



PATIENT

Bella Claar

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

9.5 years

WEIGHT

4.19 kg

INTERPRETED BY

R. McKenzie Daniel,
DVM, DABVP
(Canine and Feline)

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary
Emergency Center

REFERRING VET

Lauren Kiebler

INVOICE

10810

DATE

4/15/26

PRESENTING CLINICAL SIGNS

*P was seen 4/8 at Rossmoyne ER for vomiting and hyporexia. rx'd emeprev. owner had difficulty giving emeprev (did not get full doses). P seen second time at ER for anorexia; blood work done and was unremarkable. P rx'd mirataz transdermal. 4/11 seen a 3rd time at ER for anorexia. P was given sq fluids, depomedrol injection, and dexamethasone injection. P had been eating better after the 4/11 ER visit. Today P vomited 3 times (all food). owner contacted Rossmoyne ER whom recommended recheck with possible radiographs (which have not been done to this point) and possible abdominal ultrasound. Owner was recommended to go to another ER facility for the further diagnostics. weight loss: 4/8 P weight 9.9 pounds (4.5 kg); today 4.19 kg. P is FIV positive. P has had prior gastroenteritis in 2019 and 2020.

*concern for gastroenteritis, gi disease--primary vs secondary, IBD, other
Abnormal PE/Chem/CBC/UA Results: PE: mild abdominal pain 2/4; dehydration 8-10% retracted globes within orbits; reactive to abd palpation, tense, abdomen palpates gassy, intestines palpate thickened 4/9
Rossmoyne ER: CBC: Neu 11.46 H, PLT 68 L; EPOC: BE -6.8 L, Glucose 155 H; Chemistry: Ca 8.6 L, Glucose 164 H; T4 - 1.47 Normal 4/15 Shores: fPL 2.8 normal; epoc: TCO2 25.5 H, glucose 253 H

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and cystourethral junction exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Mild, nondependent, particulate 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.

No evidence of pathology in the area of the aortic trifurcation.

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 3.7 cm in length. The right kidney measured 3.9 cm in length.

Adrenal Glands

No overt pathology was noted in the area of the left or right adrenal glands.

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. Normal hepatic vascular volume was present. 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. The



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gallbladder was non-distended in size containing primarily anechoic content with minor gallbladder debris. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach was moderately distended with retained fluid. Regional mild to variably thickened stomach wall was noted subjectively distending into the pylorus and potentially the upper duodenum. Thickened areas of stomach, pylorus, and possible upper duodenum exhibited indistinct to loss of wall layering with an example of thickened stomach wall measuring 0.73 cm and thickened pylorus to possible upper duodenum measuring 0.65 cm. The remainder of the small intestine exhibited intact wall layering with nonchicken wall and maintained wall layer ratio. There is no evidence of small intestine mechanical / metabolic ileus to the level of the colon. Normal duodenum wall measured 0.26 cm width. The jejunum wall measured 0.20 cm width. The ileocolic wall width measured 0.30 cm width.

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

Pancreas

The area of the pancreas was sonographically normal.

Free Abdomen

Mild perigastric hyperechoic omentum and intermittent mildly enlarged gastric lymph nodes were noted.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Moderate retained gastric fluid with variably thickened gastric, pyloric and possible upper duodenum wall
- Sonographically unremarkable area of pancreas
- Minor gastric lymphadenopathy
- Mild gallbladder debris

Secondary Findings

- Mild urine sediment, normal bilateral kidneys

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Considerations for the thickened gastric, pyloric, and possible upper duodenum wall may include inflammatory, infectious, granulomatous, or emerging neoplastic etiologies, with concern for emerging neoplasia, given indistinct to loss of gastric, pyloric, and possible upper duodenum wall layering. Some degree of obstruction to pyloric or upper intestinal outflow appears present in conjunction with retained gastric fluid. Endoscopic or surgical biopsies are recommended for further diagnosis and guidance of therapy. Potential suppression of gastrointestinal mural changes owing to recent steroid administration possible. Empirically, smaller more frequent feedings of a canned novel protein or hydrolyzed diet, as-needed gastroprotectants, +/- empirical helicobacter coverage may be considered.

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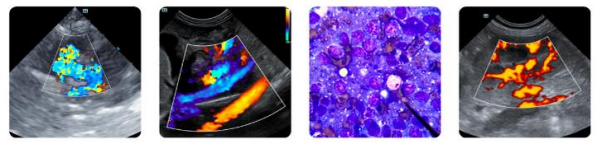
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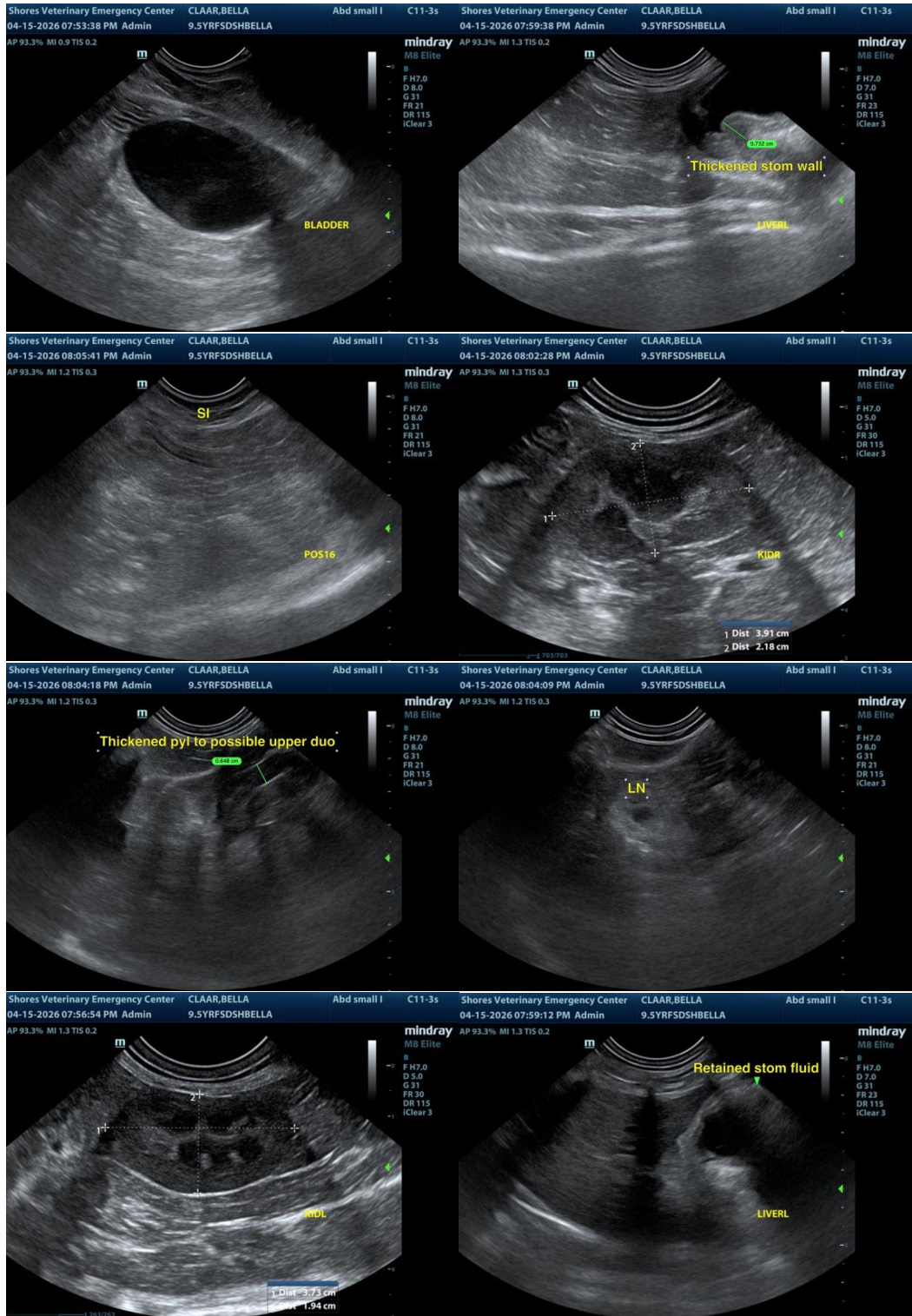
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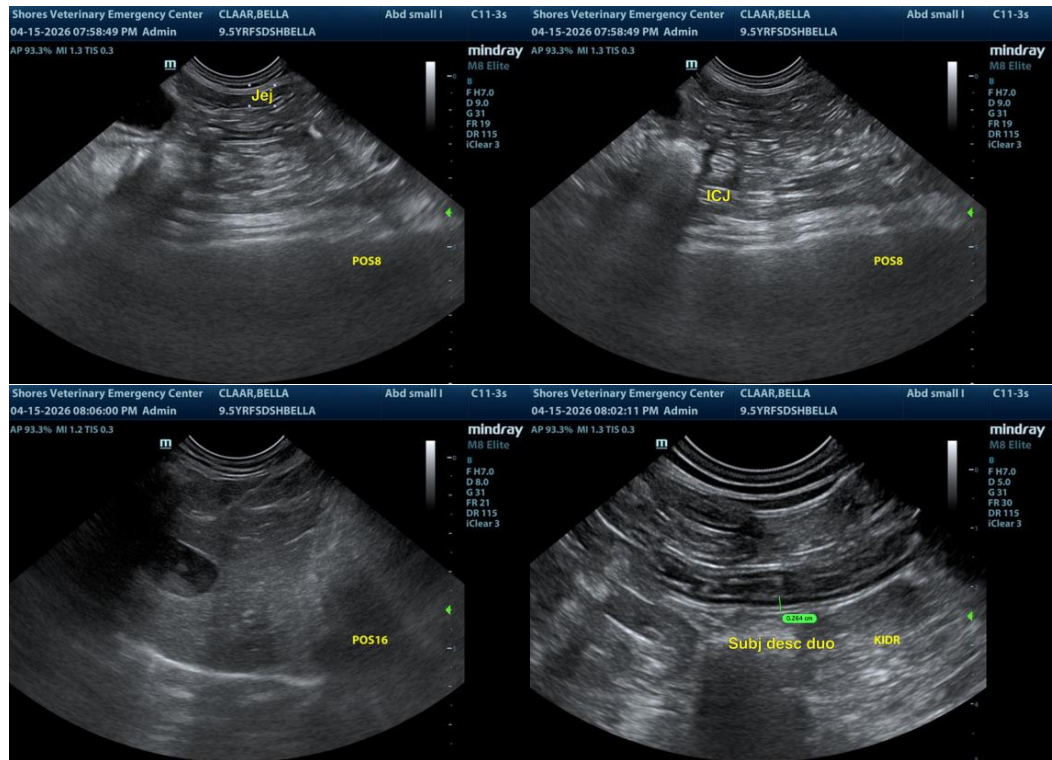
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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