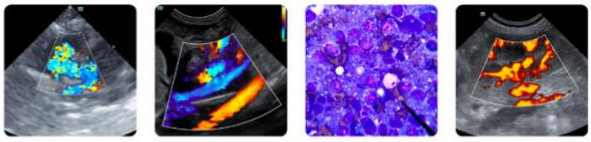


PATIENT

Dakota Schatz

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

2 Years

WEIGHT

4.25 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Rebecca Hamilton

HOSPITAL NAME

Orchard Grove Animal Hospital

REFERRING VET

Dr. Cassano

INVOICE

16596

DATE

05/29/26

PRESENTING CLINICAL SIGNS

Chronic diarrhea/ weight loss, inappetence. Meds: DexSP (5/28/26)

Abnormal PE/Chem/CBC/UA Results: Neg on fecal, Neg FELV/FIV, Low Albumin 1.7(2.6-3.9), Reticulocyte 14.1(14.4-19.2) Lymphocytes 0.623 (0.65-6.86) Eosinophils 0.056 (0.209-1.214) Calcium 8.1 (8.2-11.2)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is minimally distended with anechoic urine. While the wall appears thickened, this is likely a normal variation due to lack of distention. The ureteral papillae, trigone and pelvic urethra are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted. Urethra visualized to 1.0 cm.

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). The left kidney measured 3.6 cm. The right kidney measured 5.7 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. The left adrenal gland measured 3.7 mm. The right adrenal gland measured 4.0 mm.

Spleen

The spleen is of appropriate size 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. The spleen measured 5.6 mm.

Liver

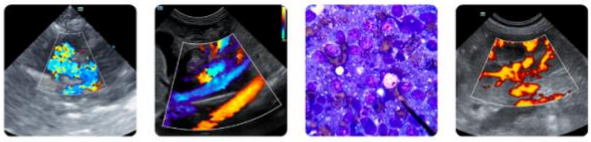
The liver is of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents and a small amount of freely moveable echogenic sludge. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

Gastrointestinal

The stomach is empty. The gastric wall is normal deviations due to rugal folds and exhibits appropriate wall layering. The pylorus is of normal appearance.

The small bowel has focal changes to the normal 1:3 muscularis to mucosa ratio, with a focal loss of wall layering. Wall measurements are increased, up to 4.0 mm. Overall wall layering is preserved. Intestinal motility appears normal. The ileocecal junction is normal.



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Pancreas

The left limb of the pancreas is swollen and hypoechoic, surrounded by hyperechoic mesenteric fat. The pancreatic duct appears normal.

Free Abdomen

There is focal free fluid present throughout the abdomen. The omentum and intra-abdominal fat are of appropriate echogenicity. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

PRIMARY FINDINGS

- Segmentally thickened small bowel with loss of wall layering typical of infiltrative bowel disease.
- Hypoechoic left pancreas with steatitis suggestive of chronic remodeling or pancreatitis.
- Focal free fluid throughout the abdomen, likely secondary to hypoalbuminemia, however, sampling would be necessary to rule out peritonitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The appearance of the small bowel and clinical history would support a diagnosis of protein losing enteropathy, secondary to either inflammatory intestinal disease or intestinal lymphoma. The possibility of concurrent exocrine pancreatic insufficiency should be considered. Additional recommendations include:

- ❖ fecal parasite testing and empiric fenbendazole treatment
- ❖ trials with a novel protein or hydrolyzed diet
- ❖ A complete GI panel, or empiric cobalamin supplementation, though a minimum of a fasted TLI is recommended to rule out exocrine pancreatic insufficiency
- ❖ continued corticosteroid therapy, either injectably or orally
- ❖ Definitive diagnosis would require biopsy of the affected tissue, however, the current corticosteroid therapy may interfere with accurate results, and the current hypoalbuminemia may increase the risk of postoperative complications.
- ❖ Clopidogrel treatment is recommended until albumin levels are greater than 2.0, dosed at 18.75 mg/CAT once daily. Clopidogrel therapy should not be started if intestinal biopsies are planned.
- ❖ Fluid sampling is recommended for fluid analysis, to rule out the possibility of concurrent peritonitis.

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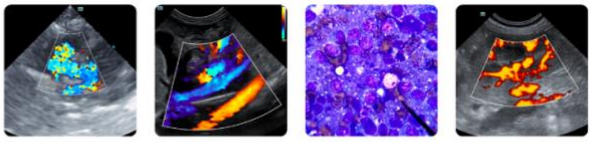

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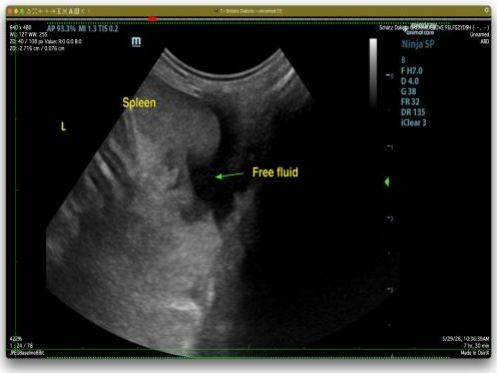

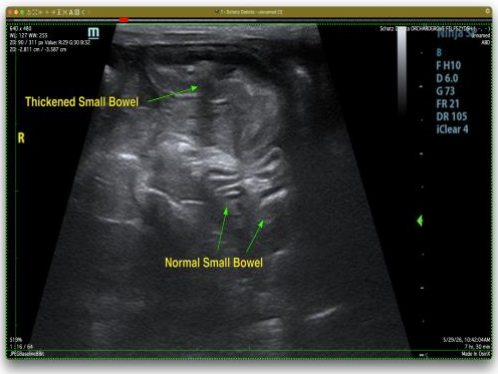

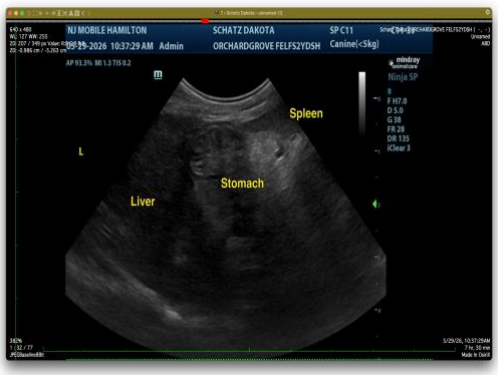

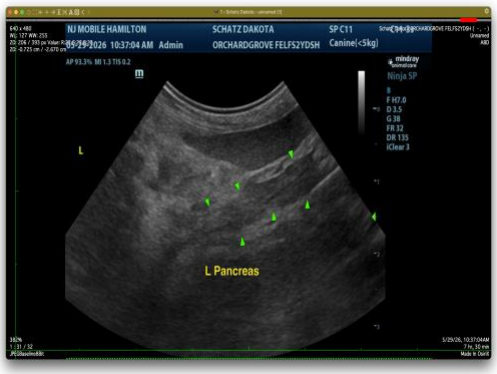

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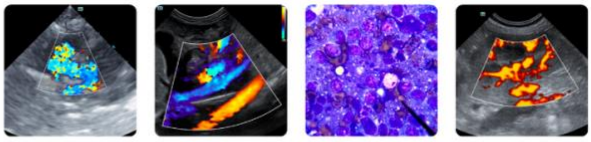

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@SonoPath.com