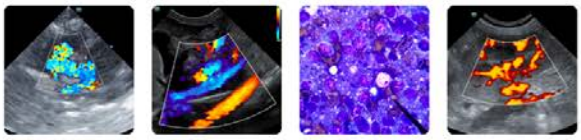


DATE

11/18/25

PATIENT

Merlin Miller

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

9/1/23

WEIGHT

11 lbs

INTERPRETED BY

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

HOSPITAL NAME

Cat Sense Feline Hospital

REFERRING VET

Dr. Sinclair

INVOICE

71919

PRESENTING CLINICAL SIGNS

Patient History: Merlin has not been acting quite right for the last few weeks. He has had some episodes of vomiting along with several hairballs. His appetite has been a little off but he is still eating. Bloodwork was pretty normal although the SDMA was 15 and the creatinine was 1.9 (not sure if significant). A radiograph was fairly unremarkable. There is a concern about possible IBD starting.

Current Medications: Cerenia 8mg SID.
Labwork Results: Labwork attached, reported as: SDMA=15, creatinine=1.9, BUN=24
Date of Previous IntraPet Ultrasound: No previous.
Sedation: IM.
Stat Report: Not requested.
Imaging Performed by: Rachel Brilhart, RDMS.

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 (3.75 cm). There is a hyperechoic line separating the cortex and medulla, most consistent with medullary rim sign. 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 (3.67 cm). There is a hyperechoic line separating the cortex and medulla, most consistent with medullary rim sign. 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 0.46 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 0.51 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 (0.86 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 <0.36cm 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 relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.31 cm. Jejunum wall measures 0.25 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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. Descending colon wall measures 0.14 cm with intact wall layering.

Pancreas
The pancreas is normal and isoechoic to surrounding 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. There is a mild diffuse lymphadenopathy with clusters of large mesenteric lymph nodes, examples measure 0.47 cm and 0.43 cm. A larger lymph node near the mesenteric root measures 0.69 cm x 1.65 cm. Additionally, there are small lymph nodes near the ileocecal junction measuring 0.59 cm and 0.53 cm. Prominent colic lymph nodes are visualized measuring 0.45 cm and 0.43 cm near the bladder neck. The omentum is generally of normal echogenicity.

Ringdown artifact is seen at the level of the diaphragm. This can be seen with pulmonary parenchymal disease.

ULTRASONOGRAPHIC FINDINGS

- Medullary rim sign visualized associated with both kidneys – Clinical significance uncertain, can be seen in normal patients and in cases of ethylene glycol toxicity, FIP, chronic interstitial nephritis, and leptospirosis.

- Mild diffuse lymphadenopathy with prominent lymph nodes near the colon – Findings are most consistent with a reactive lymphadenopathy. Early neoplastic change cannot be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the GI tract to explain the vomiting reported. This does not rule out the possibility of underlying mild gastrointestinal disease.

There is a mild diffuse mesenteric lymphadenopathy and prominent colic lymph nodes. These currently have the appearance most consistent with reactive lymph nodes, although early neoplastic change cannot be ruled out. Recommend continued monitoring.

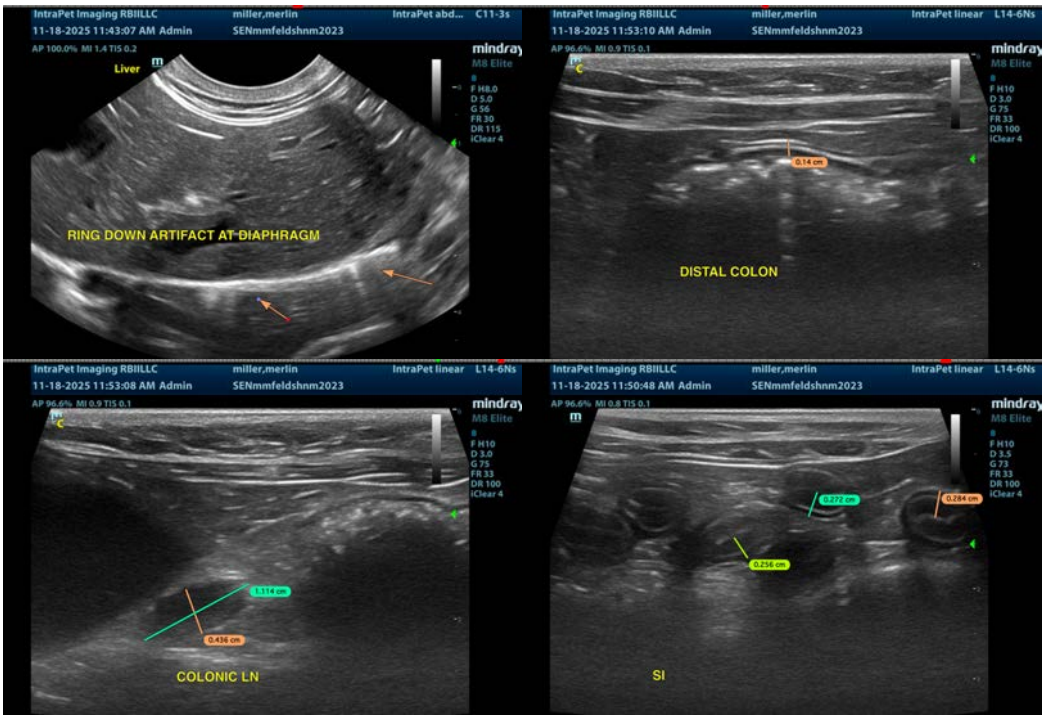
If an underlying enteropathy is strongly suspected, you could consider a GI panel to Texas A&M for a qualitative PLI,TLI, cobalamin and folate. Additionally, you could consider a food trial with a hydrolyzed protein prescription diet.

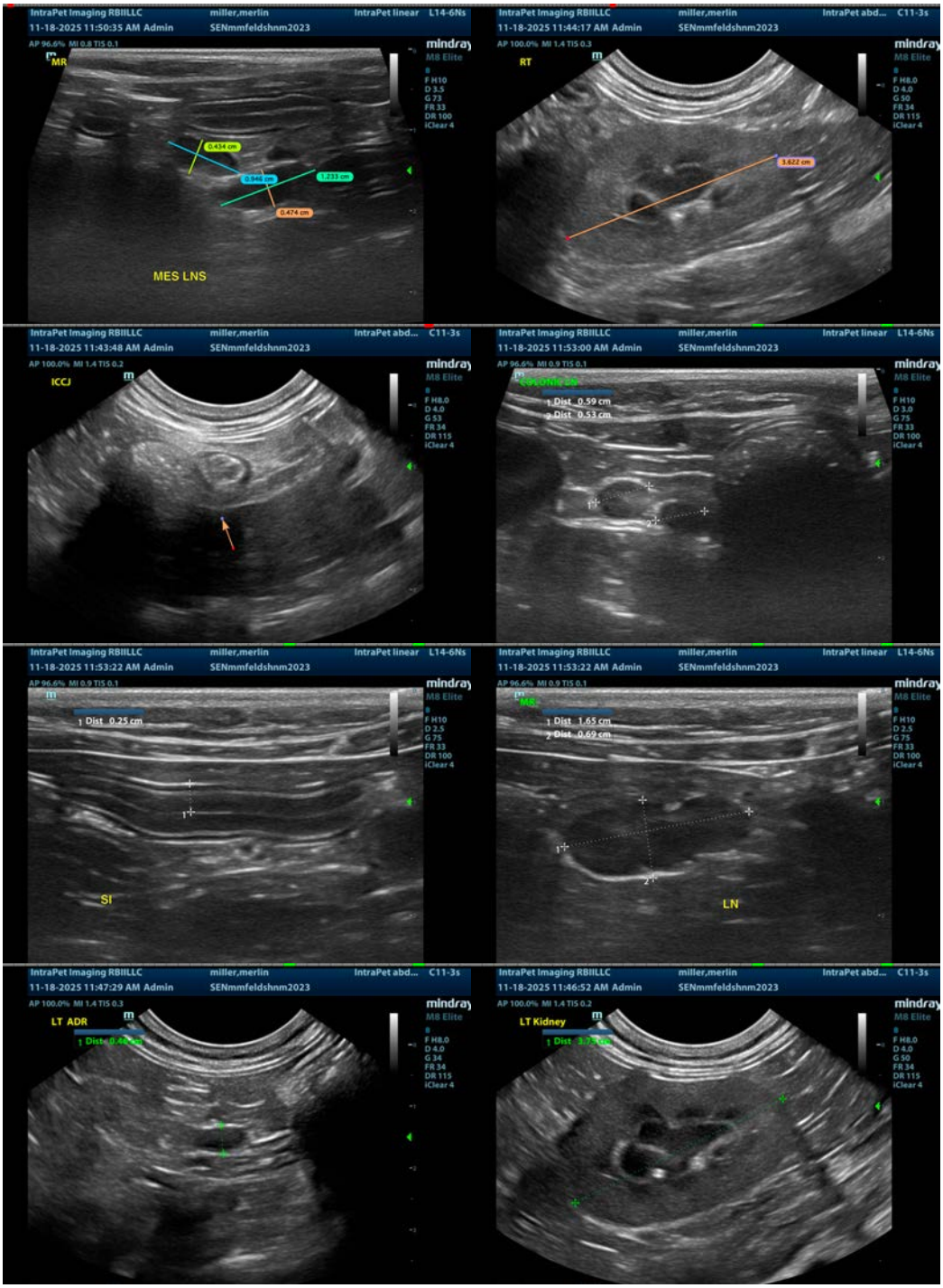
No diarrhea is reported, but there do appear to be lymph nodes in the region of the colon. Recommend continued monitoring of stool quality, as further evaluation of this area may be warranted (fecal testing, infectious disease testing, etc.).

There is mild medullary rim sign visualized associated with both kidneys. The significance of this is uncertain. Correlate with a urinalysis to assess urine concentrating ability, which could give a better idea if early renal dysfunction is present.

There is mild ringdown artifact visualized at the level of the diaphragm. Recommend thoracic radiographs to look for any evidence of pulmonary parenchymal disease.

If symptoms are persistent, consider repeat imaging in the future to reevaluate the lymph node enlargement and to look for any new/developing lesions.

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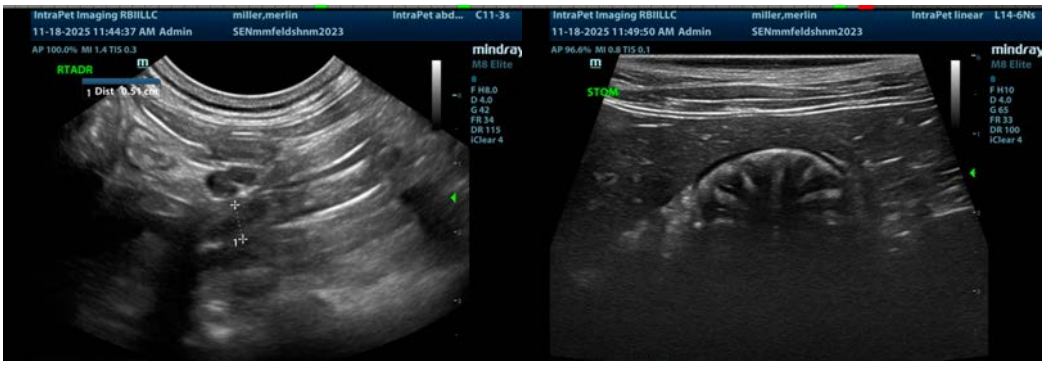

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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