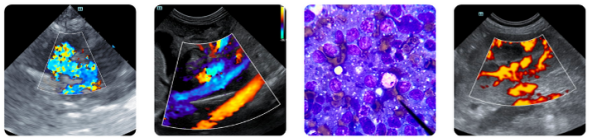


PATIENT

Hobbes Dunbar

SPECIES

Feline

BREED

DSH

SEX

MC

AGE

12 years

WEIGHT

7.4 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge Animal Hospital

REFERRING VET

Dr. Diana Strenk

INVOICE

10723

DATE

11/11/2025

PRESENTING CLINICAL SIGNS

Patient was sedated with butorphanol. 11 yo MC DSH presenting for AUS after prolonged history of d+. Patient initially presented on 9/26/2025 with diarrhea and weight loss noted over 5 months. NSF on PE. Initial treatments: SQF administered, dispensed metronidazole, probiotics, I/D. Patient represented for exam on 10/23/2025 for persistent d+. At this time, no v+ appreciated, BAR, great appetite. Patient completed course of medications but had no response. Patient has also continued to lose weight despite a good appetite. Current Diet: Purina pro plan, wet and dry. Previous Diagnostics or Scans: 9/27/2025- fecal- negative 10/23/2025- abdominal radiographs- Gas and possible thickening of SI. AUS recommended. 10/23/2025- cbc- rbc 5.84 (6.5-11.53); HCT 36.1%; leukocytosis 19.2 (3.9-19.0); monocytosis 1.306 (0.042-0.467); eosinophilia 1.306 (0.209-1.214) chem- hypocholesterolemia 89 (91-305), t4- wnl (1.9).

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 (3.89 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 0.31 cm at the cranial pole and 0.33 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.

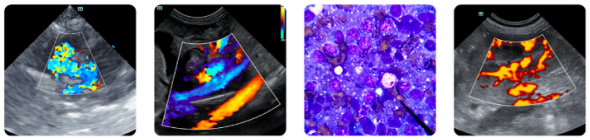
The right adrenal gland is normal in size measuring 0.46 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (0.88 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.



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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 increased (duodenum measures 0.29 cm, and jejunum measures 0.26 cm). Bowel loops follow a typical curvilinear path. Some areas have reduced detail of wall layering. Visualized peristalsis appears appropriate. The muscularis layer appears diffusely thickened.

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's a diffuse mesenteric lymphadenopathy with large, hypoechoic, rounded mesenteric lymph nodes. There is a cluster of lymph nodes at the mesenteric root. Examples measure 0.75 cm x 2.37 cm and 1.04 cm x 2.86 cm. There's a large jejunal lymph node visualized measures 1.9 cm x 1.28 cm. The omentum is diffusely hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- Pancreatic changes most consistent with pancreatic remodeling +/- chronic pancreatitis in the left limb.
- Diffusely thickened small intestine with a prominent muscularis layer and mild mucosal fogging. The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia.
- Diffuse, moderate mesenteric lymphadenopathy. Findings are concerning for metastatic lymph nodes, although highly reactive lymph nodes are possible.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine appears diffusely thickened with a prominent muscularis layer and poor detailed wall layering in some regions. Although a focal mass lesion is not observed. Additionally, there are large, hypoechoic, rounded mesenteric lymph nodes. Recommend a fine needle aspirate of a mesenteric lymph node for cytologic evaluation. As the primary concern would be severe IBD versus round cell neoplasia.

The left limb of the pancreatis is very prominent and hypoechoic, most consistent with pancreatic

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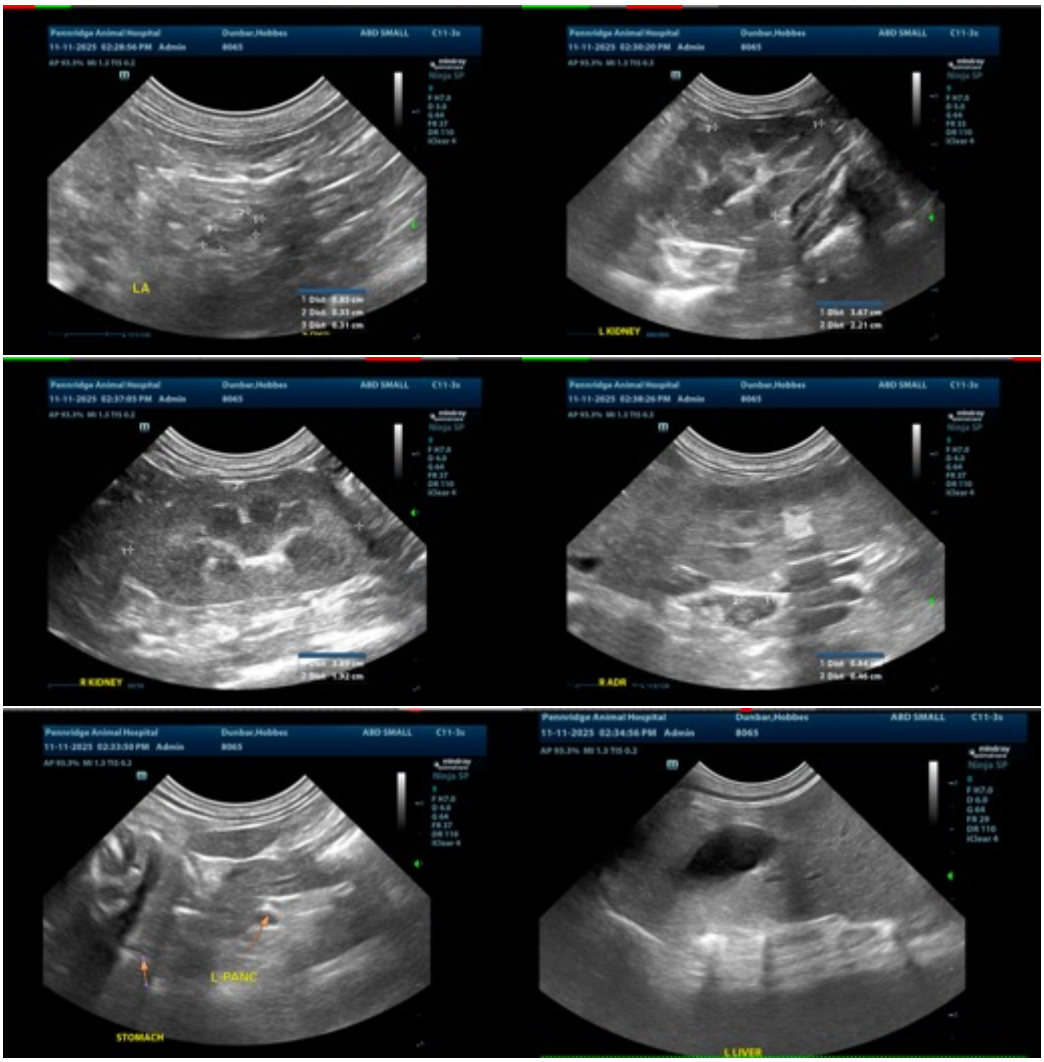
remodeling +/- chronic pancreatitis. Correlate with a PLI level and consider empirical treatment for chronic pancreatitis.

While awaiting cytologic evaluation/results, recommend 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 a fine needle aspirate of the lymph nodes is not diagnostic, biopsies of the GI tract may be necessary to obtain a definitive diagnosis.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.



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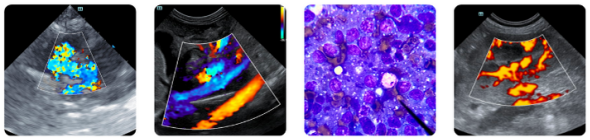

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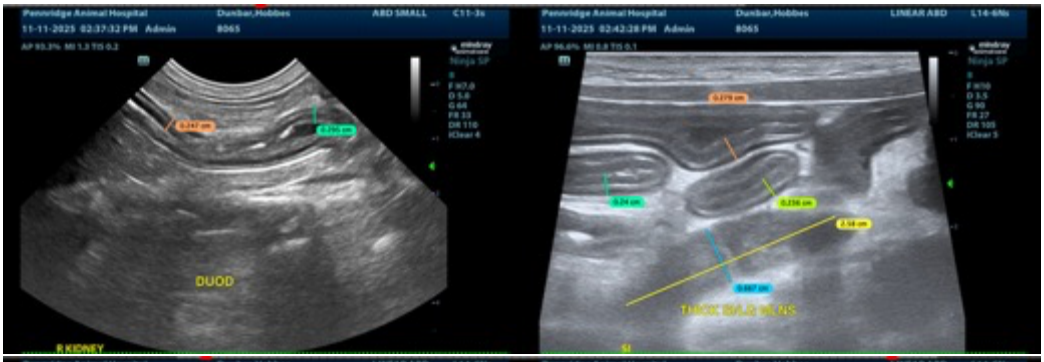

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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