



**PATIENT**

Hedwig Snow

**SPECIES**

Feline

**BREED**

Persian

**SEX**

Neutered Male

**AGE**

12 Years 9 Months

**WEIGHT**

5.5 lbs

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Kathleen Byrnes

**HOSPITAL NAME**

Pet Care Clinic of the  
 High Country

**REFERRING VET**

Dr. Sturgill

**INVOICE**

72026

**DATE**

1/7/26

**PRESENTING CLINICAL SIGNS**

P presented for US due to vomiting, 2.5 # weight loss, Alb 2.3, Proteinuria, UPC 1, T4 2.1

**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 is borderline large at 4.51 cm with decreased corticomedullary distinction. The cortex is of increased echogenicity. There is pyelectasia at 0.29 cm. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal/borderline large measuring at 4.16 cm with decreased corticomedullary distinction. The cortex is of increased echogenicity. Pyelectasia is noted at 0.22 cm. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**Adrenal Glands**

The region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

The right adrenal gland is normal in size measuring 0.43 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 (0.57 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

**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 0.24 cm 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. On one view of the stomach, the body wall in the



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region of the gastric body appeared somewhat prominent, measuring at 0.46 cm with intact wall layering.

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. Duodenum wall measures 0.32 cm. Jejunum wall measures 0.30 cm. Ileum wall measures 0.49 cm. Visualized peristalsis appears appropriate. The muscularis layer of the small intestine appears diffusely prominent, particularly in the region of the ileum.

The ileocecal junction was visualized. There is a large amount of hard shadowing material visualized in the proximal colon, which obscures a significant portion of the cranial abdomen. No significant wall thickening or pathology is noted. The distal colon appears within normal limits.

***Pancreas***

The left limb of the pancreas is prominent and mottled compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

***Free Abdomen***

There is scant free fluid noted. No lymphadenopathy. The omentum is generally normal in echogenicity.

**ULTRASONOGRAPHIC FINDINGS**

- Borderline large, hyperechoic kidneys with bilateral pyelectasia – Possible differentials include chronic kidney disease (fibrosis), fatty deposition, lymphoma, amyloid deposition, etc. Pyelectasia of the kidneys could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.
- Pancreatic changes consistent with chronic pancreatic remodeling.
- Questionable gastric wall thickening – This is not repeatable on all views. Possible differentials include imaging artifact, gastritis, or less likely infiltrative neoplasia.
- Diffusely mildly thickened small intestine with prominent muscularis layer and a thickened ileum – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The small intestine appears diffusely mildly thickened with a prominent muscularis layer. This is particularly evident in the region of the ileum. There is a large amount of shadowing firm stool in the colon, which obscures visualization of some areas of the cranial abdomen. Correlate with abdominal radiographs, looking for evidence of significant constipation, etc.

Both kidneys are hyperechoic and borderline large for a small cat. The significance of this is uncertain. Correlate with urine concentrating ability and recommend a blood pressure evaluation.



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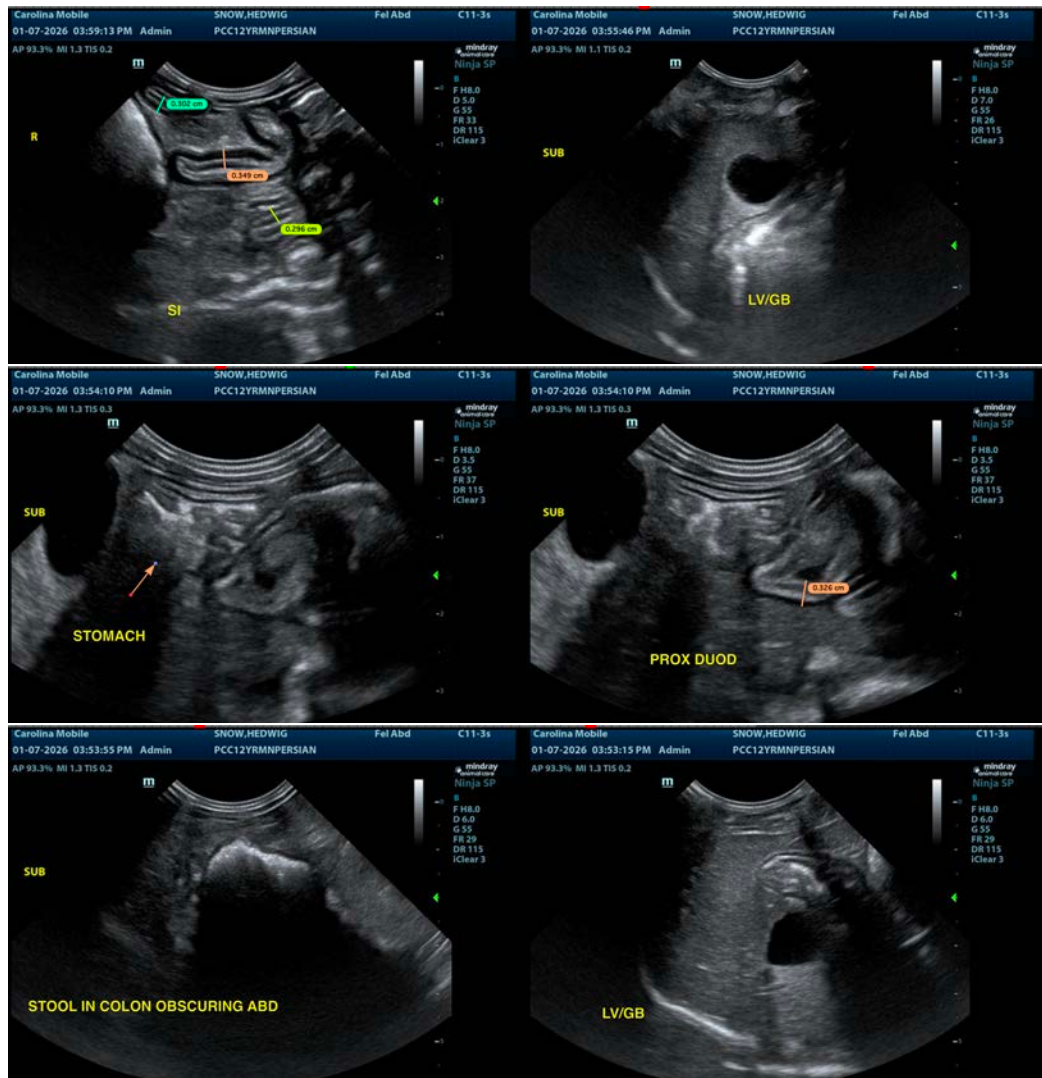
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A protein losing enteropathy is suspected based on the low albumin levels and GI symptoms reported. There is mild proteinuria reported, but this seems unlikely to be severe enough to be causing systemic hypoalbuminemia. If underlying liver disease is suspected, you could consider a liver function test to rule out liver disease as a contributing factor to hypoalbuminemia. Consider the following:

- Recommend a hydrolyzed protein prescription diet.
- 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, consider upper and lower GI endoscopy to obtain biopsies of the GI tract. Additionally, you could consider repeat imaging in the future, looking for the development of new lesions and reevaluation of the abdomen (ideally with less stool in the colon).





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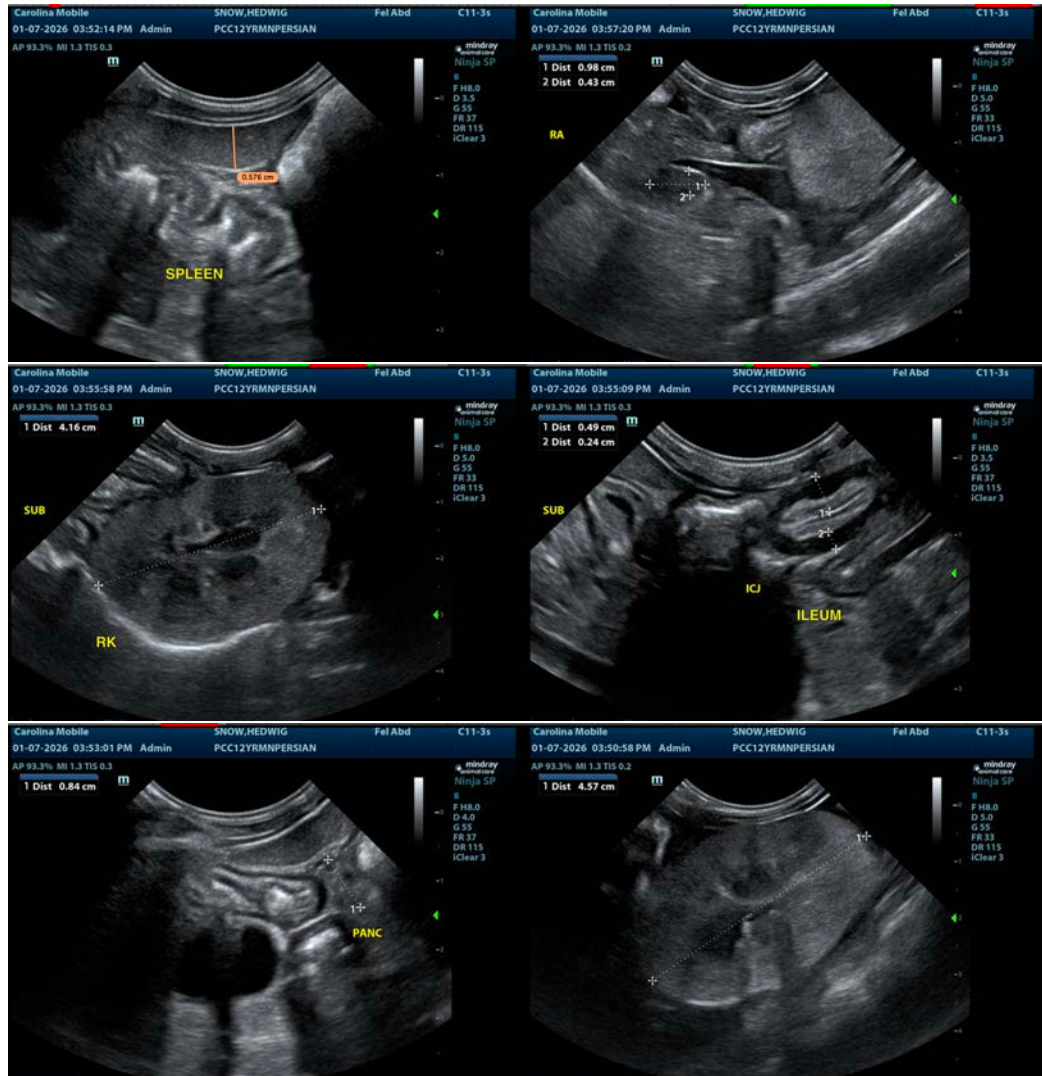
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@sonopath.com