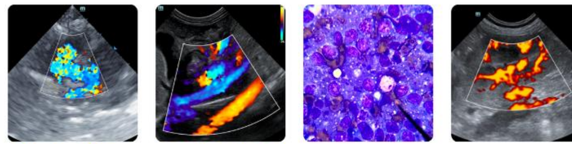


PATIENT
Benji Usilton

SPECIES
Feline

BREED
DSH

SEX
MN

AGE
2012

WEIGHT
12

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

IMAGING PERFORMED BY
Rebekah Jakum, CVT ARDMS/RVT

HOSPITAL NAME
Mt Airy Animal Hospital

REFERRING VET
Riley

INVOICE
24407

DATE
04/06/2026

PRESENTING CLINICAL SIGNS

- Chronic vomiting for several years - increased frequency
- ~2# weight loss in 2 years

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 mild non-dependent particulate sediment. 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 3.7 cm in length. The right kidney measured 3.6 cm in length.

Adrenal Glands

The left and right adrenal glands were not definitively visualized. No obvious pathology was present in the area of the bilateral 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.

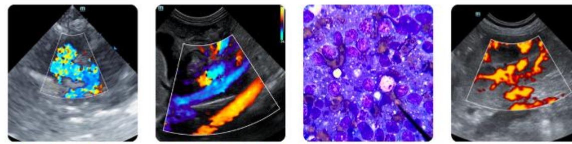
Liver/Gallbladder

The liver was subjectively normal in size, structure, and contour. 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 pylorus wall measured 0.24 cm in width.

The small intestine presented intact mildly thickened primarily jejunal wall with mild altered jejunal wall layer ratio owing to propensity for mildly thickened muscularis layer. No evidence of mechanical



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/metabolic ileus or visualized loss of wall layer detail to the level of the colon. The duodenum wall measured 0.21 cm width. The jejunum wall measured 0.26 cm width.

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

Pancreas

The pancreas was prominent size with capsule asymmetry. Heterogeneous remodeled parenchyma compared to adjacent omentum.

Free Abdomen

Intermittent mildly prominent homogenous mesenteric and medial iliac lymph nodes were present; an example measured 1.2 cm in diameter.

No evidence of peritoneal effusion.

Transdiaphragmatic brief sonographic assessment of the thorax revealed pleural effusion with subjective normal cardiac structure / function. No definitive visualized thoracic masses.

ULTRASONOGRAPHIC FINDINGS

Primary

- Normal empty stomach
- Chronic enteropathy
- Probable concurrent chronic pancreatitis
- Sonographically unremarkable non-congested liver
- Intermittent mild medial iliac /mesenteric lymphadenopathy
- Pleural effusion -subjective non-cardiogenic

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Chronic IBD or other inflammatory enteropathy in conjunction with chronic pancreatitis and mild lymphadenopathy suggestive of benign criteria, i.e. reactive hyperplasia or lymphadenitis may be favored. The possibility of emerging to occult intestinal round cell neoplasia, such as lymphoma and early metastatic lymphadenopathy not definitively excluded. No evidence of mechanical gastrointestinal obstruction. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended.

Thoracocentesis with pleural effusion analysis cytology +/- C/S if evidence of inflammatory component is recommended. Pending additional diagnostics, gastrointestinal support, which may include dietary therapy, gastroprotectants, +/- empirical IBD protocol may be considered.

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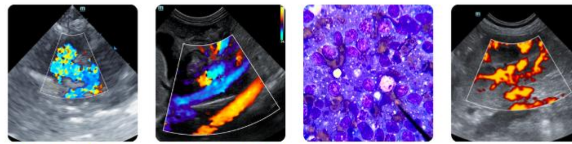

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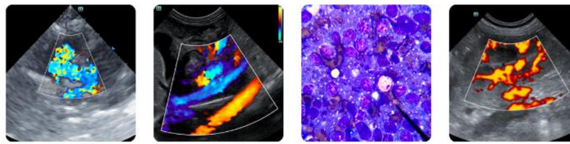
The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.



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