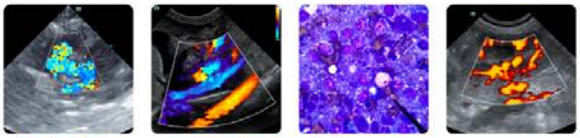

PATIENT

Nicole Holmes

SPECIES

Feline

BREED

Abyssinian

SEX

Spayed Female

AGE

8 Years

WEIGHT

2.8 kg

INTERPRETED BY

Tam Mengine, DVM, DABVP (canine/feline practice)

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Animal Emergency Clinic of the High Country

REFERRING VET

Dr. Wolverton

INVOICE

72802

DATE

12/28/25

PRESENTING CLINICAL SIGNS

P presented for several days of vomiting. Unable to keep down food or waterRADS: soft tissue density seen in the stomach R lateral, maybe seen on L lateral-possible FB? Tumor?

Abnormal PE/Chem/CBC/UA Results: Complete w/ epoc: elevated lactate, elevated amylase, normal lipase, elevated creatinine but normal BUN, pancreatic lipase test was borderline elevated, rest was unremarkable

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. A small amount of echogenic luminal sediment is present, which is freely movable. The ureteral papillae, trigone and pelvic urethra (visible to 3.0 cm) are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted.

The kidneys are of normal size and shape and exhibit appropriate corticomedullary differentiation with a normal 1:3 cortex to medulla ratio. There is no evidence of nephrolithiasis, mineralization, pyelectasia, cystic change or hydronephrosis. The proximal ureter is not visible (normal). Left measures 3.5 cm. Right measures 3.6 cm.

Adrenal Glands

The adrenal glands are both identified in their normal locations. They are normal in size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. Left measures 3.2 mm. Right measures 4.6 mm.

Spleen

The spleen is of appropriate size (7.1 mm) and has a normal, homogenous parenchyma with a smooth, continuous capsular surface. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal. Thickness at the splenic hilus is normal.

Liver

The liver is of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is distended with anechoic contents. The wall was thin and continuous with no focal lesions. The cystic duct is within normal limits, and the common bile duct is prominent, but measures normally at just under 4.0 mm with no evidence of obstruction at the level of the duodenal papilla.

Gastrointestinal

The stomach is mildly distended with gas. The gastric wall is 2.3 mm with normal deviations due to rugal folds, and exhibits appropriate wall layering. The pylorus is of normal appearance.

The small bowel has diffuse changes to the normal 1:3 muscularis to mucosa ratio. Wall measurements are increased up to 2.1 mm for duodenum and 4.0 mm for jejunum. Overall wall layering is preserved.

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Intestinal motility appears normal.

The visible portions of the colon have increased thickness, up to 2.4 mm with intact wall layering. The ileocecal junction is normal.

Pancreas

The pancreas is swollen and hypoechoic, surrounded by hyperechoic mesenteric fat. The pancreatic ducts appear normal.

Free Abdomen

There is focal free fluid present with the abdomen in the region of pancreas and cranial abdomen. The associated omentum and intra-abdominal fat are hyperechoic. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

PRIMARY FINDINGS

- Diffusely thickened small bowel & descending colon, typical of infiltrative bowel disease
- Hypoechoic pancreas with steatitis, typical of acute pancreatitis
- Scant free fluid in the cranial abdomen, consistent with regional peritonitis
- Prominent common bile duct, without evidence of obstruction

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes in the gastrointestinal tract are suggestive of infiltrative bowel disease, including both inflammatory bowel etiologies (food allergy, lymphoplasmacytic enteritis, eosinophilic enteritis) or low grade gastrointestinal lymphoma. The changes the pancreas suggest concurrent pancreatitis, with pancreatic neoplasia deemed less likely, but not excluded. Recommended next steps include:

- Fecal parasite testing and empiric fenbendazole treatment
- Trials with a novel protein or hydrolyzed diet
- Supportive care with fluids, anti-emetics and analgesics as needed
- A complete GI panel, or empiric cobalamin supplementation
- Empiric therapy with prednisolone at 2-4mg / kg daily could be considered if biopsies will not be pursued.
- Definitive diagnosis would require biopsy of the affected tissue, ideally with intra-operative ultrasonographic guidance.

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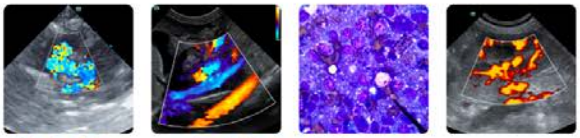

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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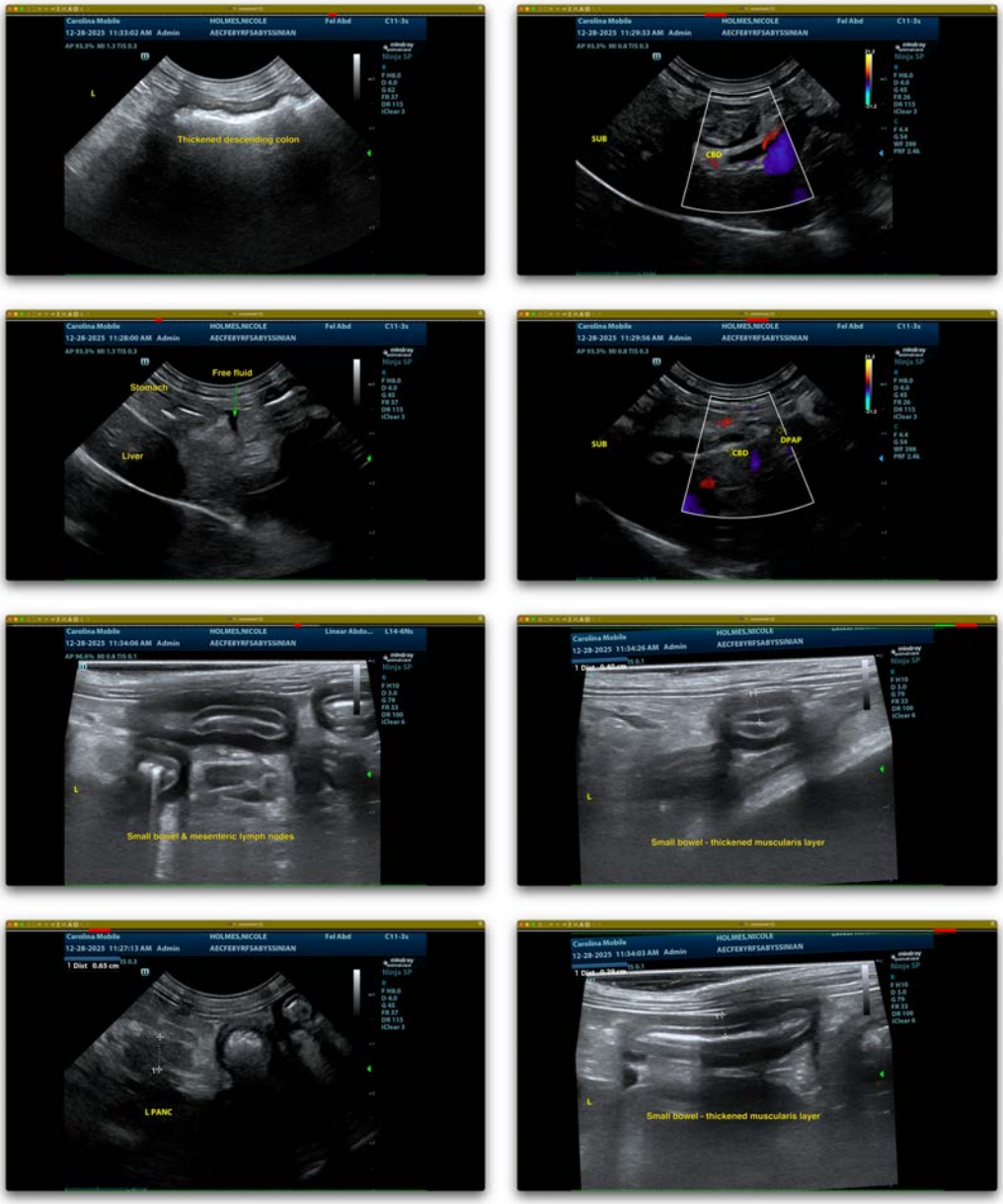

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Tam Mengine, DVM, DABVP (canine/feline practice)

info@SonoPath.com