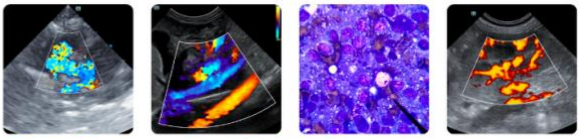


PATIENT

Sheldon Donat

SPECIES

Feline

BREED

Abyssinian

SEX

Neutered Male

AGE

5 Years

WEIGHT

5.4 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Suciu

HOSPITAL NAME

Animal Clinic of Queens

REFERRING VET

Dr. Mucera

INVOICE

15046

DATE

04/13/26

PRESENTING CLINICAL SIGNS

Intermittent chronic vomiting since January, progressively getting worse. Diagnosed with pneumonia yesterday at BluePearl, not hospitalized. Possible gastric mass (per radiologist). Anorexia, weight loss, lethargy. No diarrhea.

Abnormal PE/Chem/CBC/UA Results: Dyspnea, body condition score 3/9 BW 4/10/26: High ALT (317). High creat (2.6), normal BUN (26) and SDMA (11.8). Low sodium (140). High WBC (26,4) with neutrophilia (21,384) and monocytosis (792). T4 2.2

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.

The area of the aortic trifurcation was free of pathology.

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 hyperechoic and thickened resulting in an altered cortex: medulla ratio. Mild indistinct corticomedullary border demarcation was also present. The left kidney measured 3.5 cm in length. The right kidney measured 3.6 cm in length.

Adrenal Glands

The adrenal glands were bilaterally enlarged in size with symmetrical contour and homogenous parenchyma that appeared nonmineralized. The left adrenal gland measured 0.60 cm width at the caudal pole. The right adrenal gland measured 0.57 cm width at the caudal pole.

Spleen

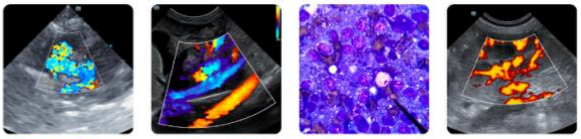
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver & Gallbladder

The liver presented subjectively normal in size. Homogenous mildly hypoechoic parenchyma compared to the spleen exhibiting mild coarse echotexture. Increased prominence of the intrahepatic hyperechoic portal vascular borders. The capsule of the liver was normal in margination. Distinct masses or nodules were not evident. 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



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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained variably echogenic, focally echogenic yet nonshadowing ingesta and lumen gas without signs of obstruction or foreign material. The esophageal inlet was free of overt pathology. No obvious obstruction to pyloric outflow. The stomach wall measured 0.21 cm wall width.

Segmental mild ingesta and chyme distended intestinal segments subjective proximal small intestine subjectively involving the duodenum. Ill-defined thickened cranial abdomen intestine visualized in the area of the mild ingesta and chyme distended intestine with adjacent empty small intestine. The thickened intestinal segments exhibited indistinct wall layer ratio and mild mural hypoechogenicity. An example of thickened intestine to potential intestinal mural lesion measured approximately 0.85 cm in diameter. The thickened intestine wall measured 0.39 cm wall width. The remainder of the visualized small intestine exhibited intact wall layering and maintained wall layer ratio with empty lumen. An example of intact normal small intestine measured 0.23 cm wall width.

Normal visible colon wall layers were present with semi formed fecal matter.

Pancreas

The pancreas presented mildly prominent in size with capsule asymmetry and mild nonhomogenous hypoechoic parenchyma compared to adjacent omentum.

Free Abdomen

No visualized significant or swollen mesenteric lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Variably echogenic nonshadowing to retained upper gastrointestinal ingesta and lumen gas.
- Ill-defined thickened intestine cranial abdomen in the area of retained intestinal ingesta and empty intestinal segments.
- Semi formed fecal matter in colon.
- Suspect concurrent pancreatitis.
- Bilateral nonspecific nephrosis pattern with mild adrenomegaly.
- Nonspecific possible acute hepatopathy, sonographically normal gallbladder.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

In conjunction with clinical history and recent diagnosis of aspiration pneumonia, the ill-defined intestinal mural lesions appear to be at least partially obstructive to gastric and upper intestinal outflow given retained upper gastrointestinal ingesta and empty intestinal segments distal. Inflammatory, infectious, granulomatous, neoplastic etiologies with potential for stricture or other are possible. Given lack of diarrhea, large intestinal involvement is thought less likely yet not definitively excluded.

Assuming no pathology on three view chest radiographs, exploratory laparotomy with gross inspection of the intestine with potential for biopsies or resection of pathological intestine could be considered. Abdominal CT is likely ideal if available for further clarification and surgical planning. Hepatic biopsies if surgery is elected and assuming normal clotting status versus screening hepatic FNA cytology is recommended.

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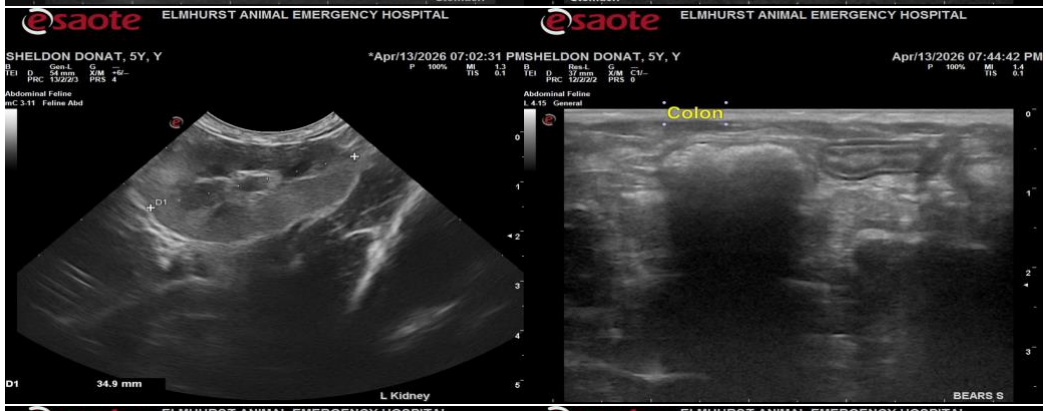

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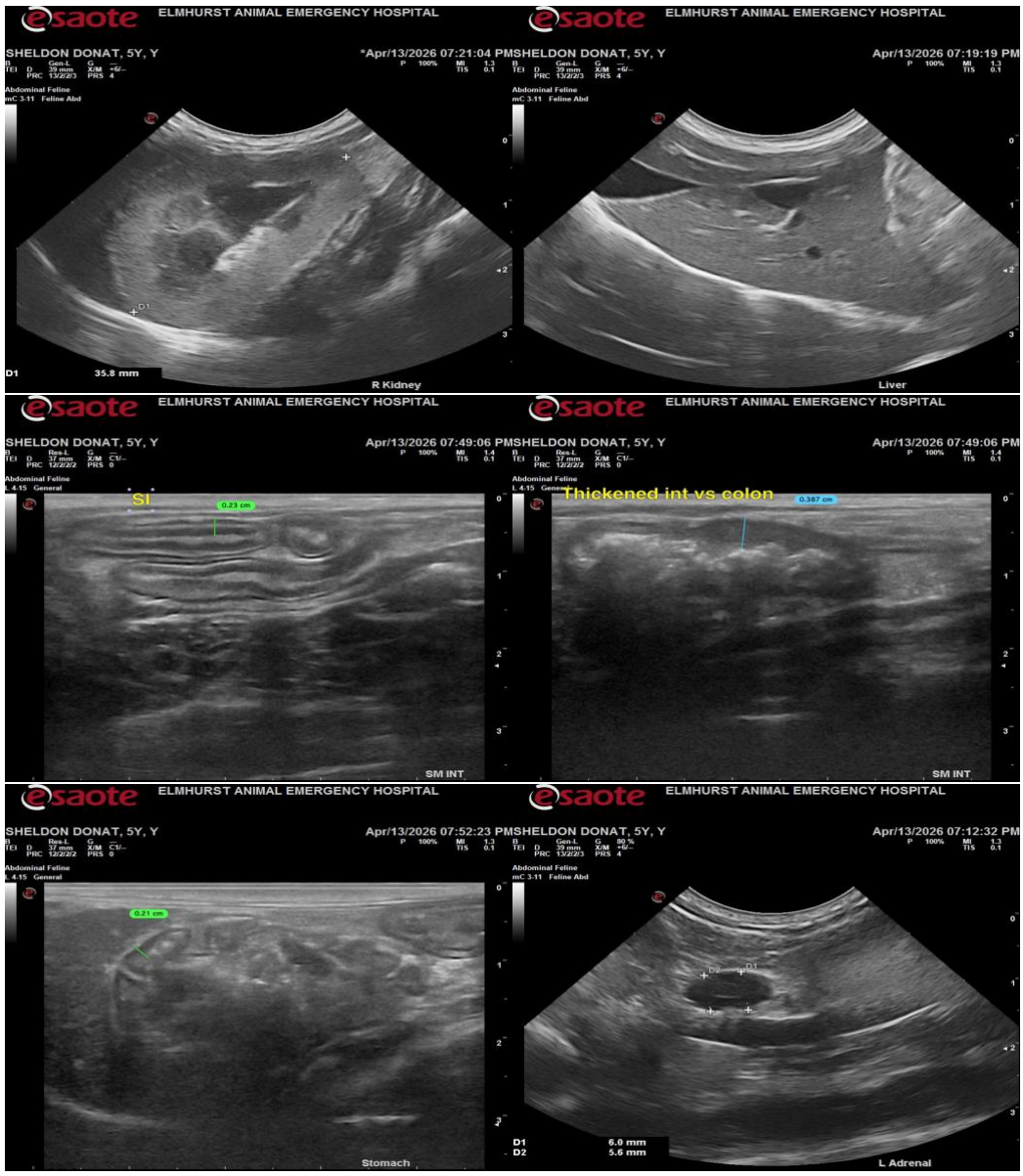

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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