

PATIENT

Sweetie Riley

SPECIES

Feline

BREED

Domestic shorthair

SEX

Female, spayed

AGE

11/1/2009

WEIGHT

3.68 kg.

INTERPRETED BY

Andrea Nicastro, DVM,
 Diplomate ACVIM
 (Small Animal Internal
 Medicine)

IMAGING PERFORMED BY

Andrea Nicastro, DVM,
 Diplomate ACVIM
 (Small Animal Internal
 Medicine)

HOSPITAL NAME

Sun Dog Cat Moon

REFERRING VET

Dr. Fetterolf

INVOICE

13669

DATE

4/21/26

PRESENTING CLINICAL SIGNS

Presented on 4/17/26 for continued hyporexia and weight loss. Previously seen on March 23rd, 2026 and before that 12/8/25 - Sr Panel performed and all parameters unremarkable (12/8/25). History obtained on 4/17/26: Activity level somewhat decreased - moving around less, seen less frequently throughout the day but maintains normal schedule of being downstairs in evening and early morning. Current food intake consists of licking juice from wet food and taking a couple bites, approximately 10-12 pieces of kibble. Small amount of stool production noted. Recent episodes of vomiting - clear, watery consistency found on steps, not hairball-like, no blood noted.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (3.45 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.71 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.32 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.43 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is prominent in size (1.10 cm in width at the level of the hilus) with slight scalloping of the medial contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen. A 1.3 x 0.8 cm irregular cyst is observed on the right side. The remaining parenchyma is homogeneous. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1:1.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of mostly gravity-dependent echogenic debris is observed within the lumen. The cystic and common bile ducts are normal. The duodenal papilla is normal in size (0.41 cm in width).

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The



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pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal. There is disruption in the normal 1:3 muscularis: mucosal ratio in several segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The left limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph nodes

2-3 prominent periportal lymph nodes are visualized, one of the nodes measuring 1.06 x 0.51 cm. At least 2 prominent mesenteric lymph nodes are also seen, one of the nodes measuring 0.79 x 0.53 cm. Surrounding mesentery is mildly hyperechoic.

Free Abdomen

There is no obvious evidence of free fluid.

Other

A brief echocardiogram reveals no obvious evidence of pericardial or pleural effusion in the visible window.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The small intestinal wall changes could be consistent with inflammatory bowel disease or less likely emerging lymphoma.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- An obvious cause for the elevated liver enzymes is not identified in the study. However, a microscopic hepatopathy (i.e., bacterial cholangiohepatitis, lymphoplasmacytic hepatitis, hepatic lipidosis, reactive hepatopathy, infiltrative neoplasia (less likely) should be considered.
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a lower possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).

Secondary Findings:

- Bilateral nonspecific, age-related renal changes
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Right hepatic cyst, likely a benign incidental finding

*Given the sonographic changes and the patient's clinical history, "triaditis" is a consideration in this patient,



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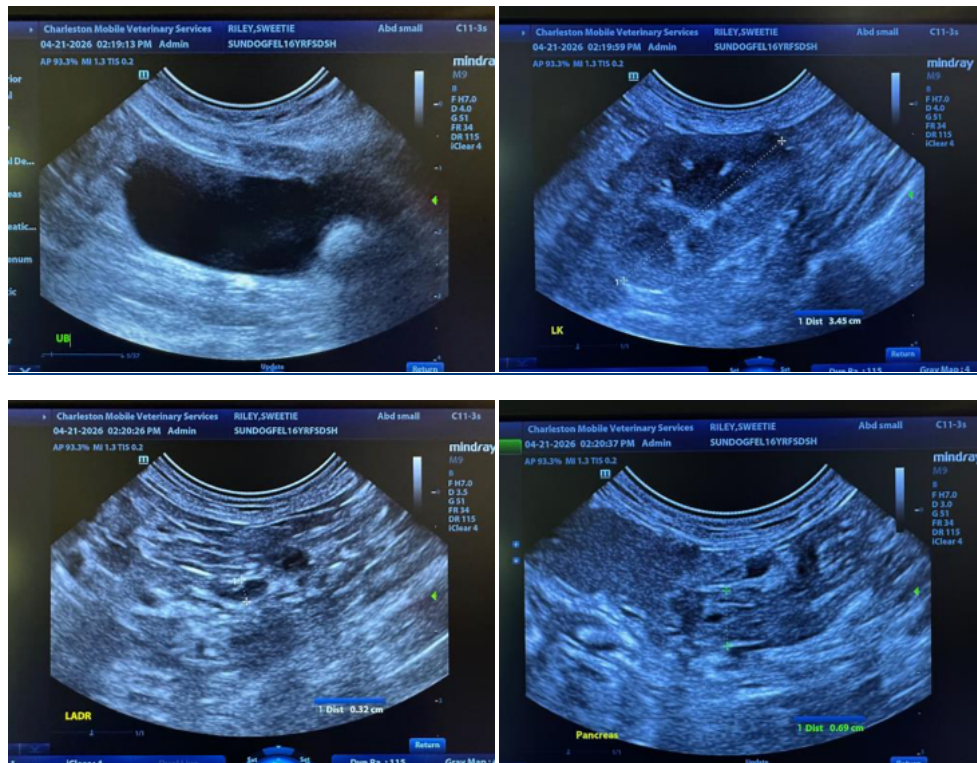
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. A GI panel including serum cobalamin, folate, TLI and PLI is recommended.
2. Given the elevated liver values, consider empirical treatment for bacterial cholangiohepatitis along with cobalamin supplementation (while awaiting GI panel results).
3. Ultimately, endoscopic or surgical GI biopsies +/- liver biopsies and aerobic and anaerobic bile cultures may be necessary to get a definitive diagnosis. If biopsies are not pursued and the patient does not clinically improve, consider empirical treatment for inflammatory bowel disease (i.e., corticosteroids, limited antigen diet) as long as the client understands the risks of treatment without a definitive diagnosis.
4. Three-view thoracic radiographs can also be considered to assess for occult pathology in the chest.
5. Consider a final aspiration of the spleen, particularly if the patient does not improve with medical management.





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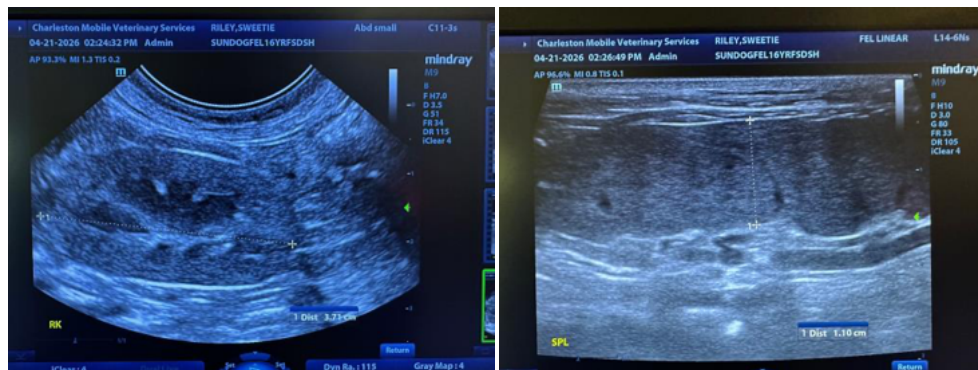
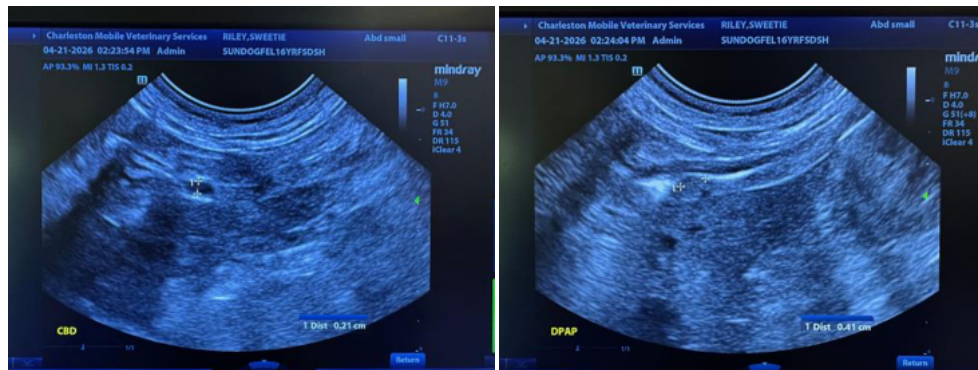
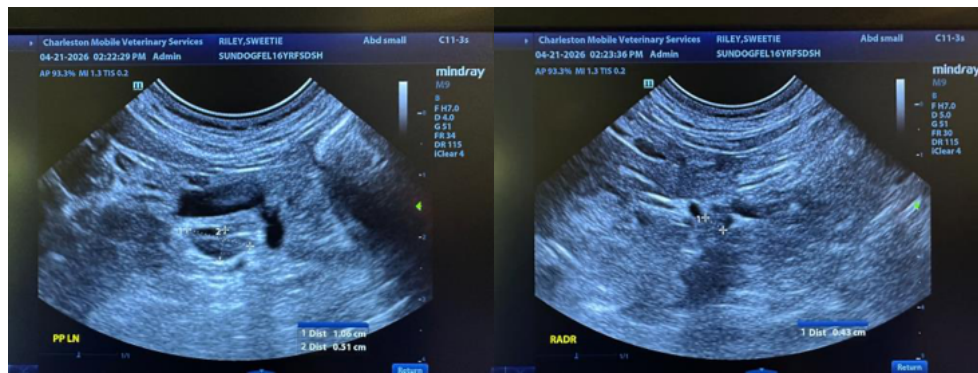
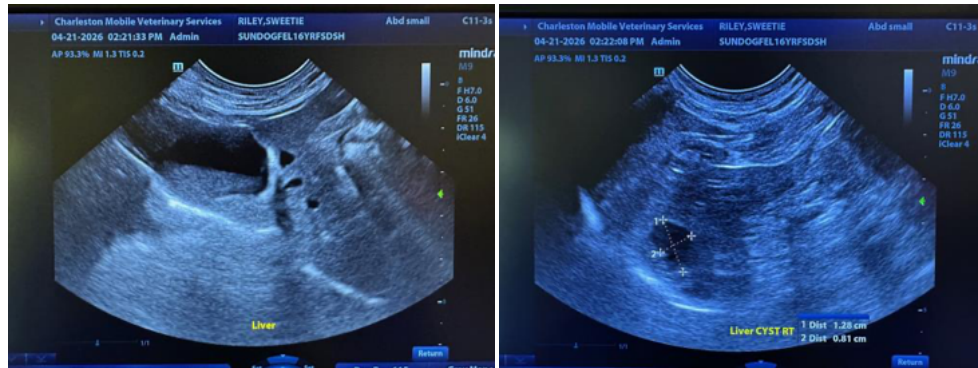
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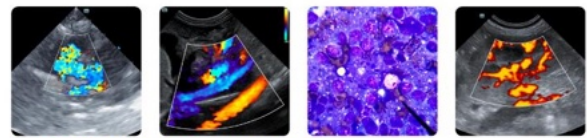
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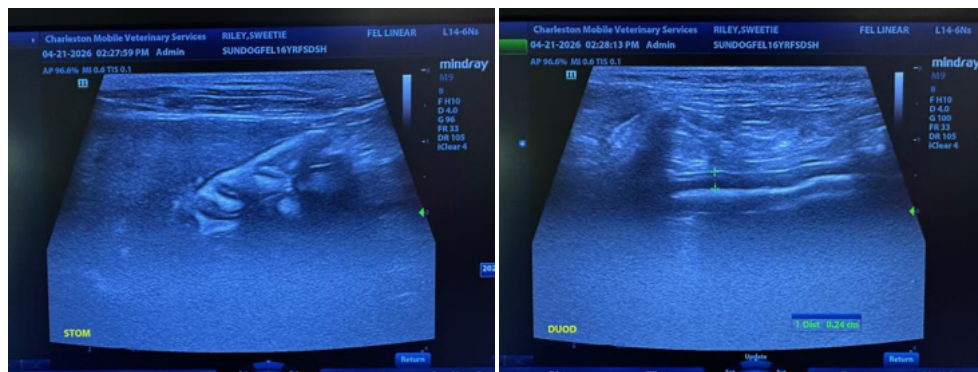
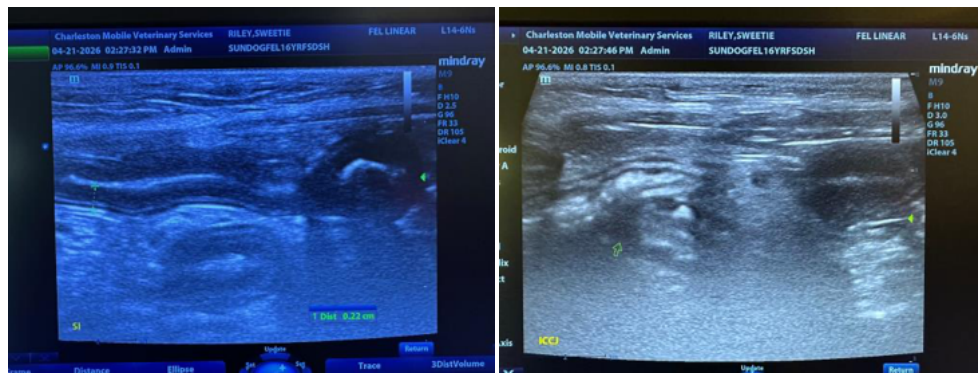
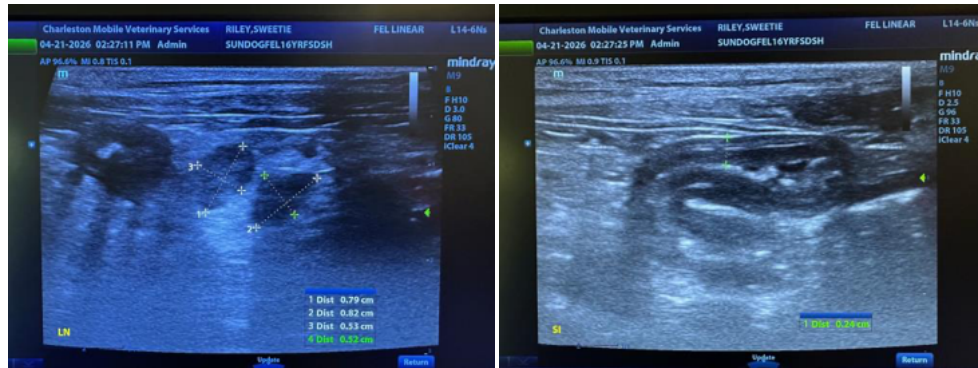
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com