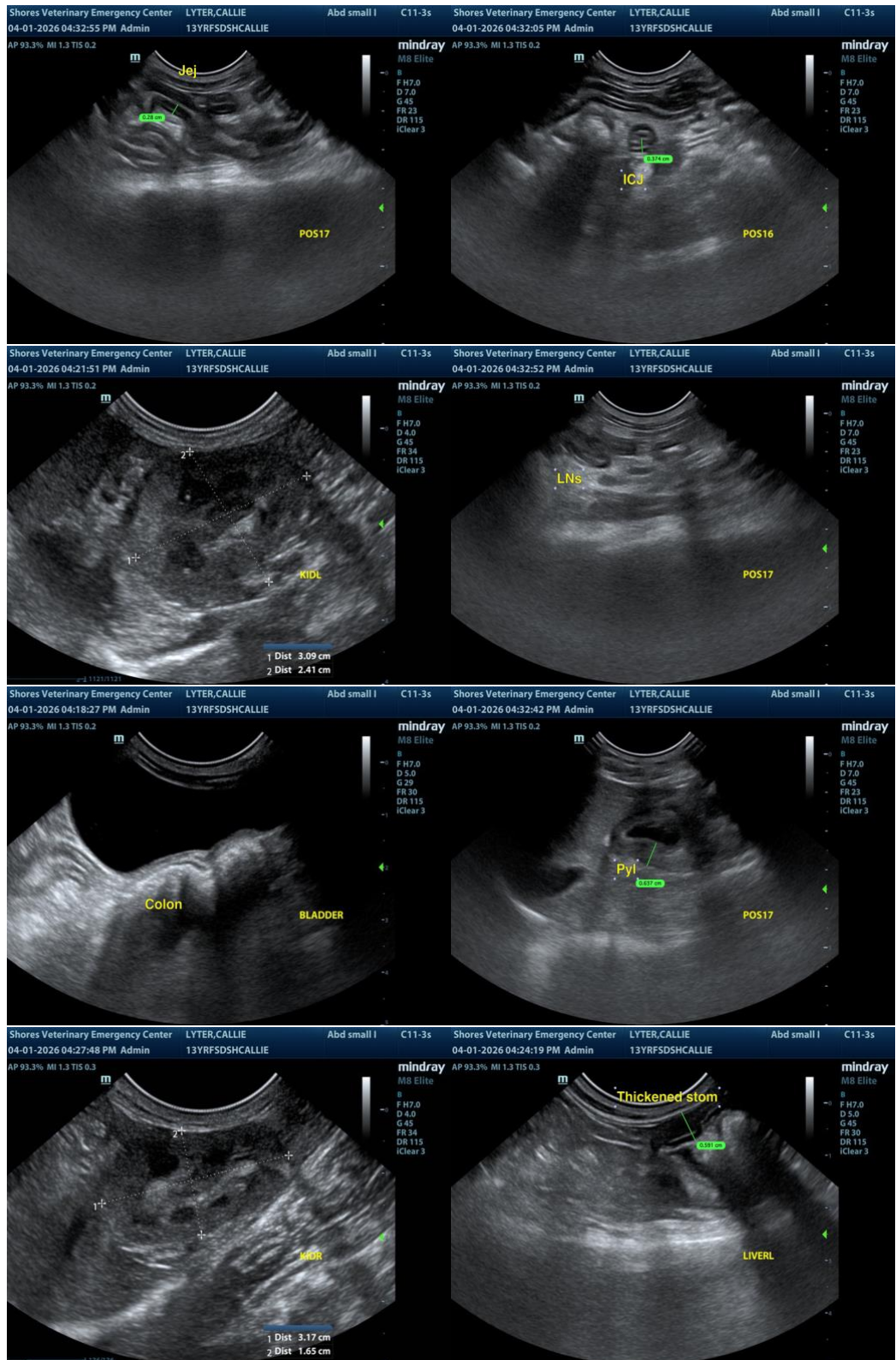
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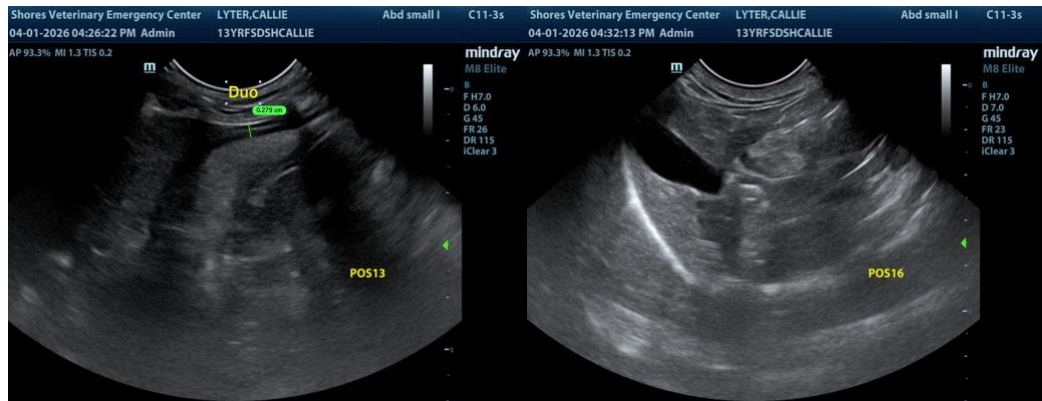
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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