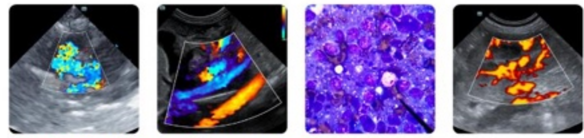
Charleston Mobile Veterinary Services
IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND



Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath FOSTERING THE ART OF VETERINARY MEDICINE™
www.charlestonmobile.net
info@charlestonmobile.net 800.403.5408

PATIENT
Blue SRC

SPECIES
Feline

BREED
Domestic shorthair

SEX
Male, neutered

AGE
3/4/2014

WEIGHT
10.6 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
Cats Meow

REFERRING VET
Dr. Levy

INVOICE
13586

DATE
5/27/26

PRESENTING CLINICAL SIGNS

-chronic diarrhea even on strictly royal canin hp
-insulin resistance
-lethargy, decreased appetite

LYM 0.83, PCT 0.89, GLU 656, TP 9.4, GLOB 6.6

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 visible portion of the proximal urethra are normal.

The left kidney is mildly enlarged (4.59 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. Moderate pyelectasia is present (0.32 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is mildly enlarged (4.89 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. Moderate pyelectasia is present (0.36 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands
The left adrenal gland is normal size (0.47 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.41 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen
The spleen is prominent in size (1.06 cm in width at the level of the hilus) with smooth peripheral contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver
The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is isoechoic to hyperechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. 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 mildly distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal. The duodenal papilla is normal in size (0.27 cm in width).

Gastrointestinal
The gastric lumen is mildly to moderately distended with ingesta consistent with a post-prandial presentation. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is segmentally dilated with chyme. The small intestinal wall is normal to mildly thickened (up to 0.32 cm) with retention of the normal layering

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pattern. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no obvious evidence of an obstructive pattern.

Pancreas
The base and limbs 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
1-2 prominent lymph nodes are observed in the left mid to caudal abdomen, one of the nodes measuring 1.45 x 0.57 cm. Surrounding mesentery is 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

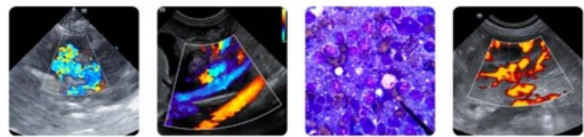
Primary Findings:

- The mild small intestinal wall thickening may be a normal variant for this patient or may be secondary to enteritis or, less likely, 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 prominent abdominal lymph nodes are most consistent with reactive change. However, emerging neoplasia (i.e., lymphoma) cannot be completely excluded.
- The bilateral renomegaly may be a normal variant for this patient or could be consistent with interstitial nephritis/pyelonephritis or less likely emerging neoplasia. The bilateral pyelectasia may be secondary to parenchymal remodeling, pyelonephritis, PU/PD or some combination thereof.

Secondary Findings:

- Hepatic parenchymal changes could be consistent with a diabetic hepatopathy, inflammatory disease (i.e., cholangiohepatitis, lymphoplasmacytic hepatitis), hepatic lipidosis, emerging neoplasia (less likely) and/or other hepatopathy. Correlation with the patient's liver values is recommended.
- The mild splenomegaly may be secondary to lymphoid hyperplasia, extramedullary hematopoiesis, splenitis, antigenic stimulation or less likely, emerging neoplasia.

**An obvious cause for the patient’s clinical signs is not definitively identified in this study. Considerations include a microscopic enteropathy (i.e., food allergy/intolerance, inflammatory bowel disease, infectious/parasitic disease), underlying metabolic issue, other.



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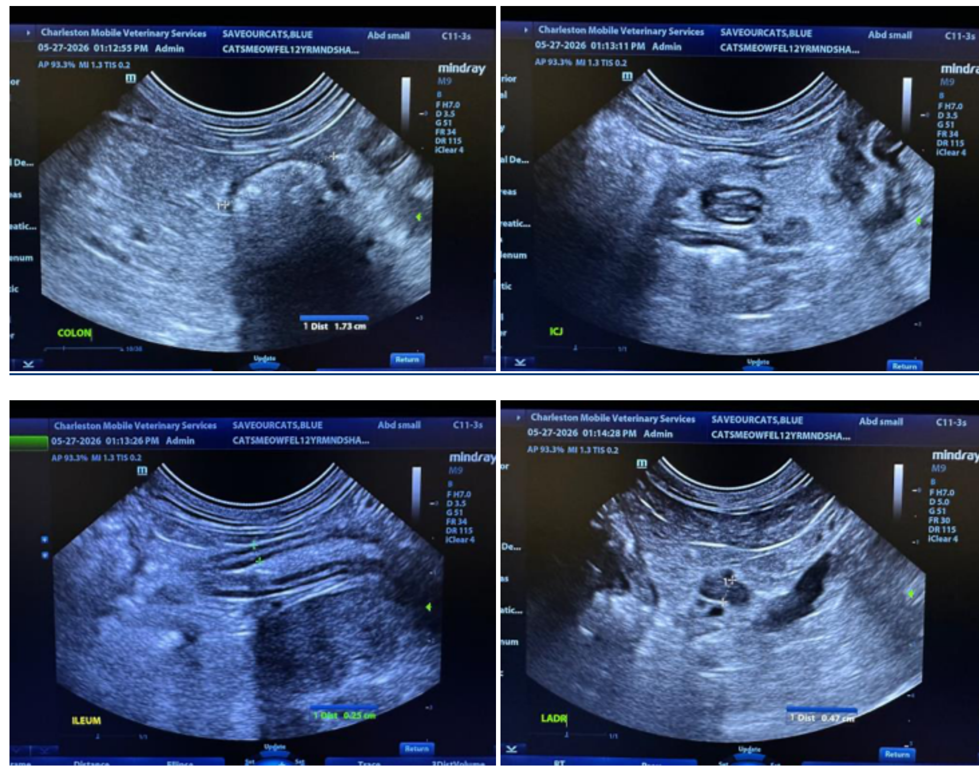
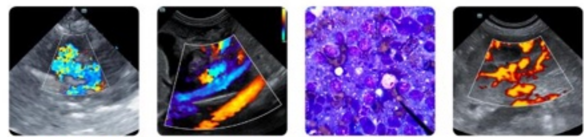
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. A fecal evaluation for ova and Giardia as well as a fecal PCR infectious disease panel is recommended if not already performed.
2. Also consider prophylactic deworming with fenbendazole.
3. A GI panel including serum cobalamin, folate, TLI and PLI should also be considered.
4. Depending on the results of the above diagnostics, endoscopic or surgical GI biopsies may be warranted.
5. Regarding the bilateral renal changes, consider a urinalysis with a culture and sensitivity to assess for infection.





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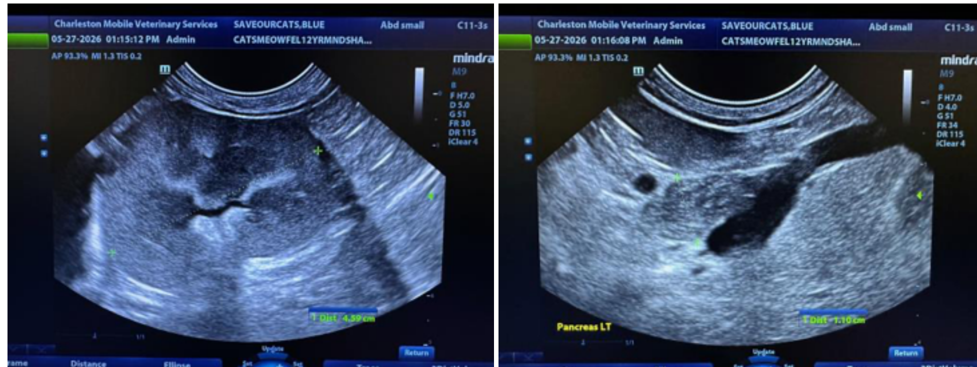

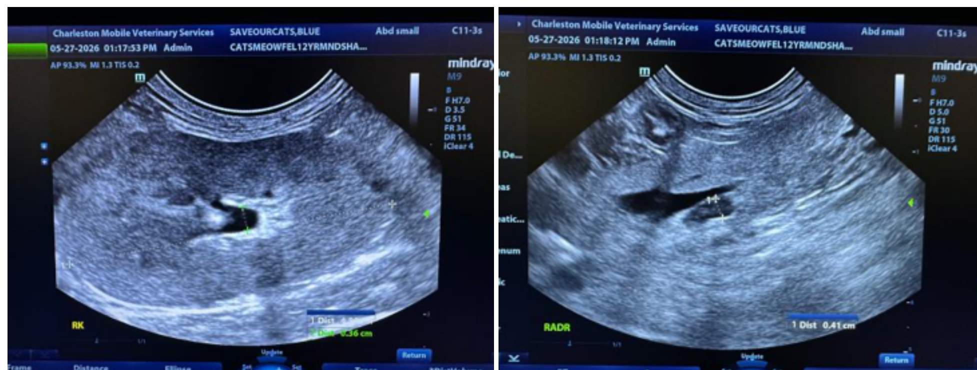

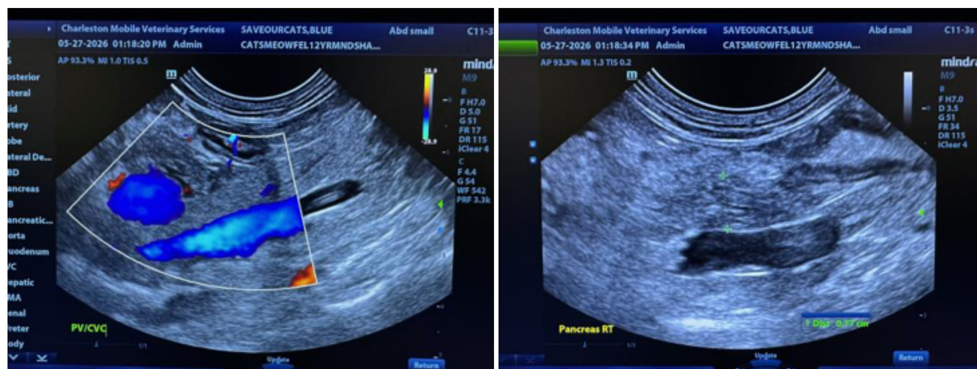

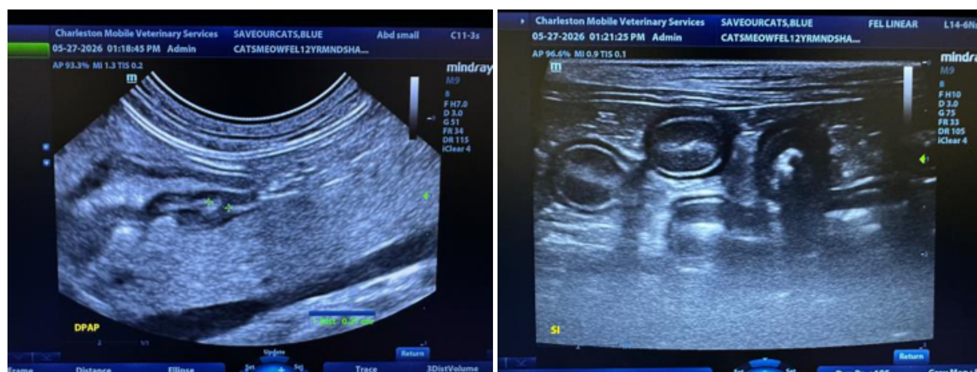

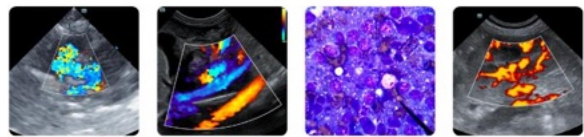

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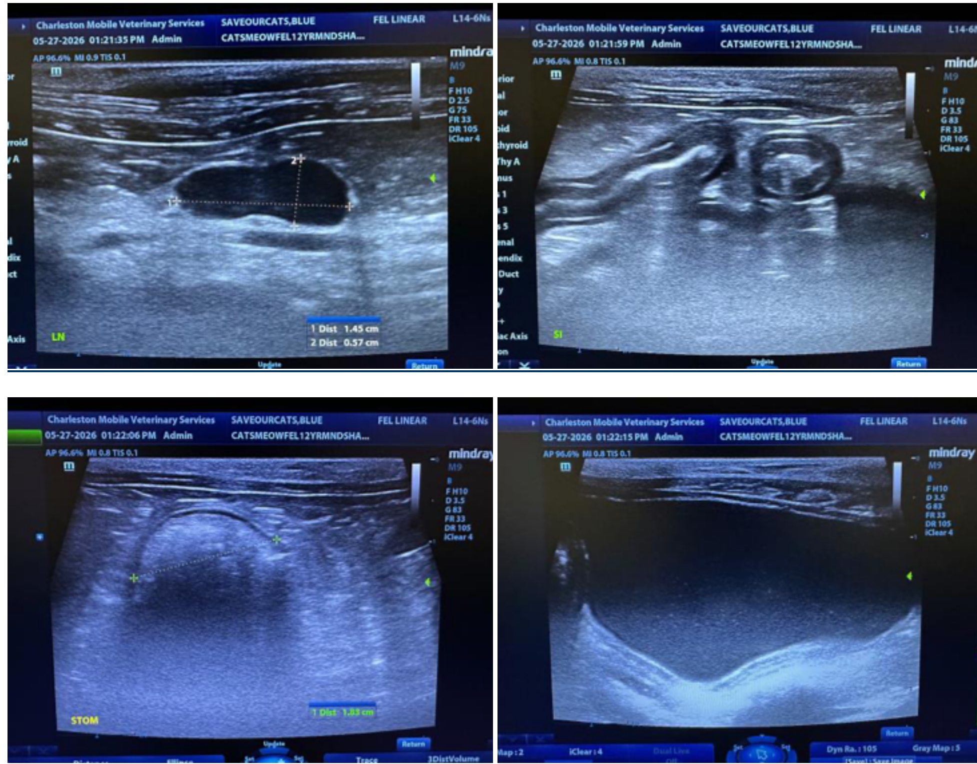

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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