



PATIENT

Eddy Already
Stockburger

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

13 Years

WEIGHT

5.5 kg

INTERPRETED BY

Greg Kuhlman, DVM,
DACVIM (SAIM)

IMAGING PERFORMED BY

Carlie Koltek, RVT

HOSPITAL NAME

Tuxedo Animal
Hospital

REFERRING VET

Dr. Kulczycki/Dr.
Stockburger

INVOICE

75334

DATE

5/21/26

PRESENTING CLINICAL SIGNS

Presented for not being himself last 1-2 weeks. Clinical signs include hyporexia, occasionally vomiting, being less active, acting sore, moving slowly, being hesitant to jump up on the couch, and being more fussy with his food. History of untreated diabetes mellitus for 3-4 years before diagnosis and treatment. Senvelgo started September 2025. History of pancreatitis and suspected feline asthma. On hypoallergenic diet for pruritis but occasional flare up. Current meds: Senvelgo, buprenorphine, sulcrate, cerenia pending AUS report. We are also wondering if the renal changes/pyelectasia could be a side effect from Senvelgo?

Abnormal PE/Chem/CBC/UA Results: PE: Lethargic, palpable spine, BCS 4/9, CBC WNL Eos 1.49 (0.17 - 1.57 x10⁹/L) - Previously 1.64 Dec 2025 CHEM: GLUC 10.44 (3.95 - 8.84 mmol/L) CHOL 6.21 (1.68 - 5.81 mmol/L) Panc Lipase 4.7 (0.0 - 4.4 U/L) previously 6.1 Dec 2025 Urinalysis (cysto): Glucose 1,000 mg/dL, WBC 2/hpf, RBC <1/hpf, <1 non-squam cell/hpf Blood ketones on senvelgo: around 0.3 mmol/L, with the highest ever being 0.6 mmol/L Chest radiographs showed increased peribronchial density and a possibly narrowed trachea (radiology report attached)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder is moderately distended with anechoic urine. No uroliths are seen. The bladder wall is normal in appearance and thickness. No masses are seen.

The right kidney is irregular in shape, measuring 3.9 cm. There is moderate loss corticomedullary distinction. Marked renal pelvic dilation noted with mild hyperechoic surrounding tissue. Renal pelvis measures 6.3 mm in width. The right proximal ureter is markedly dilated at 7.4 mm in width. No obstructive lesions seen.

The left kidney presents normal size (4.5 cm) with normal shape and architecture. There is mild loss of corticomedullary distinction. Very mild renal pelvic dilation noted at 1.3 mm in width, with surrounding hyperechoic tissue, consistent with possible pyelonephritis.

Adrenal Glands

The right adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The right adrenal gland measures 3.4 mm in width.

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The left adrenal gland measures 4.5 mm in width.

Spleen

The spleen is normal in size with mildly scalloped margins and heterogeneous echotexture. In the body of the spleen there is an ill-defined hypoechoic lesion that measures 1.9 mm in width, most likely benign extramedullary hematopoiesis.

Liver

The liver presents normal size and shape with smooth lobar margins. The parenchyma has normal echogenicity with normal echotexture. No focal lesions are seen. Intrahepatic bile ducts are normal. Normal vascular pattern.



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The gallbladder presents normal size. In one view there is mild suspended gallbladder debris, appears clinically insignificant. Normal gallbladder wall. The proximal common bile duct is mildly tortuous and prominent yet normal in width at 2.9 mm in width.

Gastrointestinal

The stomach has normal wall layering and thickness. The jejunum appears normal in width with normal layering, measuring 2.7 mm in width. However, the muscularis is prominent. The ileum is thickened at 3.5 mm in width. Colon contains normal contents with normal wall thickness.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. Several hypoechoic nodules are found throughout the body. There is a mildly dilated pancreatic duct. There is slight hyperechoic fat around the pancreas.

Free Abdomen

There are mildly to moderately enlarged hypoechoic rounded lymph nodes in the area of the ileocolic junction. The largest node seen measures 4.9 mm in width. No free abdominal fluid is seen.

ULTRASONOGRAPHIC FINDINGS

- Bilateral renal pyelectasia.
- Heterogeneous spleen with an ill-defined hypoechoic lesion.
- Mild gallbladder debris, not significant at this time.
- Prominent muscularis layer of jejunum and thickened ileum.
- Heterogeneous pancreas with hypoechoic nodules and mildly dilated pancreatic duct.
- Mildly to moderately enlarged lymph nodes in the area of the ileocolic junction.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The renal pelvic dilation is most likely due to PU/PD or hyperglycemia, given the patient's urinalysis, or possibly pyelonephritis. If not already performed, recommend urine culture. Renal pelvic dilation is not suspected to be due to administration of Senvelgo. If urine culture is negative and an infectious etiology to the pyelectasia is not identified, consider CT scan of the abdomen to evaluate further for a possible obstructive process causing the bilateral pyelectasia (more significant on the right).

The right proximal ureter dilation may be due to an obstructive lesion not seen on this exam, or possibly due to pyelonephritis causing inflammation and dilation.

Consider a fine needle aspirate of the spleen with submission for cytology to rule out a neoplastic cause for this lesion such as lymphoma or mast cell disease.

No obvious ultrasonographic evidence of cholangitis seen on this ultrasound.

The appearance of the pancreas is likely due to chronic intermittent pancreatitis. Based on the pancreatic lipase provided, the patient appears to have mild pancreatitis at this time. Most likely the patient's pancreatic inflammation is reactive and not likely to be a primary disease process.



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The prominent muscularis of the jejunum and thickened ileum may indicate chronic GI disease, which may be the cause of the changes seen with the common bile duct and with the patient's pancreas. The patient appears to most likely have Triaditis. Recommend submitting a GI panel that includes cobalamin, folate, cPLI and TLI. If chronic enteropathy is confirmed based off GI panel, consider GI biopsies either surgically or endoscopically. Given the patient's age, neoplasia such as lymphoma or mast cell should be prioritized, with inflammatory bowel being possible but less likely. Consider histoplasmosis if geographically relevant.

The enlarged lymph nodes are most likely enlarged due to neoplasia such as lymphoma or mast cell disease, less likely reactive.





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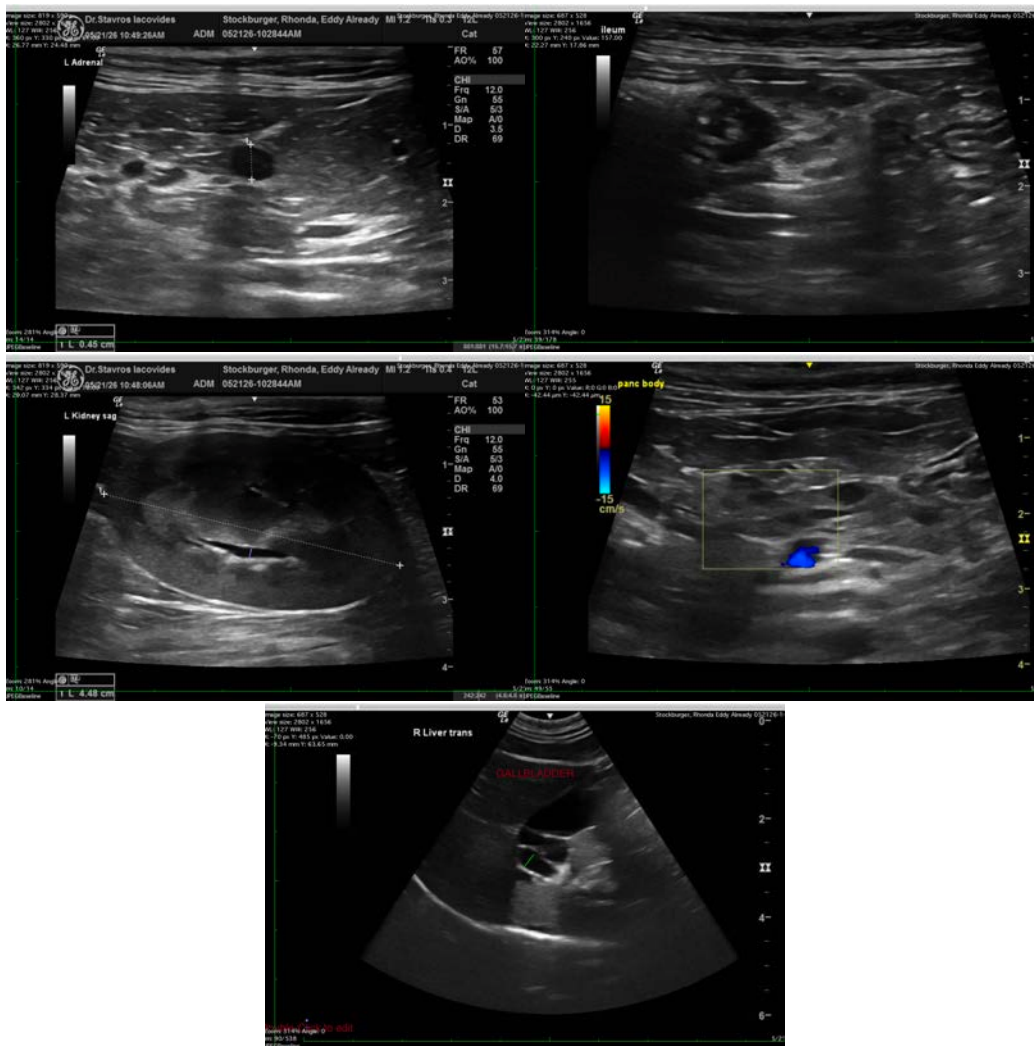
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Greg Kuhlman, DVM, DACVIM (SAIM)

Veterinary Internal Medicine Specialist

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