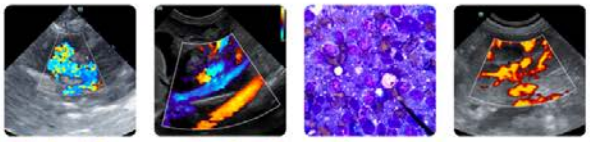

PATIENT

Nibbler Hanses

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

17 Years 5 Months

WEIGHT

7.16 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Lucas Budden

HOSPITAL NAME

Frontier Veterinary Hospital

REFERRING VET

Dr. Lucas Budden

INVOICE

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DATE

11/11/25

PRESENTING CLINICAL SIGNS

Clinical signs: Diarrhea, weight loss, vomiting History: Chronic diarrhea. Ultrasound submitted to Sonopath last year. Started on budesonide and B12 injections due to low B12 levels. Did very well with that treatment (diarrhea resolved and gained weight). Weight increased from about 7.9# at the time of the previous ultrasound (7/9/24) to 9# on 1/26/25. Diarrhea and weight loss noted and seen October 4, 2025 (weight down to 7.5#). Intermittent vomiting noted as well. Ultrasound to reassess for any GI changes that would indicate neoplasia or a reason for the recurrence of symptoms. Appetite is normal to increased. History of hyperthyroidism, CKD IRIS 2, heart murmur, cataracts OU Current medications: Recently restarted B12 injections (see in early October 2025 and owners had stopped giving injections) 250mcg SC Budesonide 1 mg non-sustained release once per day Methimazole 2.5mg transdermal every 12 hours

Abnormal PE/Chem/CBC/UA Results: Physical exam: BCS 3/9, MCS 2/3, thyroid slip palpated, grade 1/6 parasternal systolic HM, bilateral mature cataracts, menace absent AU, well hydrated, moderate dental tartar, no obvious masses on abdominal palpation Lab work: hyperthyroid panel 10/4/25 K 3.2 low, NA/K ratio 48 BUN 58 high, creatinine 1.9 high, SDMA 10.1 Neutrophils 10449 high, lymphocytes 1161 low T4 1.8 normal

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.

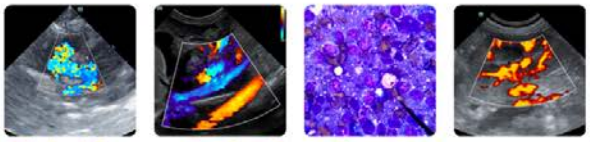
The left kidney has a normal shape and size (3.61 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.8 cm). Overall echogenicity is slightly hyperechoic with poor 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 0.33 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 0.39 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.



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Spleen

The spleen is subjectively normal in size (0.76 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 is large with a minimal amount of echogenic debris. The proximal bile duct appears somewhat dilated and tortuous measuring 0.31 cm, then is lost to visualization. The region of the duodenal papilla is visualized and appears normal.

Gastrointestinal

The stomach contains minimal luminal contednts. 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. Bowel loops follow a typical curvilinear path. Duodenum wall measures 0.37 cm. Jejunum wall measures 0.32 cm. Visualized peristalsis appears appropriate. The muscularis layer appears diffusely prominent and mildly thickened.

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 both limbs, particularly the left limb. There is no evidence of nodules or cystic lesions. There is mildly reactive mesentery around the left limb of the pancreas.

Free Abdomen

There is scant free fluid present. There are occasional prominent mesenteric lymph nodes. A medial iliac lymph node is prominent and hypoechoic measuring 0.60 cm x 0.94 cm. Jejunal lymph nodes are visualized measuring 0.43 cm and 0.29 cm. A colic lymph node is visualized measuring 0.22 cm. The omentum is mildly diffusely hyperechoic, particularly around the left limb of the pancreas.

ULTRASONOGRAPHIC FINDINGS

- Age related changes visualized associated with both kidneys.
- Pancreatic changes most consistent with chronic pancreatic remodeling +/- mild chronic pancreatitis, particularly in the left limb.
- Large gallbladder with a distended bile duct – Dilation of the common bile duct could be consistent with a functional obstruction (i.e. primary hepatic disease resulting in hepatocellular swelling) or with an extrahepatic bile duct obstruction (ie. choledocholith, bile duct tumor,

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pancreatic disease, other).

- Diffusely thickened small intestine with some areas exhibiting a mildly to moderately 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.

- Scant free abdominal fluid and occasional prominent mesenteric lymph nodes – Findings are generally most consistent with reactive lymph nodes, although early neoplastic lymph nodes cannot be ruled out.

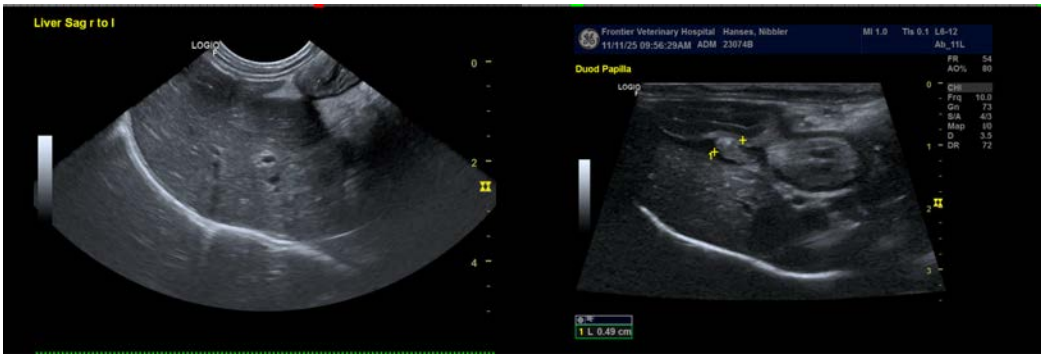
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes described on today's exam are similar to those previously described in the exam on 7/9/24, although subjectively the small intestinal changes appear milder than on the previous exam. The significance of this is uncertain in the face of steroid therapy, as this can result in visual improvement of some of the lesions. Subjectively the bowel wall and lymph node changes appear milder than described in previous exam.

It is possible that this pet is out of remission from significant inflammatory bowel disease or round cell neoplasia. Additionally, the pancreas appears hypoechoic and prominent with some surrounding reactive mesentery as previously described, although this could represent a bout of recurrent chronic active pancreatitis. Correlate with PLI level.

This patient is significantly azotemic. Progressive uremia could be contributing to the symptoms described. Consider fluid therapy and symptomatic treatment to see if this helps improve patient's clinical signs.

It will likely be necessary to obtain biopsies of the GI tract if a definitive diagnosis is desired. Ideally, this should be done off steroid therapy to obtain most diagnostic biopsies. Otherwise consider continued treatment for IBD, chronic renal disease, and pancreatitis with close continued monitoring.



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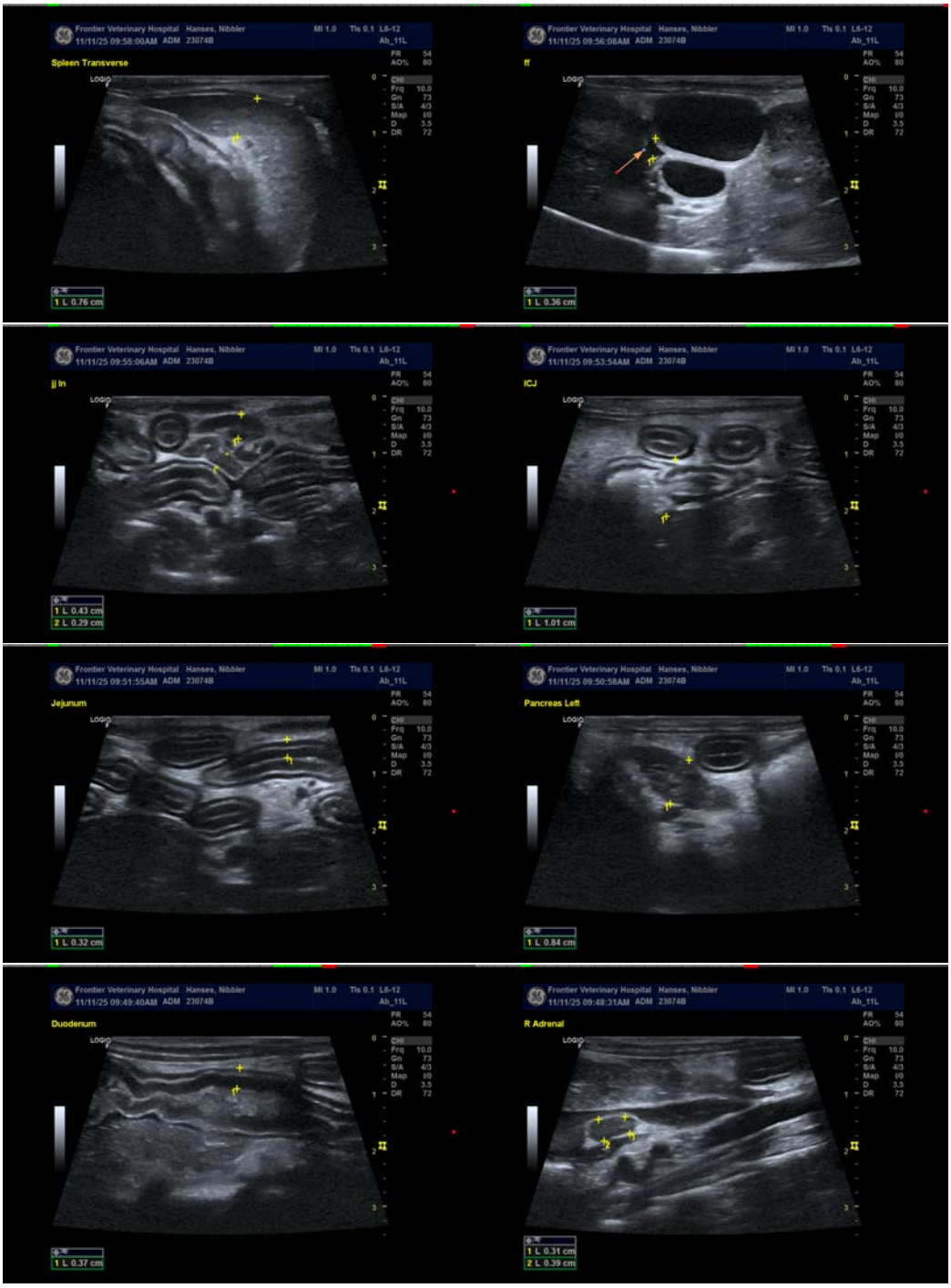

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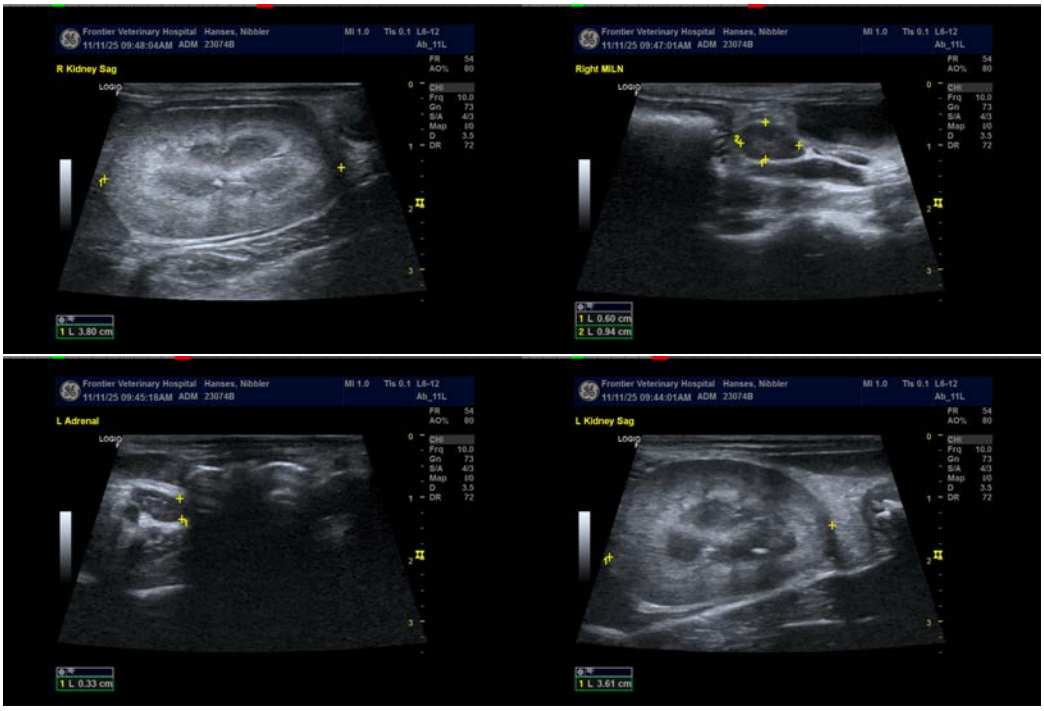

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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