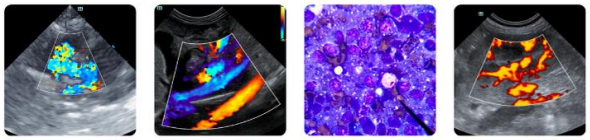


PATIENT
Lilly Gigli

SPECIES
Feline

BREED
DSH

SEX
FS

AGE
8Y

WEIGHT
5.7lbs

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

IMAGING PERFORMED BY
Michelle Roche

HOSPITAL NAME
Fredon Animal Hospital

REFERRING VET
Dr. Sikkes

INVOICE
75268

DATE
6-2-26

PRESENTING CLINICAL SIGNS

V/D for one month, weight loss
Abnormal PE/Chem/CBC/UA Results: dehydration, increase fluid palpable in bowels. WBC 36.6

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 changes was noted.

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

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. Indistinct corticomedullary border demarcation was also present. Minor pyelectasia was present in both kidneys. The left kidney measured 3.2 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 in the area of the left and 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 presented possible borderline enlargement. 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.

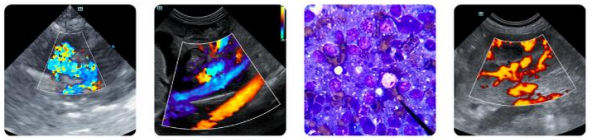
The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The proximal common bile duct was dilated and tortuous without overt post hepatic obstruction.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty without evidence of retained ingesta, fluid, or foreign material.

The small intestine presented intact mildly thickened wall layering with minor altered wall layer ratio. An example of the small intestinal wall measured 0.30 cm. The lumen of the small intestine was empty with no signs of ileus, obstruction, or foreign material. The ileocolic wall measured 0.45 cm.

The colon exhibited thickened intact to mildly indistinct wall layering with semi-formed to soft fecal matter. The descending colon wall at the level of the urinary bladder measured 0.34 cm.



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Pancreas

The left pancreas presented normal in size with asymmetrical contour and mild nonhomogeneous parenchyma. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease were evident.

Free Abdomen

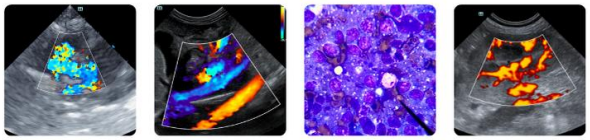
Variable to asymmetrical mild nonhomogeneous jejunocolic lymphadenopathy was present. An example of a lymph node measured 2.2 x 0.84 cm. Minor pockets of peritoneal effusion were also present.

ULTRASONOGRAPHIC FINDINGS

- Enterocolonopathy
- Suspect chronic pancreatitis
- Subjective borderline hepatomegaly
- Nondistended gallbladder with nonobstructive proximal common bile duct dilation.
- Variable jejunocolic lymphadenopathy and scant effusion.
- Nonspecific chronic renal changes exhibiting mild pyelectasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

IBD or other inflammatory enteropathy with triaditis and reactive to possible inflammatory jejunocolic lymphadenopathy suspected. Neoplasia such as lymphoma may present in a similar sonographic manner and not excluded. Dry form FIP considered less likely. FNA cytology, if accessible, of a jejunocolic lymph node could be considered for initial clarification. Gold standard intestinal lymphatic +/- pancreatic biopsies required for definitive diagnosis. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Empirical therapy for IBD/triaditis with gastrointestinal support and clinical/sonographic monitoring would be more conservative. CBC pathology review if considered clinically indicated could be considered.



SonoPath.com info@sonopath.com 1.800.838.4268

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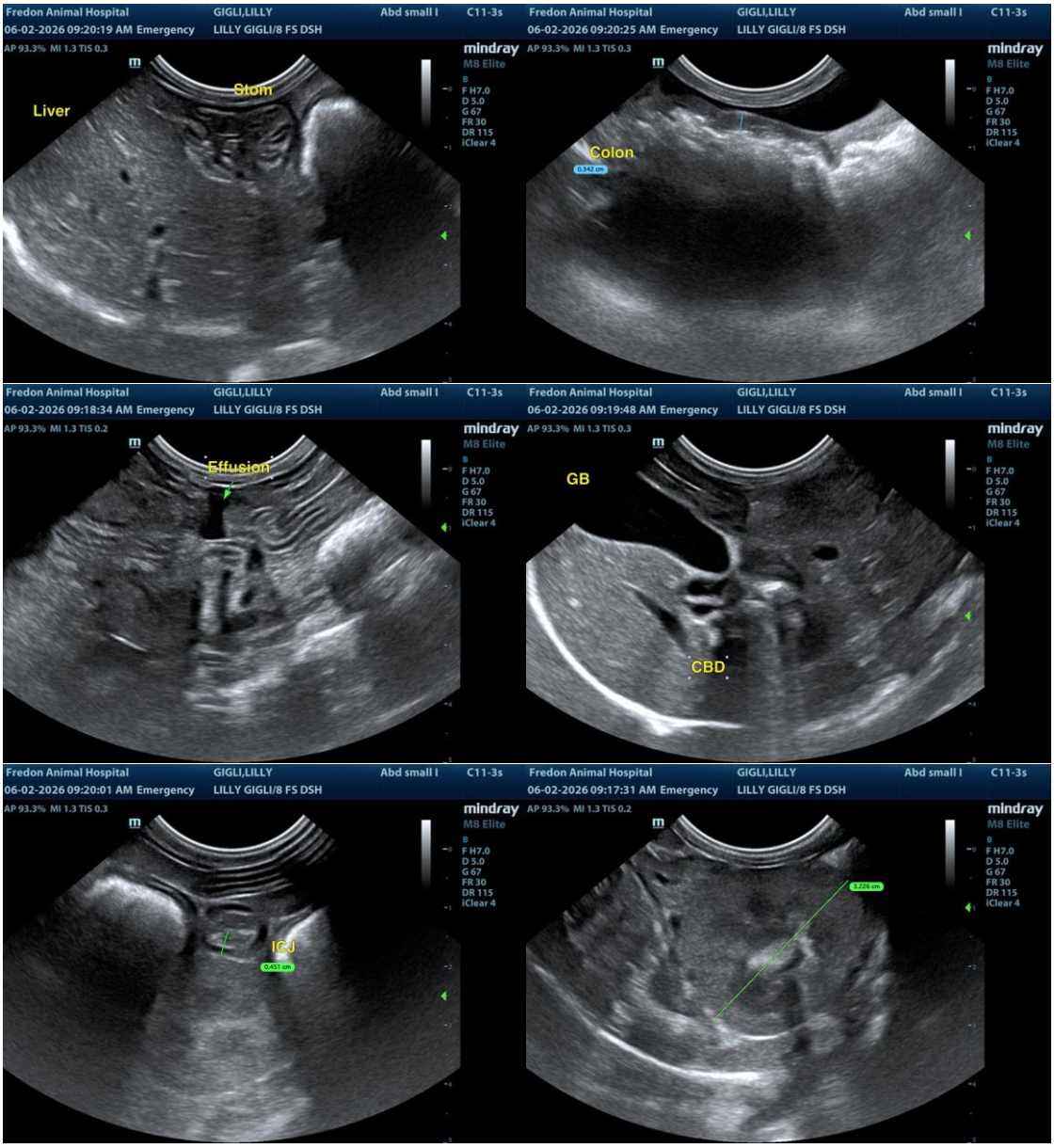

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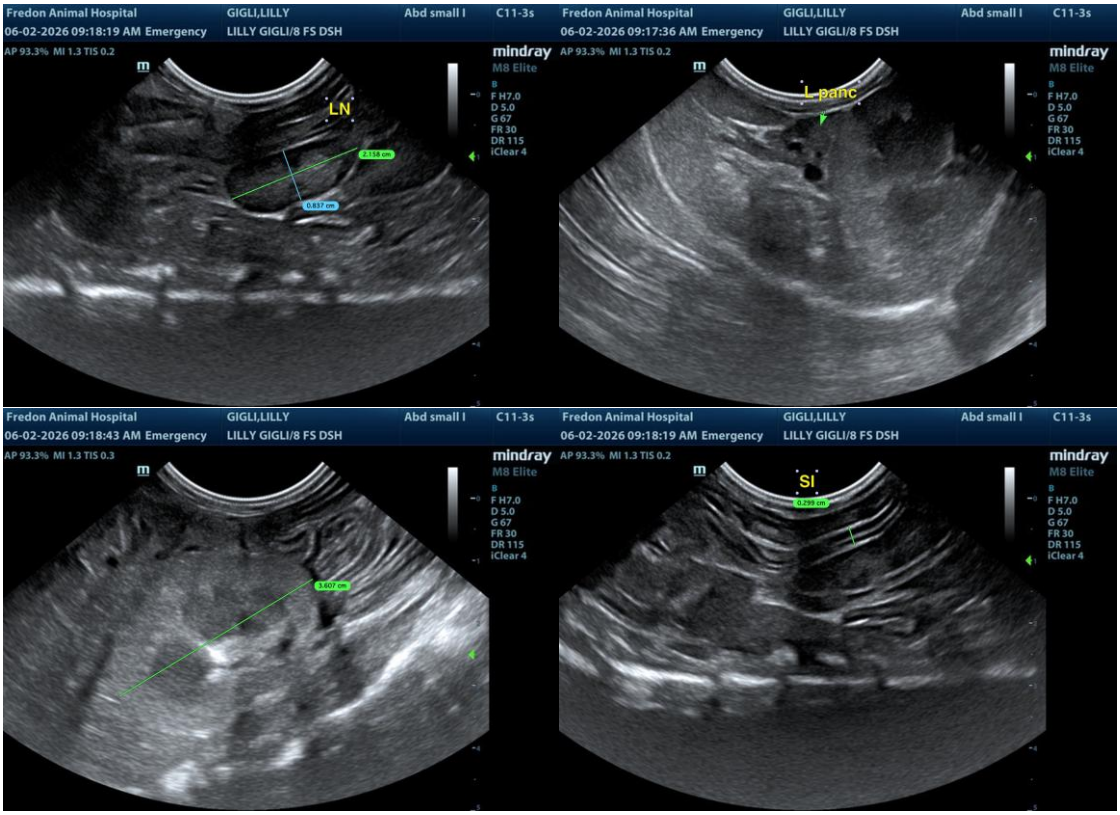

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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