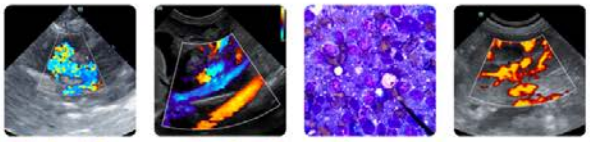

PATIENT

Tigger Schweitzer

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

13 Years 8 Months

WEIGHT

3.3 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

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PRESENTING CLINICAL SIGNS

AUS to further evaluate continued weight loss (3 lbs in 2 months) and mildly elevated liver enzymes (new, normal on Sept 2025 BW). Reported to have a good appetite and energy levels. Vocalizes more. September 2025 was seen at pDVM for weight loss despite a good/increased appetite, occasional vomiting, and possible D+ (multi-cat house). Represented to rDVM on 11/7/25 for continued weight loss, still E/D, vocalizing, constantly on the move.

Abnormal PE/Chem/CBC/UA Results: BCS 2/9, MCS 1/3 pDVM Diagnostics 11/7/25: - AXR: Distal colon is mod-markedly distended with gas and formed fecal matter. The SI aer distended with gas, however, some loops are more distended than others. R/O illeus vs partial FBO, r/o megacolon. - CBC: Hct 41%, PLTs 360-n; NSF - Chem: ALB 3.5-n , ALKP 115 H (6 - 102), ALT 125 H (10 - 100), AST 52-n, BUN 25-n, Cr 0.9-n, Gluc 100-n, remainder NSF - T4: 2.0-n - Keyscreen fecal (9/10/25): No parasites detected

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 (3.02 cm) with mild pyelectasia at 0.15 cm. Overall echogenicity is slightly hyperechoic with mildly reduced 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.35 cm). Overall echogenicity is slightly hyperechoic with mildly reduced 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.

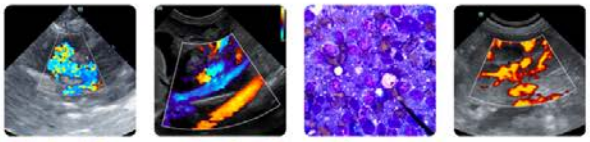
Adrenal Glands

The left adrenal gland is normal in size measuring 0.23 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 0.19 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 (0.64 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.



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Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The vasculature appears normal. There are shadowing mineralizations visualized within the intrahepatic bile ducts.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. In the dependent portion of the gallbladder there is shadowing mineralization most consistent with mineralized debris or small choleliths. 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 to mild fluid and gas. 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. Jejunum wall measures 0.15 cm. Duodenum wall measures 0.42 cm. Visualized peristalsis appears appropriate. Many areas of bowel appear somewhat "gassy" with gas shadowing/interference and some free abdominal fluid. There is segmental thickening and prominence of the muscularis layer.

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 large, prominent, hypoechoic and mottled with a prominent pancreatic duct. There is no evidence of nodules or cystic lesions. There is evidence of mild regional mesenteric inflammation or fluid.

Free Abdomen

There is scant free fluid noted. There is a mild to moderate mesenteric lymphadenopathy with clusters of hypoechoic mesenteric lymph nodes. Examples measure 0.51 cm x 0.55 cm and 0.52 cm x 1.44 cm. The omentum is mildly diffusely hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- Age related changes visualized associated with both kidneys as well as mild left-sided pyelectasia.
- Pancreatic changes most consistent with chronic pancreatitis.
- Intrahepatic biliary mineralizations and choleliths/mineralizations in the dependent portion of the gallbladder.
- Mildly heterogeneous liver – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.

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- Segmental thickening of the small intestine with some areas exhibiting 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.
- Large, hypoechoic, rounded mesenteric lymph nodes – Findings could be consistent with severely reactive lymph nodes or early metastatic change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine appears diffusely "gassy" with some areas exhibiting mild fluid distention. Some areas appear very normal in thickness, others are more thickened with a prominent muscularis layer. These changes could be consistent with inflammatory change (possibly malabsorptive disease with a good appetite?), although early neoplastic change cannot be ruled out. Consider the following:

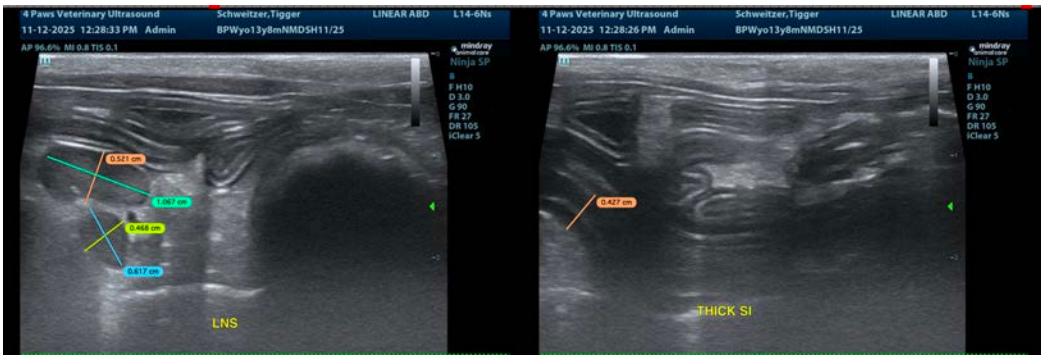
- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.
- Consider treatment for chronic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

There are small intrahepatic biliary mineralizations and dependent mineralization within the gallbladder. Given the liver enzyme elevations, mild cholangiohepatitis could be present. Consider Ursodiol therapy, a course of antibiotics and chronic Denamarin. If liver enzyme elevations are persistent or progressive, repeat imaging in the future may be warranted to look for any evidence of a developing obstruction, etc.

If weight loss and GI signs are persistent, eventually biopsies of the GI tract may be warranted. If biopsies are obtained, consider concurrent liver biopsies with samples for histopathology and culture.

With the changes involved associated with the biliary tract, pancreas and small intestine, an early Triaditis-like process could be present. Consider a fine needle aspirate of the liver (provided coagulation parameters are normal) to help rule out underlying round cell neoplasia.

There are numerous prominent mesenteric lymph nodes noted. If a safe window for sampling is available and a fine needle aspirate is possible, cytologic evaluation could be considered.



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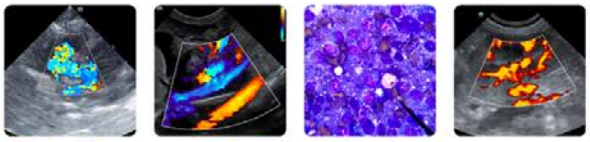

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Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

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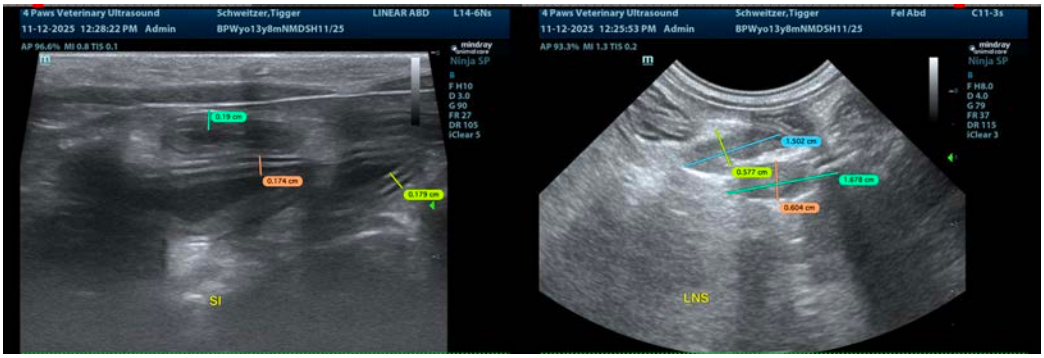

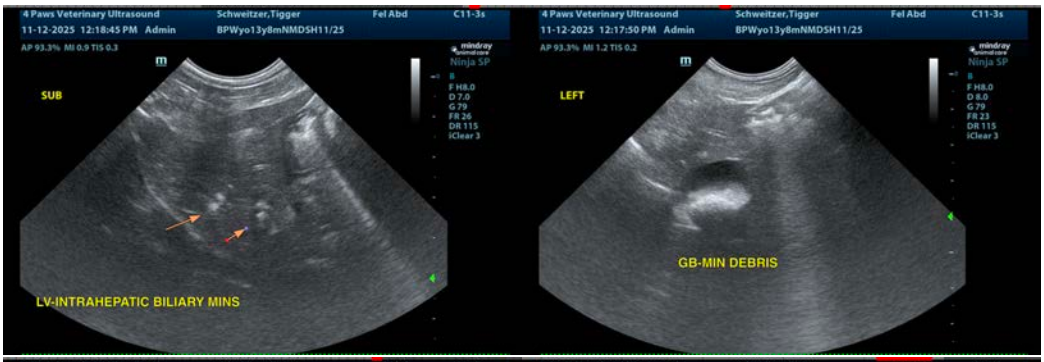

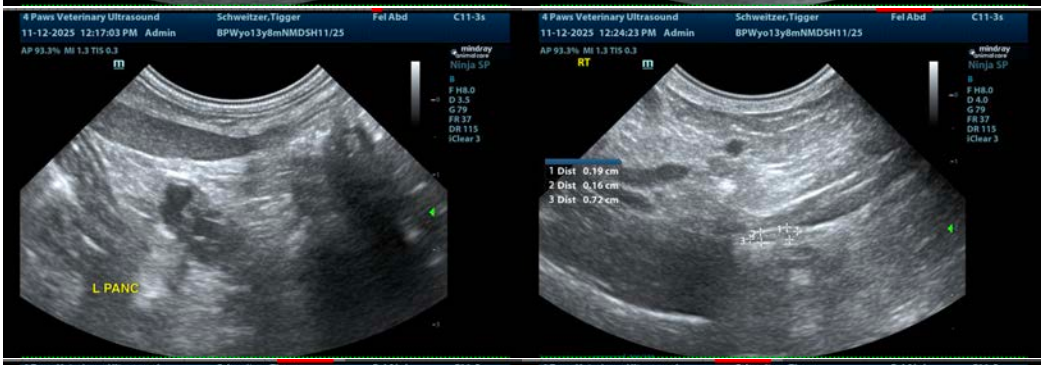

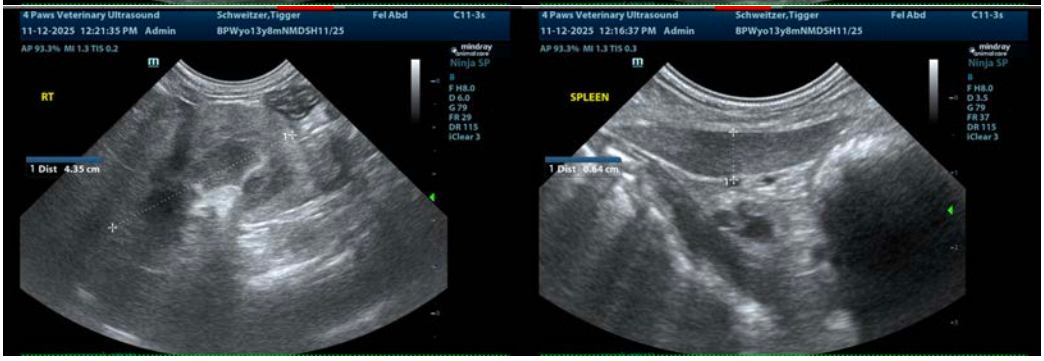

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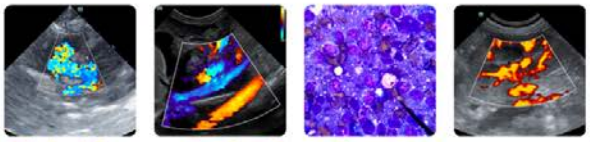

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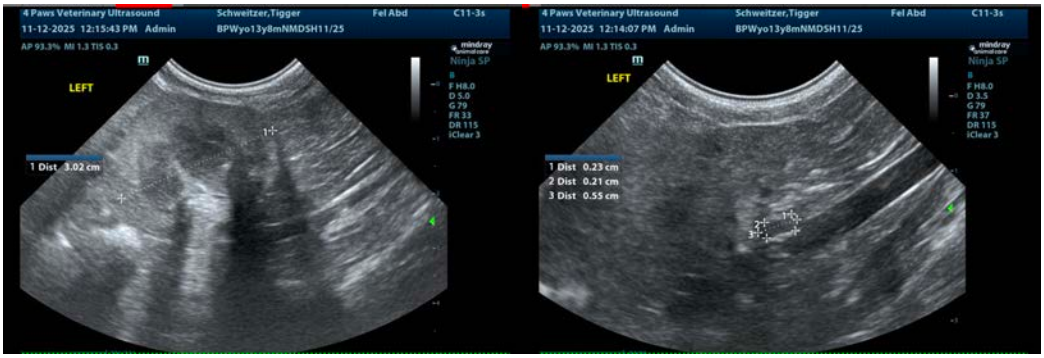

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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