DATE

01/09/2026

PATIENT

Levi Wootten

SPECIES

Feline

BREED

DSH

SEX

Nuetered Male

AGE

12/22/2012

WEIGHT

13.5 pounds

INTERPRETED BY

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

HOSPITAL NAME

Cat Sense Feline Hospital

REFERRING VET

Dr. Sinclair

INVOICE

13056

PRESENTING CLINICAL SIGNS

Patient History: Levi presented for vomiting that has become more frequent. He now vomits small amounts once or twice a day. It's found around the house – sometimes digested, sometimes undigested food as well as clear and brown liquid on and off. He has been on a diet and has lost 2# since he was seen at his previous veterinarians in 2022. A grade 3/6 murmur was ausculted (it almost sounded both systolic and diastolic?) on PE. Bloodwork shows that Levi has stage 2 ckd. His BNP is also quite elevated at 1,126.

Current Medications: None currently.
Labwork Results: Labwork attached, reported as: BUN=40, creat=1.8, urine s.g.=1.029, BNP=1,126
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mild primarily suspended echogenic debris present. 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 calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (4.11 cm). Overall echogenicity is slightly hyperechoic with mild decreased 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 (4.33 cm). Overall echogenicity is slightly hyperechoic with mild decreased 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 0.50 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. Pinpoint mineralizations were noted.

The right adrenal gland is normal in size measuring 0.56 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. Pinpoint mineralizations were noted (this is likely an incidental finding for both adrenal glands).

Spleen

The spleen is subjectively normal in size (when evaluated with the high frequency probe). The spleen echotexture is heterogenous and mottled, 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. The spleen measured 0.85 cm.

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 primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains mild fluid/shadowing ingesta. It measures at a normal thickness of <0.7 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. There is some focal gas and shadowing material visualized in the region of the pylorus but no evidence of an obstructive pattern.

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 0.31 cm in diameter, and the jejunum measured 0.23 cm in diameter. Visualized peristalsis appears appropriate. The muscularis layer is diffusely prominent and thickened throughout the small intestine.

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 mottled in the right limb 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

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Suspended echogenic debris in the urinary bladder- The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus. Recommend urinalysis and culture.
- Age-related changes visualized associated with both kidneys.
- Mildly mottled spleen- The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.
- Pancreatic changes consistent with chronic pancreatitis remodeling +/- chronic pancreatitis.
- Diffusely thickened small intestine with a very prominent muscularis layer.

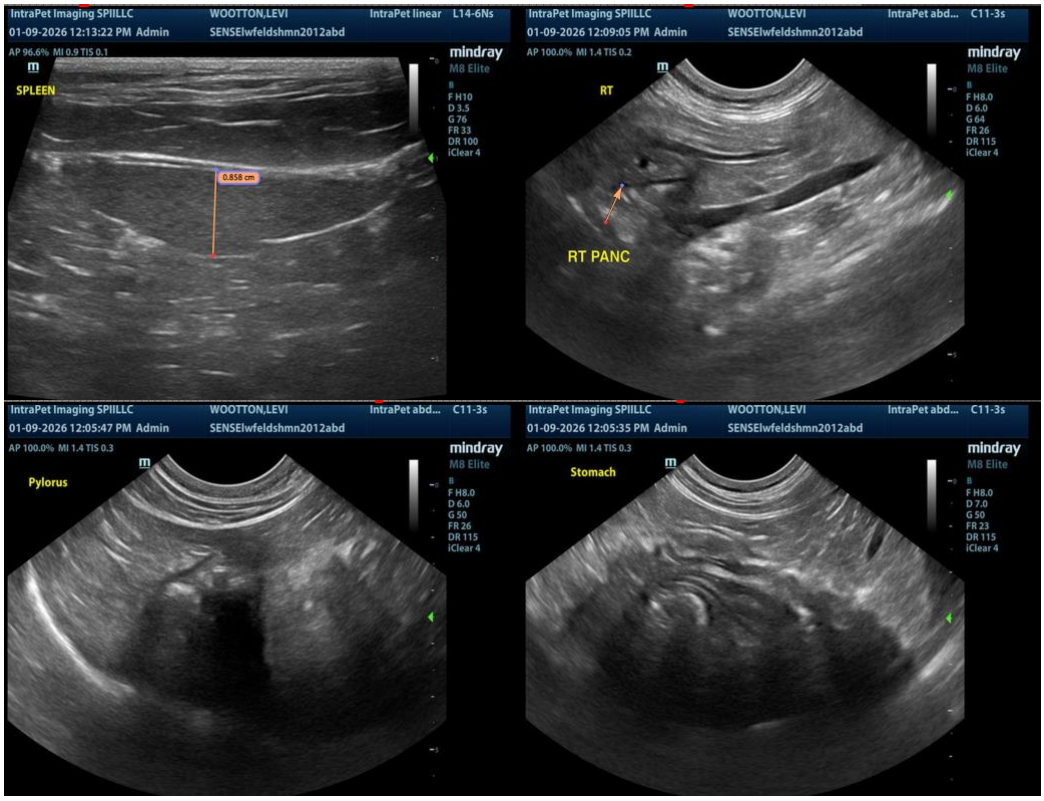
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

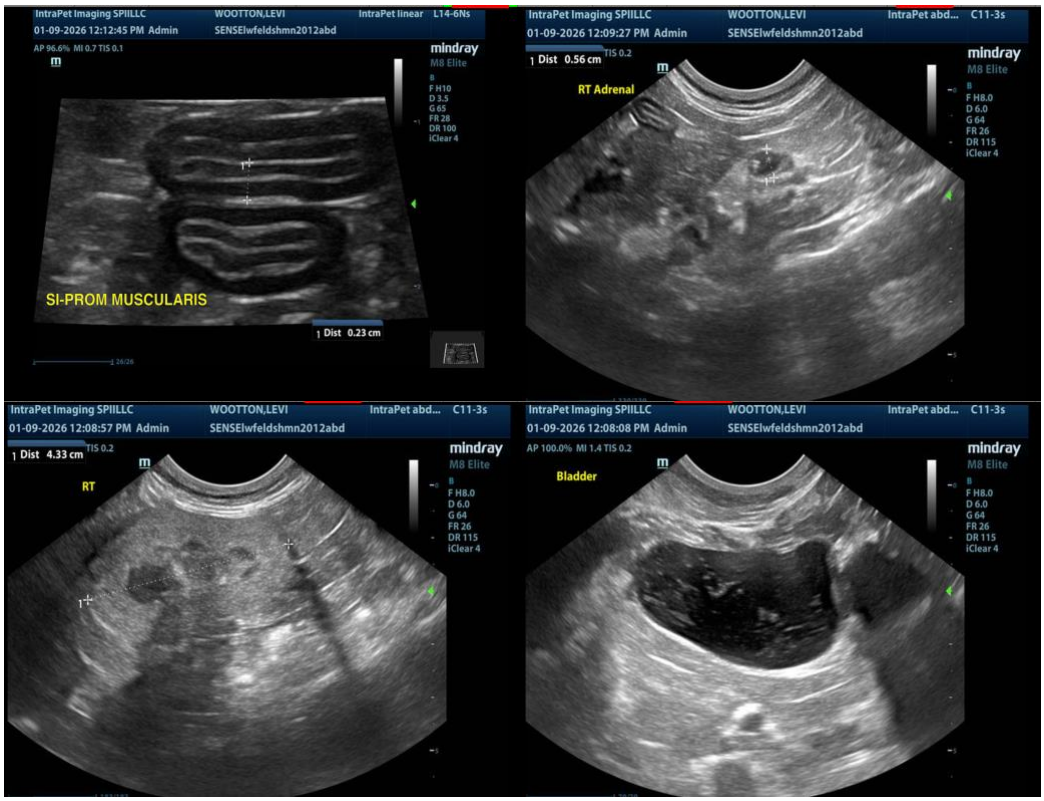
The small intestine appears diffusely thickened with a very prominent muscularis layer. These changes are most consistent with significant inflammatory disease change although early neoplastic change cannot be ruled out. Additionally, the pancreas (particularly in the right limb) is prominent. Correlate with a PLI level and consider empirical treatment for chronic pancreatitis if this is significantly elevated. Consider 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 vomiting is persistent despite taking these measures, then biopsies the GI tract may be warranted. If this is not an option, you could consider repeat imaging in the future looking for the progression of today's lesions.

The spleen is mildly mottled when evaluated with the high frequency probe. Options moving forward would include a fine needle aspirate or continued monitoring with ultrasound.

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WOOTTON,LEVI
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Bladder
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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.

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