PATIENT

Minnie McNully

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

13 years

WEIGHT

11.8 lbs

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

South Reno Veterinary Hospital

REFERRING VET

Dr. Schmitt

INVOICE

11176

DATE

1/20/2026

PRESENTING CLINICAL SIGNS

- Hx: Owner reports no diarrhea coughing sneezing. Eating and drinking normal. Mobility and activity normal. See staff notes. Owner believes patient has actually gained weight based on her scale at home. They recently changed to a "human grade" food and patient stopped vomiting. Prior to change in human food.
- Assessment: Weight loss. Chronic vomiting. can't feed P too much at once.. Severe dental and gingival disease.
- DDX: Dietary indiscretion, infectious, inflammation, neoplasia, metabolic, other.

Abnormal PE/Chem/CBC/UA Results: MS: 12/31/2025 at 10:29a: Chemistry screen: Mild increase PSL 30 CBC: Increased hemogram values and also upper and of normal Total T4: Within normal limits Fecal: All undetected Urinalysis: Specific gravity a little low. A: Suspect mild dehydration causing mild increased and PSL. However, cannot rule out a possible pancreatitis: Inflammation, neoplasia, cyst, infection, other. CPK was increased last year but is within normal limits. P: Recommend abdominal ultrasound.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (3.67 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.35 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

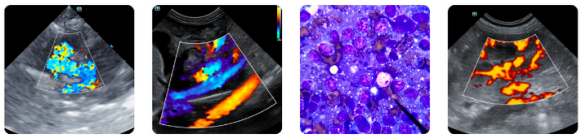
Adrenal Glands

The left adrenal gland is normal in size measuring 0.28 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.31 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (0.79 cm in width at the level of the hilus), and shape. Echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There are numerous hyperechoic nodules.



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The three most prominent measures 0.62 cm, 0.52 cm and 0.36 cm. Appearance is most consistent with benign myelolipomas.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. Bowel loops follow a typical curvilinear path with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis:mucosa layer ratio. The duodenum measured 0.32 cm in diameter and the jejunum measured 0.25 cm in diameter. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is prominent and hypoechoic in the left limb. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is no significant diffuse lymphadenopathy. A mesenteric lymph node is prominent measuring 0.42 cm. The omentum is of normal uniform echogenicity.

SECONDARY FINDINGS

- Pancreatic changes consistent with chronic pancreatic remodeling and possible chronic active pancreatitis.
- Prominent/mildly thickened small intestine with a prominent muscularis layer. The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma

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SECONDARY FINDINGS

- Hyperechoic lesions in the spleen most consistent with benign myelolipomas.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

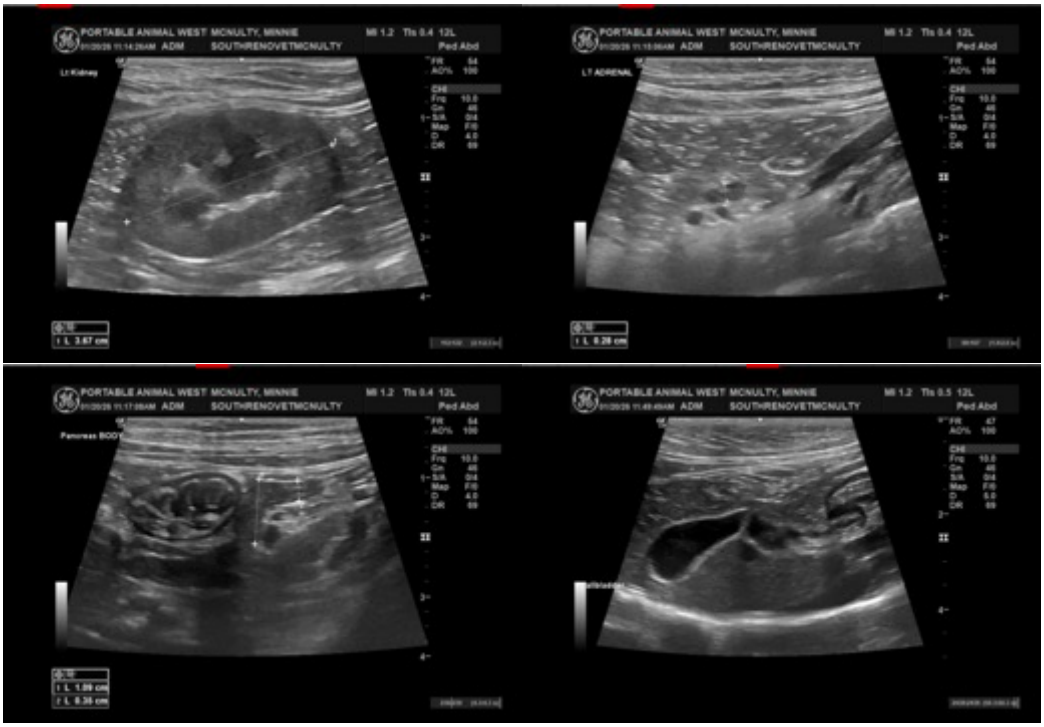
Pancreatic changes could be consistent with chronic pancreatitis given the elevation in PSL reported. Consider treatment for chronic pancreatitis.

The small intestine appears diffusely “ropey” with a prominent muscularis layer. These changes are most consistent with inflammatory type change although early neoplastic change cannot be definitively ruled out. Typically, the first steps would involve the following:

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks.)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.

If symptoms are persistent despite making these changes, biopsies of the GI tract may eventually be warranted to further evaluate.

Additionally, you could consider repeat imaging in the future, looking for the progression of today’s lesions.



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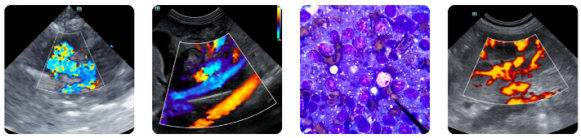

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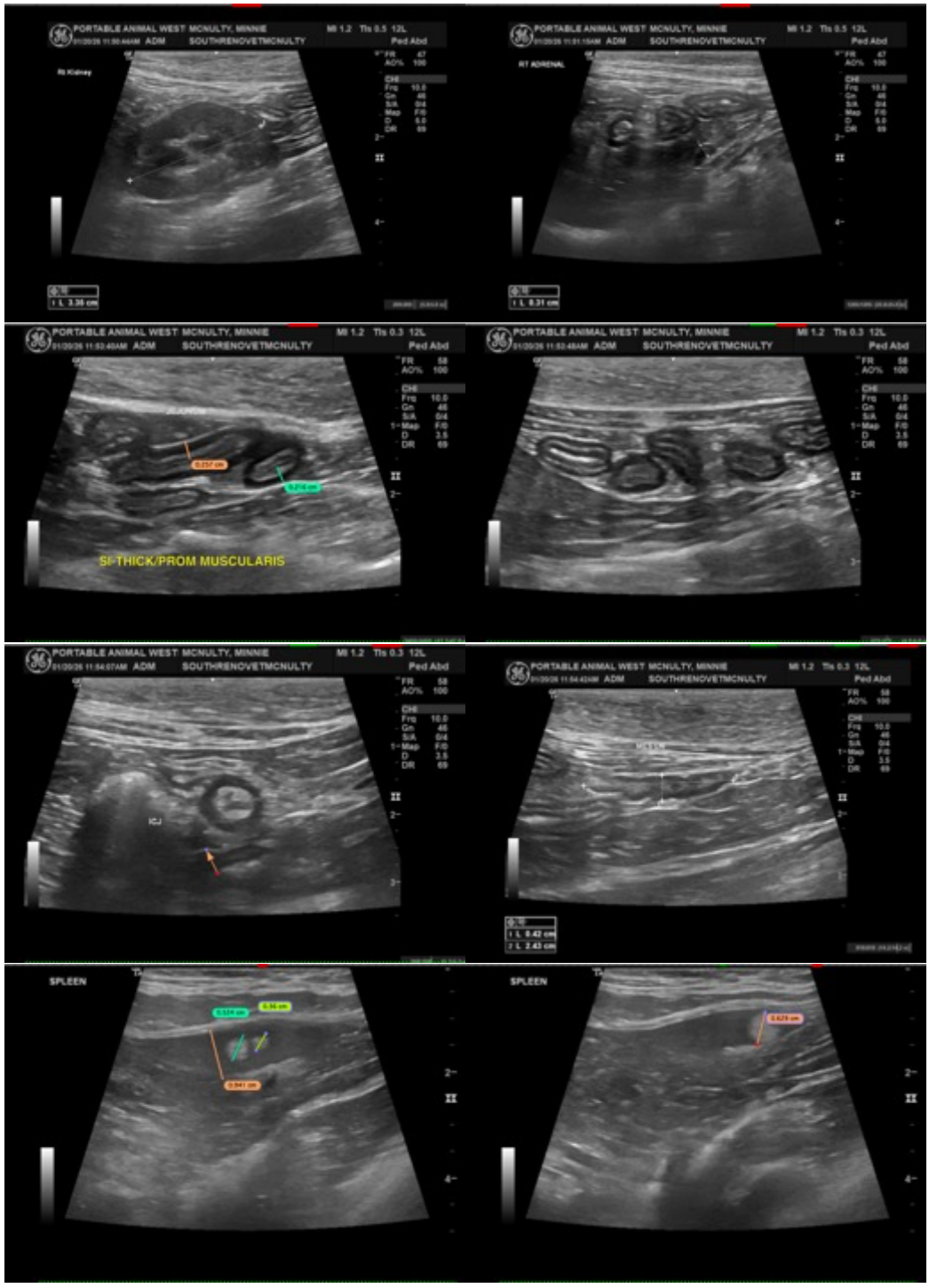

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

info@sonopath.com