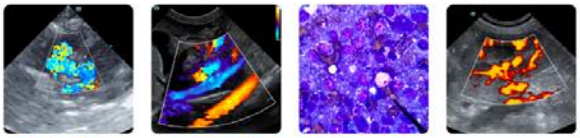


SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Isla Stevenson

SPECIES

Feline

BREED

DLH

SEX

Spayed Female

AGE

10 Years

WEIGHT

7 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Hillview Veterinary Clinic

REFERRING VET

Dr. Stevenson

INVOICE

72143

DATE

11/26/25

PRESENTING CLINICAL SIGNS

Hiding more, not around as much, not eating well last few days, chronic vomiter, not on any meds. Refused tuna. BAR, HR 180, RR 20, MM pink, gums tacky, moderate skin tent, nothing obvious palpable in abdomen other than stool and small bladder, BCS 4/9, some crusting around right nostril.

Abnormal PE/Chem/CBC/UA Results: Please see attached radiographs and lab results. Low creatinine and BUN, elevated Calcium, USG 1.034

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with moderate suspended echogenic debris and some mineralized debris present. 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 calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (3.82 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 (3.63 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 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.

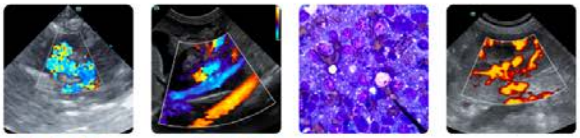
The right adrenal gland is normal in size measuring 0.39 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

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.



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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 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. Duodenum wall measures 0.23 cm. Visualized peristalsis appears appropriate. There is the general impression of mildly thickened small intestine with some edema and segmental thickening of the muscularis layer.

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 visible and mildly mottled. 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 no significant lymphadenopathy. The omentum is generally hyperechoic and mildly mottled.

ULTRASONOGRAPHIC FINDINGS

- Moderate suspended echogenic debris with some mineralized debris – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.
- Pancreatic changes most consistent with chronic pancreatic remodeling. Mild chronic pancreatitis is possible.
- Prominent small intestine with segmental thickening of the 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

There is the general impression of hyperechoic mesentery with poor intestinal detail, most consistent with edema. There is segmental thickening and thickening of the small intestine with a prominent muscularis layer, and some areas that appear mildly corrugated. No focal GI lesions are observed, and the visualized areas of pancreas appear slightly prominent, but not overtly inflamed. A definitive source of the inflammation is not identified. The GI tract would be suspected, particularly based on the low globulin and low-normal albumin levels, but this is uncertain, as B12 levels are normal, which would be unlikely in a chronic enteropathy. If no other cause for abdominal inflammation is identified, consider

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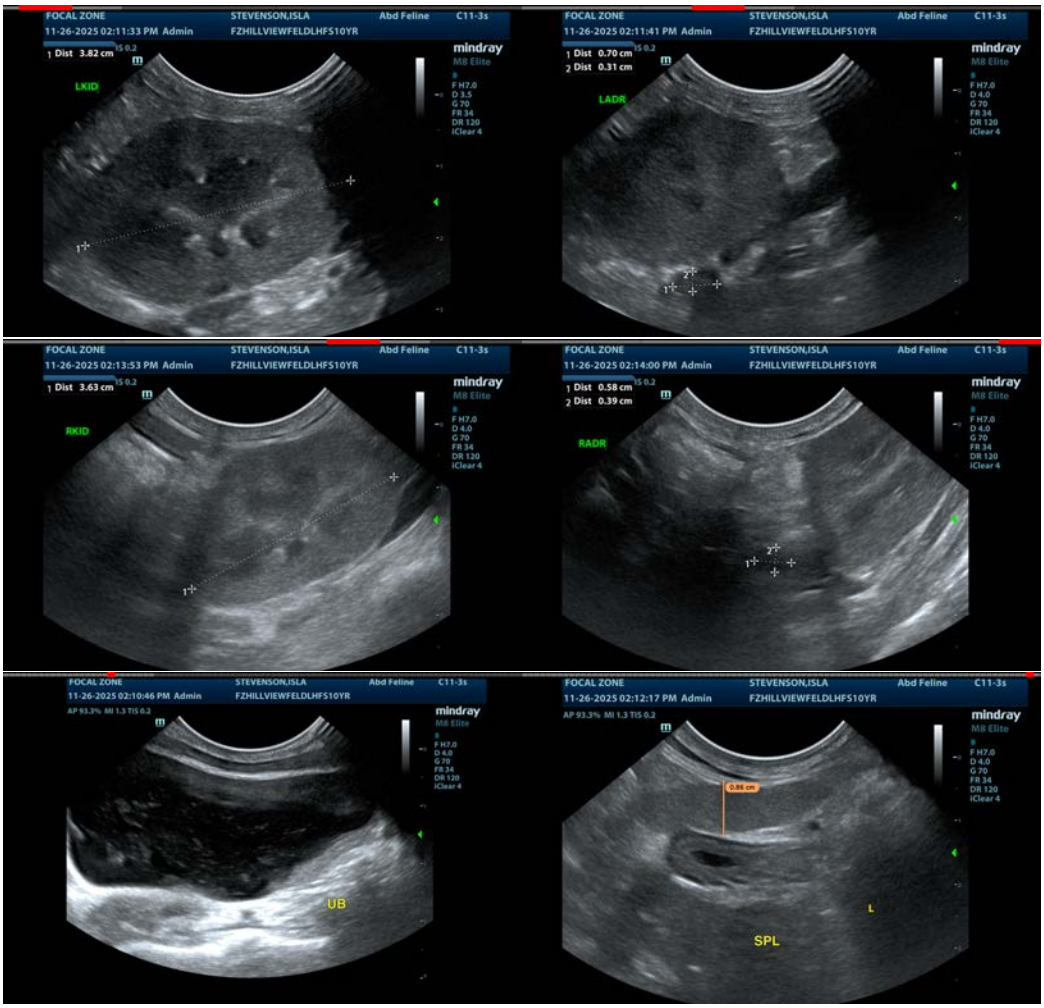
the following:

- 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 GI signs are persistent, consider a repeat GI panel and lab work to reassess the leukopenia, borderline hypoalbuminemia, etc. If underlying gastrointestinal disease is strongly suspected, biopsies of the GI tract may eventually be warranted. Additionally, you could consider repeat imaging in the future looking for progression of today's lesion.



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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