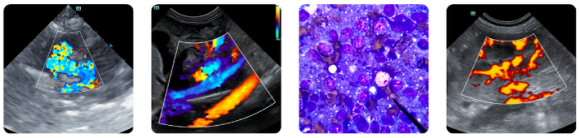



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**PATIENT**

Dexter Heywood

**SPECIES**

Feline

**BREED**

DLH

**SEX**

Spayed Female

**AGE**

8 years

**WEIGHT**

4.33 kgs

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Crystal Hill

**HOSPITAL NAME**

Beatties PH Stoney Creek

**REFERRING VET**

Dr. Salib

**INVOICE**

10762

**DATE**

11/19/2025

## PRESENTING CLINICAL SIGNS

Not eating since Nov 14, started vomiting bile that day. Was seen 11/16 and had BW and Rads done then, went home with meds. Returned today as still not eating, no BM since last Appt, abdomen somewhat tense on palpation in cranial abdomen, no obvious pain. Has been on Cerenia and Gabapentin.

Abnormal PE/Chem/CBC/UA Results: Please see attached blood results, radiographs and rad report.

## 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 (3.51 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 (3.32 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 0.57 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 0.34 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.

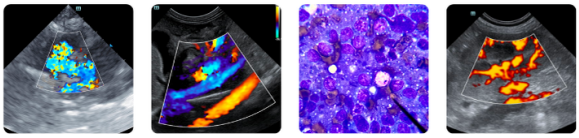
### *Spleen*

The spleen is subjectively normal in size (0.78 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.





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### *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 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 jejunum measured 0.26 cm in diameter. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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 right 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, 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

- Pancreatic changes most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.
- Diffusely “ropey” small intestine with 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

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions were visualized associated with the gastrointestinal tract to explain the anorexia and vomiting reported. The small intestine appears somewhat ropey with some areas exhibiting segmental thickening or the muscular layer. These changes are most consistent with inflammatory type change, although early neoplasia change cannot be ruled out.

Additionally, the right limb of the pancreas is somewhat mottled. This likely represents pancreatic remodeling, but mild active inflammation is possible. Correlate with a PLI level, and if this is elevated, consider concurrent treatment for pancreatitis.

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.

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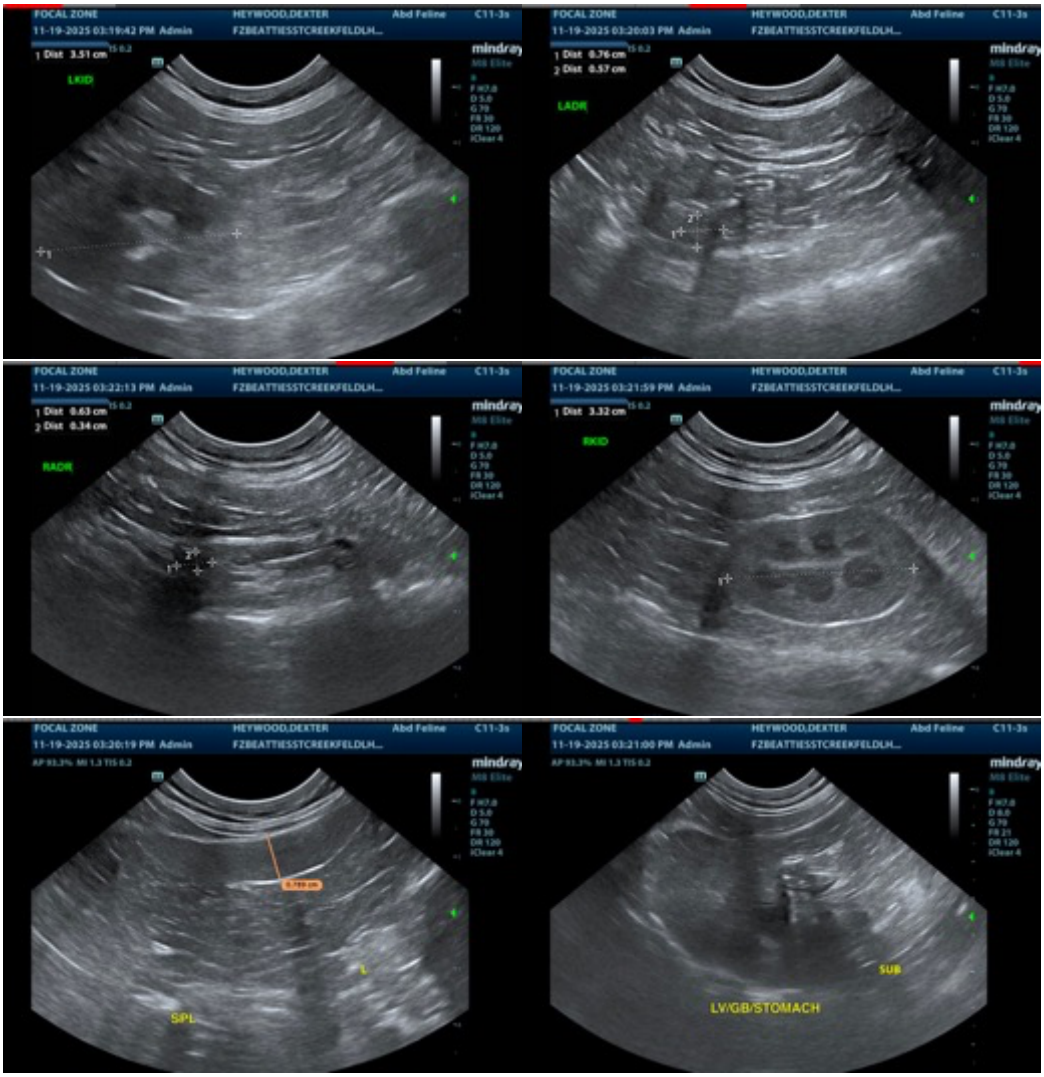
- Recommend chronic probiotic therapy.

Recommend non-specific treatment for gastroenteritis. If anorexia is persistent, consider a feeding tube as prolonged fasting may result in other issues. If the above recommendations do not result in improvement, then biopsies of the GI tract may be warranted (surgical versus endoscopic.)

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



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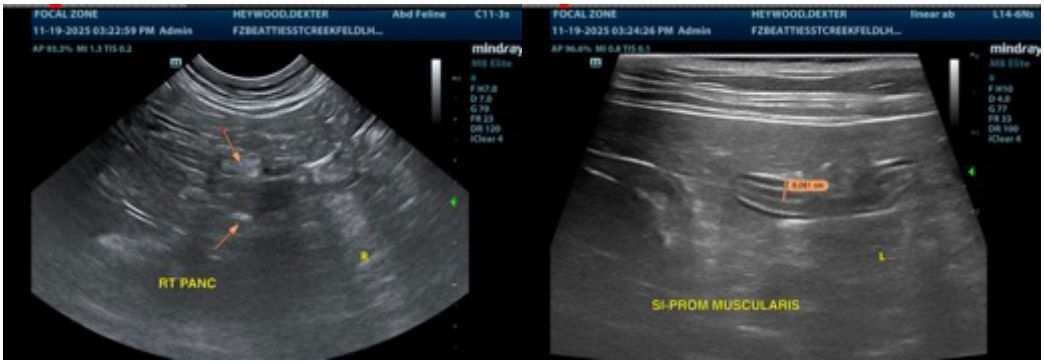


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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