PATIENT
River Butler

SPECIES
Feline

BREED
Domestic shorthair

SEX
Male, neutered

AGE
10/30/26

WEIGHT
10 lbs.

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
Meadowlawn Loris

REFERRING VET
Dr. Graham

INVOICE
13694

DATE
4/29/26

PRESENTING CLINICAL SIGNS

There is a known history of pancreatitis and chronic vomiting
Explained that the clinical signs and history are suspicious for IBD or triaditis.
Recommended an abdominal ultrasound to evaluate the gastrointestinal tract wall thickness and assess the liver and pancreas for concurrent disease. Pt's diarrhea improved with corticosteroids.

Baseline lab work is pending. Pt sedated with Dexdomitor, Ketamine and Butorphanol for this study.

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. A small amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2.5 cm, are normal.

The left kidney is normal in size (3.98 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 (4.22 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.

Adrenal Glands
The left adrenal gland is mildly enlarged (0.63 cm width) with slightly swollen peripheral contours. Glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.46 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen
The spleen is normal in size (0.88 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver
The liver is subjectively prominent in size with swollen peripheral contours. The parenchyma is isoechoic relative to the spleen. A 0.96 x 0.45 cm hypoechoic nodule is observed approximately mid-liver. The remaining parenchyma is relatively homogenous in appearance. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. The cystic and common bile ducts are visible but not overtly dilated. The duodenal papilla is normal in size (0.27 cm in width).

Gastrointestinal
The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is mildly fluid distended. The gastric wall and pylorus are normal in thickness with a normal layering

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pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal to mildly thickened (up to 0.27 cm). There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas
The left limb and base of the pancreas are 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
A few prominent mesenteric lymph nodes are visualized, one of the nodes measuring 0.92 x 0.44 cm. In addition, a 0.41 x 0.38 cm gastric lymph node is seen.

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 are suggestive of inflammatory bowel disease with lower possibility of emerging neoplasia (i.e., lymphoma).
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The diffuse hepatic parenchymal changes could be consistent with hepatic lipidosis, an inflammatory hepatopathy (i.e., bacterial cholangiohepatitis, lymphoplasmacytic hepatitis, feline infectious peritonitis), infiltrative neoplasia (i.e., lymphoma) and/or other hepatopathy. However, correlation with the patient's liver values is recommended. The small hepatic nodule trends toward the benign (i.e., inflammatory focus, other) with a lower possibility of emerging tumor.

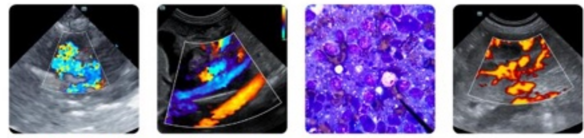
Secondary Findings:

- Bilateral nonspecific, age-related renal changes
- The left adrenomegaly could be secondary to stress hyperplasia or less likely an emerging tumor. Correlation with the patient's electrolytes is recommended.

*Given the sonographic changes, "triaditis" is a consideration in this patient.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. A minimum database including a CBC chemistry panel, urinalysis and T4 is recommended along with a GI panel including serum cobalamin, folate, TLI and PLI.



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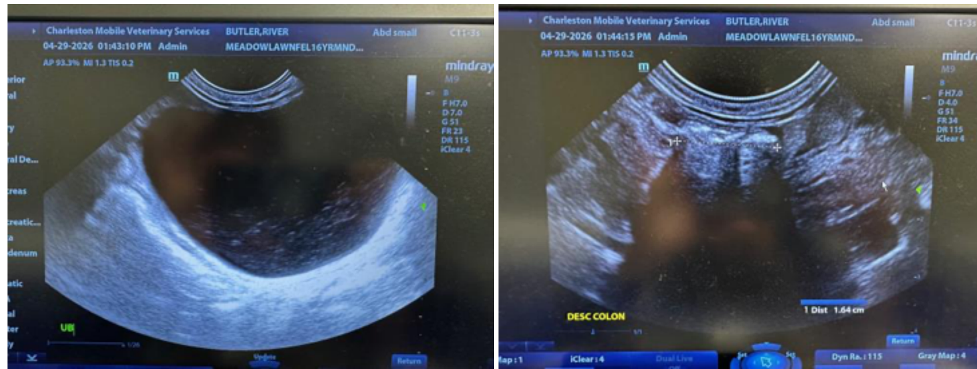
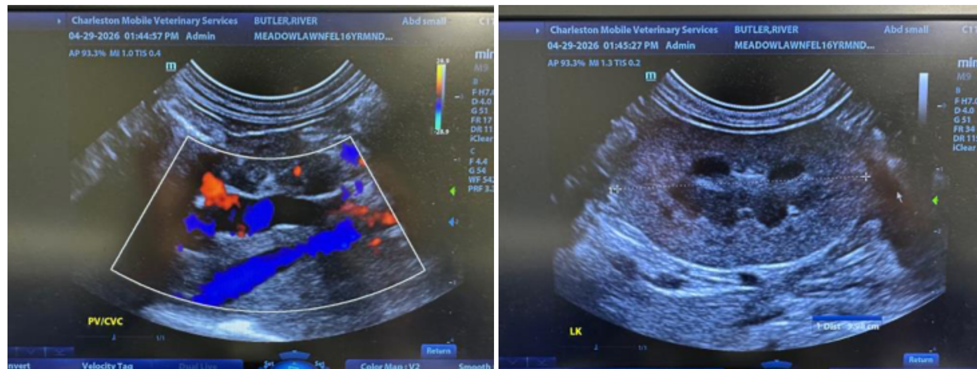
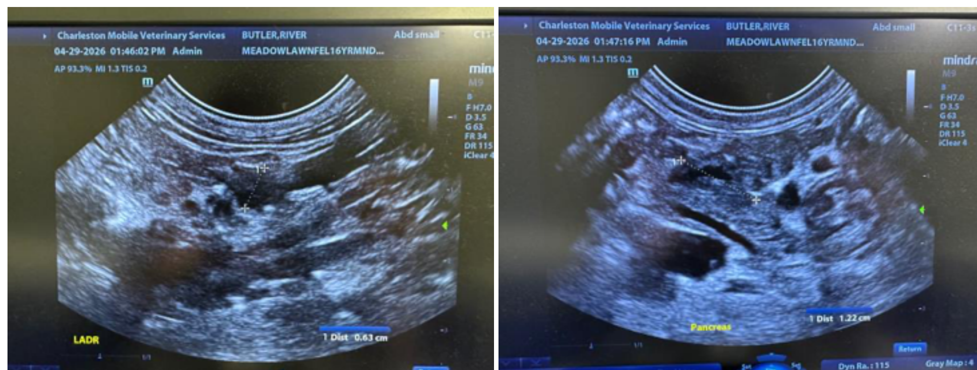
2. A fecal evaluation for ova and Giardia should also be considered.
3. Also consider prophylactic deworming with fenbendazole.
4. Consider a 3-4 week limited antigen or hydrolyzed protein diet trial.
5. Ultimately, endoscopic or surgical GI biopsies may be necessary to get a definitive diagnosis. if biopsies are pursued, the patient should be weaned off of corticosteroids to avoid masking of underlying pathology. If biopsies are not pursued, consider empirical treatment for inflammatory bowel disease (i.e., corticosteroids, limited antigen diet +/- cobalamin supplementation) as long as the client understands the risks of treatment without a definitive diagnosis.







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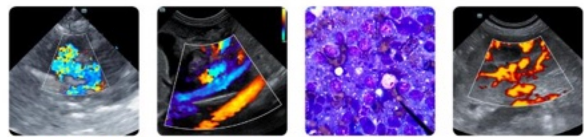

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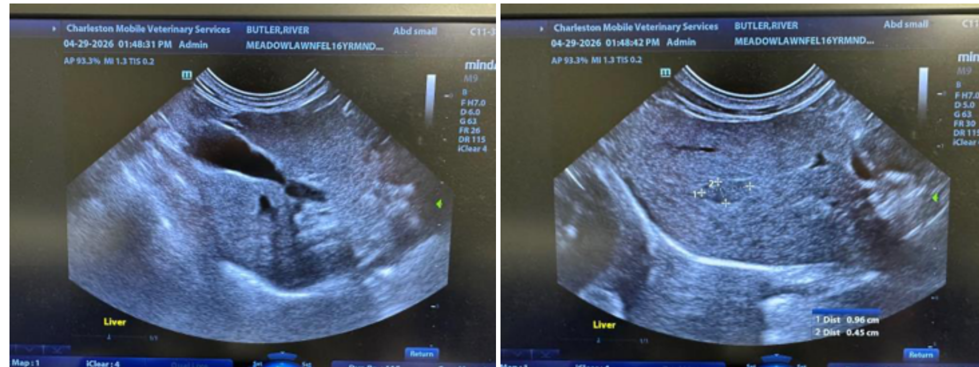

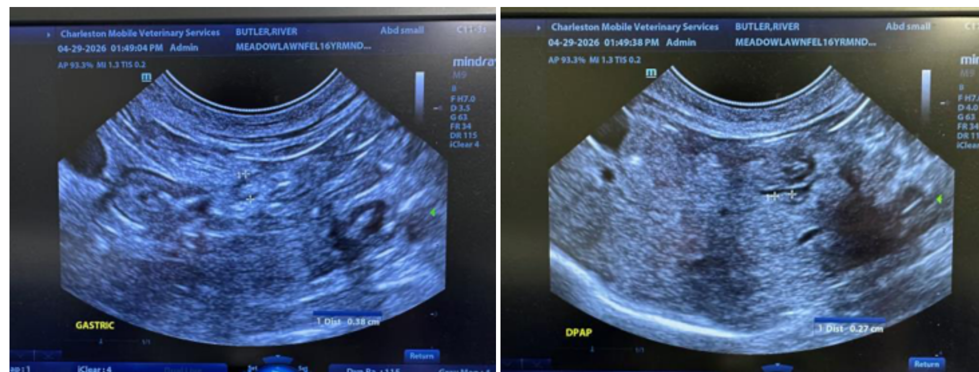

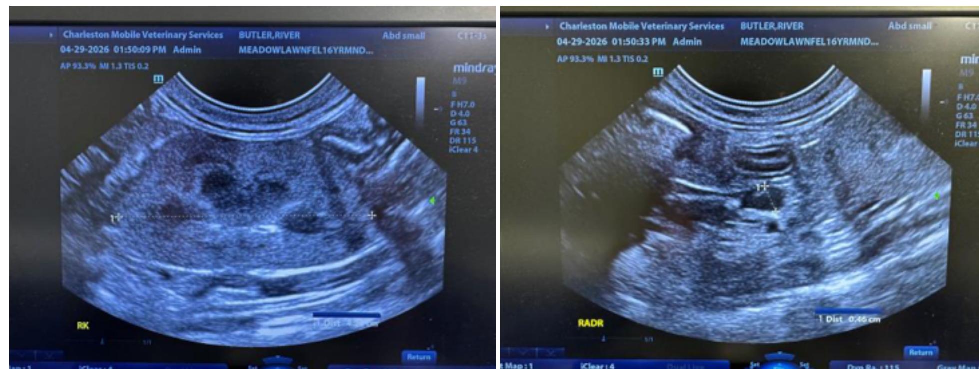

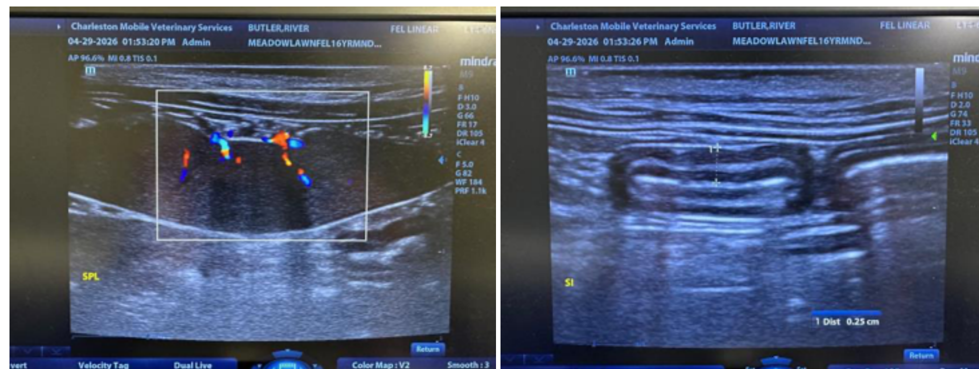

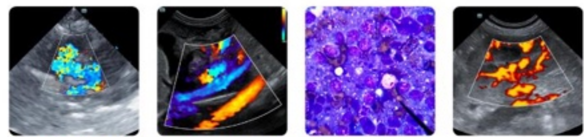

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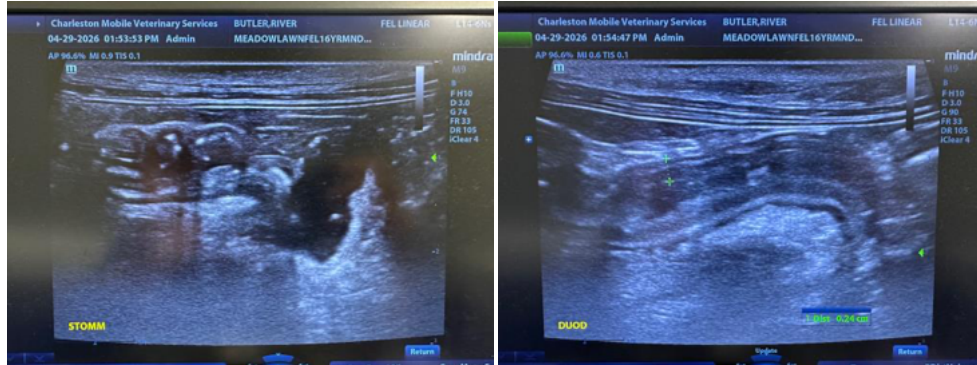

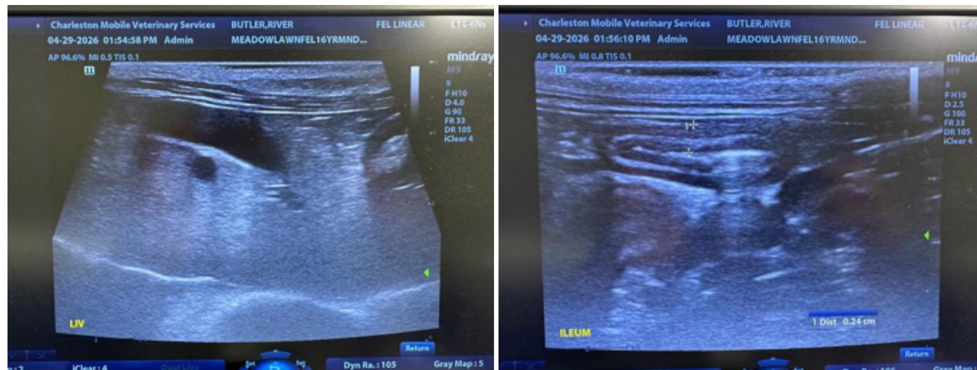

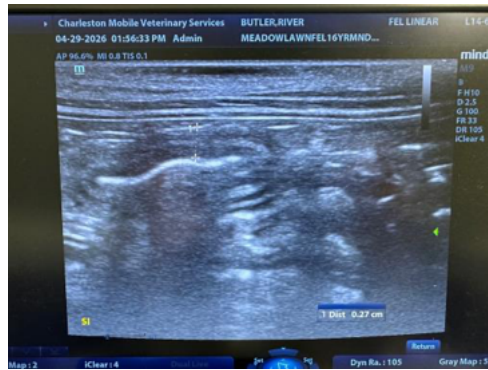

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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