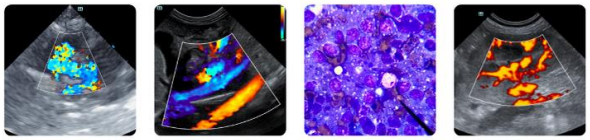


PATIENT

Mushu Cuba

SPECIES

Feline

BREED

DSH

SEX

Male (Neutered)

AGE

6 yrs

WEIGHT

7.9 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Sophia Riscavage

HOSPITAL NAME

North Winds VS

REFERRING VET

Dr. Sarah Hosie

INVOICE

10946

DATE

6/3/26

PRESENTING CLINICAL SIGNS

Presented for intermittent vomiting with weight loss.
Abnormal PE/Chem/CBC/UA Results: CBC/Chem/T4- unremarkable Radiographs- unremarkable

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. 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 3.2 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, 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. The spleen measured 0.94 cm width at the level of the mid-spleen.

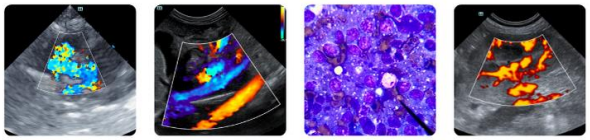
Liver/ Gallbladder

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 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 without evidence of retained ingesta, fluid, or foreign material.

The small intestine presented intact thickened wall with altered to inverted wall layer ratio owing to generalized thickened intestinal muscularis layer. The duodenum wall measured 0.43 cm width. The jejunum wall measured 0.40 cm width.



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

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

Intermittent, mildly enlarged, nonhomogeneous, jejunocolic lymph nodes were present. An example measured 1.7 cm x 1.1 cm. Subtle perilymphatic hyperechoic omentum was noted. No evidence of effusion was noted.

ULTRASONOGRAPHIC FINDINGS

- Normal empty stomach
- Intact thickened small intestinal wall with altered / inverted wall layering
- Intermittent mild nonhomogeneous jejunocolic lymphadenopathy
- Mild urine sediment
- Sonographically normal pancreas

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The appearance of the small intestine is compatible with infiltrative enteropathy. Primary considerations may include inflammatory infiltrative enteropathy such as IBD or neoplastic infiltrative enteropathy with round cells such as lymphoma or mast cell disease among potential etiologies. Dry form FIP may also present in this manner. Associated jejunocolic reactive lymphatic hyperplasia, lymphadenitis, or early metastatic lymphadenopathy possible.

Diagnosis would require biopsies for histology, obtained either via endoscopy or, ideally, full thickness biopsies via laparotomy. A GI Panel to include PLI/TLI/Cobalamin/Folate is recommended. If additional diagnostics are not elected, empirical medical therapy for IBD which may include dietary therapy, cobalamin supplementation, probiotics +/- steroids trial with assessment of clinical response and monitoring of body weight could be considered.

Correlation with urinalysis +/- C/S, if inflammatory sediment on urinalysis, is recommended.

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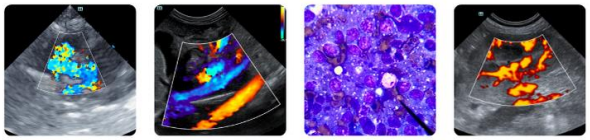

Clinical Sonography & Telecytology
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SonoPath.com info@sonopath.com 1.800.838.4268

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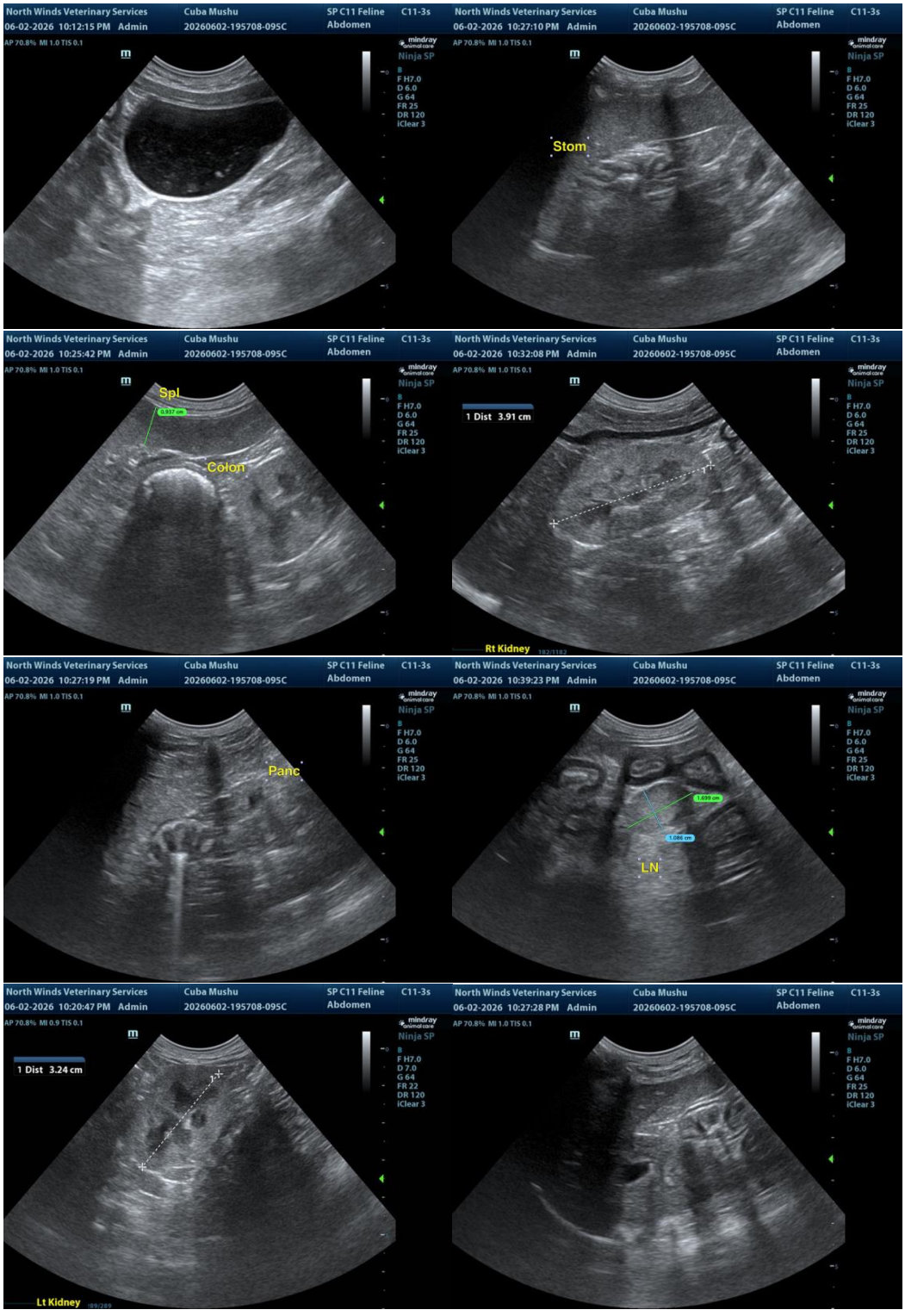

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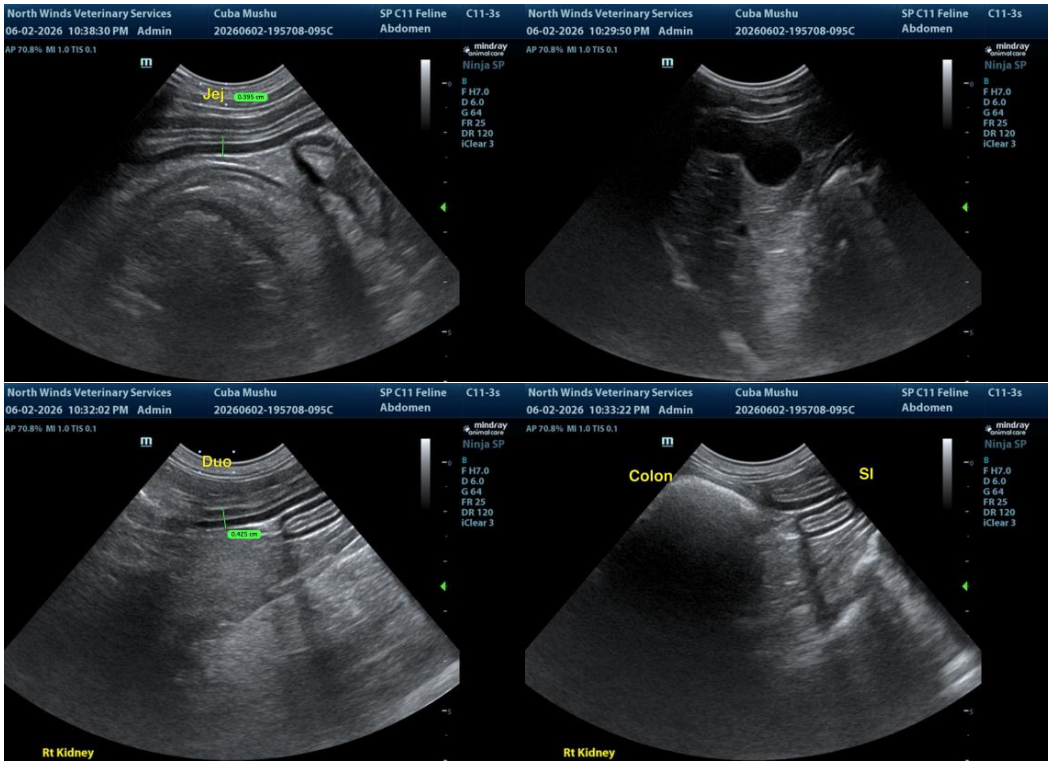

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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