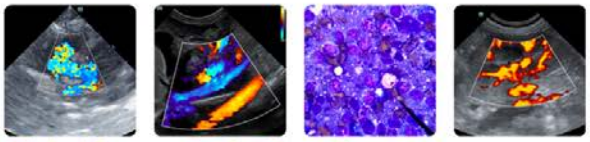


PATIENT

Nala Abel

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

12 Years

WEIGHT

6.7 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Nicole Hession

HOSPITAL NAME

SODO Veterinary Hospital

REFERRING VET

Dr. Englehardt

INVOICE

72117

DATE

11/26/25

PRESENTING CLINICAL SIGNS

P presented on 11/25/25 for not eating and drinking. Last full meal at that time was two days ago. 2 weeks ago P was having diarrhea and went to another vet where she was prescribed abx for bacteria in gut. P has lost weight. P vomited bile about a week ago, and vomited clear foam 11/21/25. Last night P did well, ate on her own after a dose of Elura. P is hospitalized today on IVF and IV abx.

Abnormal PE/Chem/CBC/UA Results: Liver values normal 8/2024 BW 11/2/25- MCHC 37 (28.1-35.8), NEU 10.94 (2.3-10.29), EOS 0.05 (0.17-1.57), CREA 0.7 (0.8-2.4), BUN 15 (16-36), PHOS 2.9 (3.1-7.5), ALT 340 (12-130), ALKP 155 (14-111), TBILI 1.9 (0-0.9), AMYL 404 (500-1500), K 3.1 (3.5-5.8). BW 11/25/25- RBC 6.3 (6.54-12.2), HGB 9.4 (9.8-16.2), RETIC 50.7 (3-50), HCT 30.8 (30.3-52.3), GLU 65 (71-159), CREA 0.7 (0.8-2.4), BUN 14 (16-36), ALT 282 (12-130), ALP 307 (14-111), TBILI 4.2 (0-0.9). FNA taken of liver-pending

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 (3.94 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 (3.62 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.

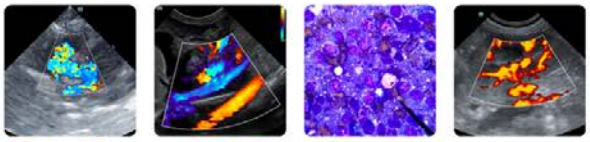
Adrenal Glands

The left adrenal gland is normal in size measuring 0.37 cm at the cranial pole and 0.38 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 cranial pole and 0.45 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 (0.61 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 large in size with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in 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 bile duct at the level of the duodenal papilla appears normal at 0.20 cm.

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 0.26 cm. Jejunum wall measures 0.27 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.

Pancreas

The pancreas is large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild pancreatitis.

Free Abdomen

There is scant free fluid noted. No significant lymphadenopathy. A mesenteric lymph node is visualized measuring 0.33 cm. The omentum is mildly diffusely hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- Pancreatic changes most consistent with mild pancreatitis.
- Large, hyperechoic liver – Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- Inflammatory type pattern visualized associated with the small intestine and mild duodenal corrugation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver is large and hyperechoic. Given the prolonged anorexia, lipidosis would be a concern, as would round cell neoplasia and other differentials. Recommend fine needle aspirate for further evaluation (I believe this was done today).

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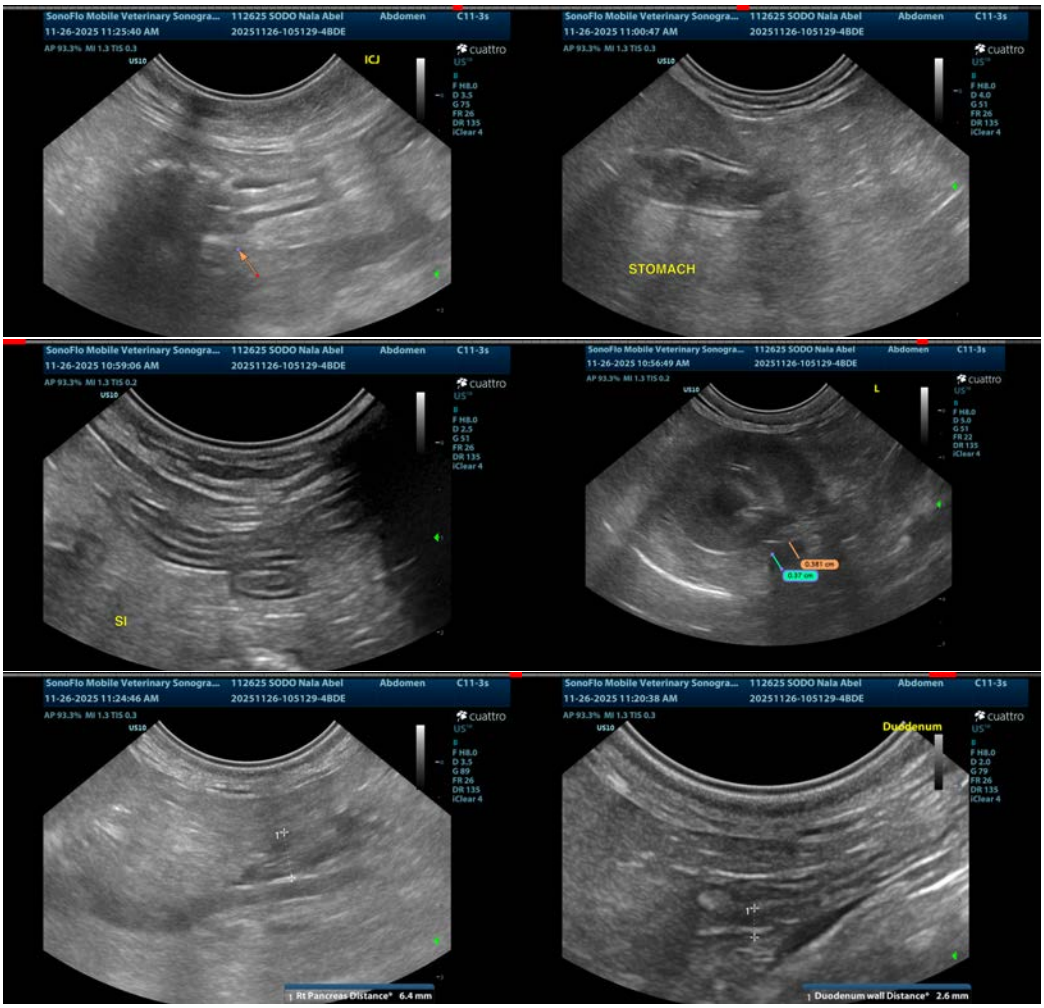
Recommend placement of a feeding tube to assist with nutritional support if the patient continues to not eat. There are some mild inflammatory type changes visualized associated with the small intestine. If these are persistent, further evaluation for a primary enteropathy may be warranted in addition to treatment for chronic pancreatitis. You could consider the following:

- Recommend an ultra low-fat/hydrolyzed protein prescription diet.
- 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 symptoms are persistent, biopsies of the GI tract may eventually be warranted.



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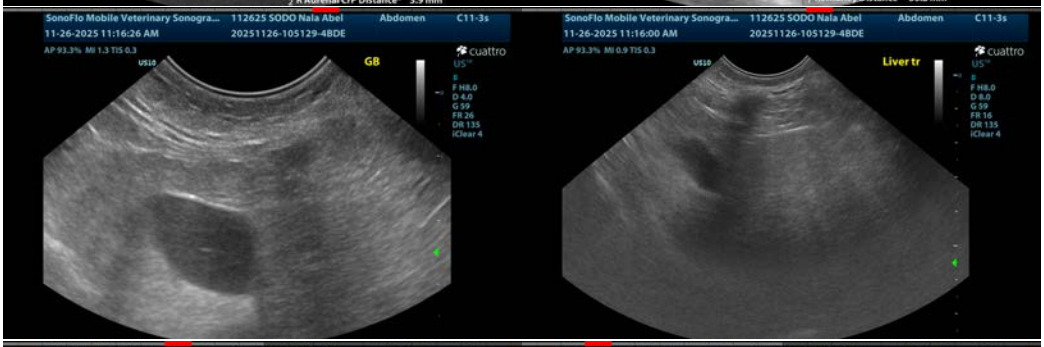

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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