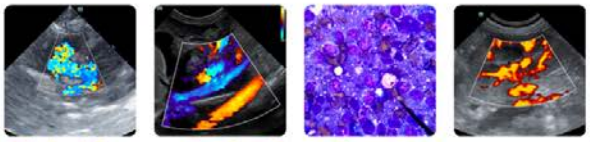


PATIENT

Stormy Fehnel

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

8 Years 6 Months

WEIGHT

12.5

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Jessica Green

HOSPITAL NAME

Stanglein Veterinary Clinic

REFERRING VET

Dr. Suzanne DiNello-Schleicher

INVOICE

72316

DATE

1/20/26

PRESENTING CLINICAL SIGNS

Mid-December patient began vomiting and losing weight. The vomiting improved after a week or two and switching from z/d dry to HA dry, but patient's appetite has continued to be decreased and patient is losing weight, now down ~4lb in the last month or so per owner. Patient has a hx of significant inflammatory bowel disease pattern based on U/S 3/27/24 (invoice #50678). At that time was started on prednisolone which patient was slowly weaned off of after diet change. Exam on 12/30 showed grade 2/6 systolic heart murmur and some discomfort on palpation of mesentary/mesenteric LN.

Abnormal PE/Chem/CBC/UA Results: 12/30/25--CBC/Chem/Lytes overall unremarkable, T4 2.6, USG 1.052, IPS negative

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal is size (4.13 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (4.2 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (0.53 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

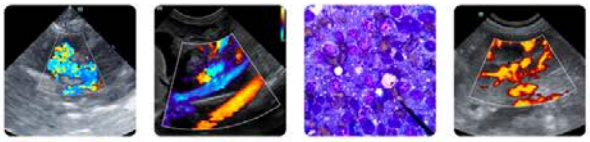
The left adrenal gland is normal in size (0.42 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver), except for an approximately 0.30 cm x 0.60 cm non-capsule disrupting, hypo- to anechoic density in the mid medial spleen. Splenic vasculature appears normal.

Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.



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The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is moderately distended with hard shadowing echogenic contents, likely consistent with normal ingesta and gas, although non-obstructive foreign material can't be ruled out.

The visible small intestine demonstrates areas of moderately thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

Throughout the cranial abdomen, primarily medial to the spleen, extending caudal to the stomach, in the area of the left limb and body of the pancreas, is an ill-defined, irregularly shaped, scalloped, coarse hypoechoic density surrounded by echogenic appearing free fluid and markedly clumped, almost nodular appearing hyperechoic mesentery and fat. I believe this tissue, while ill-defined and difficult to definitively identify, represents pancreas.

Free Abdomen

As described above under pancreas, there is a moderate amount of echogenic appearing free fluid.

No definitive lymphadenopathy noted.

ULTRASONOGRAPHIC FINDINGS

- Suspect severe acute pancreatitis, with infiltrative neoplasia affecting the pancreas and resulting in a mass-like appearance unable to be definitively ruled out.
- The free fluid and enhanced fat/steatitis throughout the abdomen are likely secondary to pancreatitis, but other reaction to diffuse bowel disease versus other can't be ruled out.
- Moderate inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.
- The gastric contents could represent normal ingesta/gas, but non-obstructive foreign material, given the shadowing pattern, can't be ruled out. Reassessment following an additional 12-24 hours of fasting could be considered.
- Hypo to anechoic splenic nodule – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions and cannot be ruled out.

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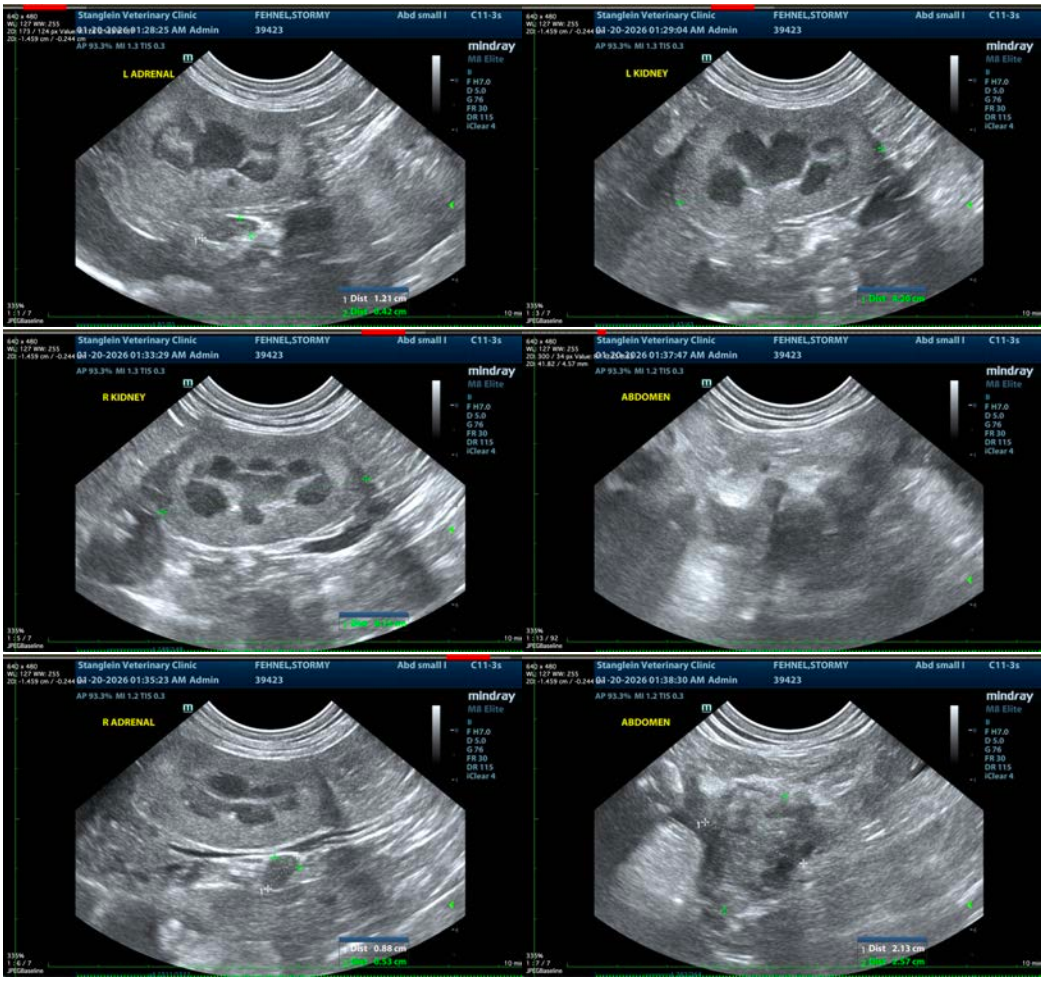
- Moderate amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Sampling of the free abdominal fluid as well as fine needle aspirates of the pancreas could be considered if patient's coagulation status is appropriate.

In the meantime, medical management of pancreatitis with anti-emetics, gastroprotectants, appetite stimulants or nutritional support (including a feeding tube) as needed, pain management, broad spectrum antibiotics, and fluid therapy is recommended. Monitoring of the pancreas with power doppler is recommended to identify possible necrosis as well as other potential sequelae such as abscesses, etc.



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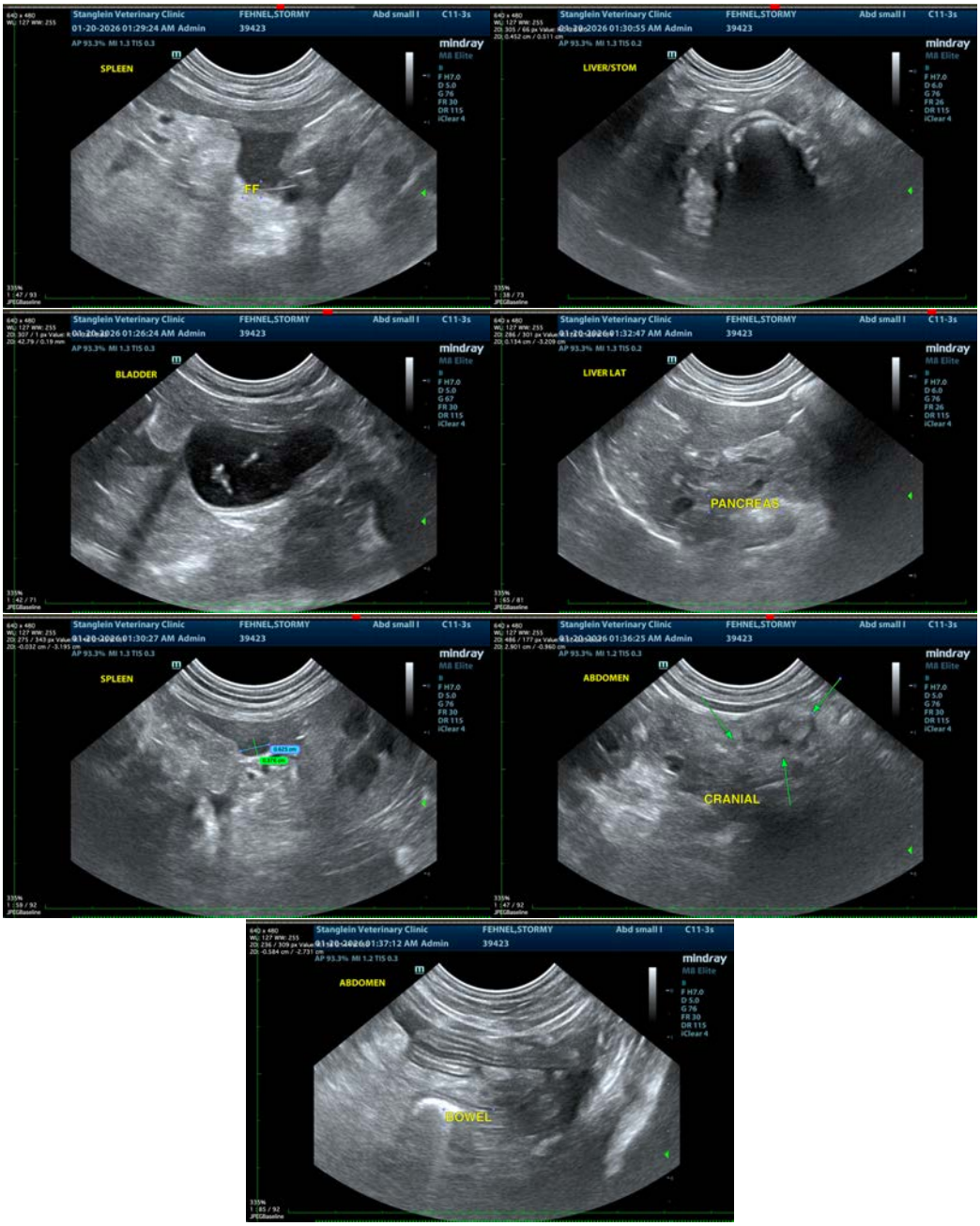

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM info@sonopath.com