



**DATE PRESENTING CLINICAL SIGNS**

11/4/25 **Patient History:** 10/28/25-bloody stools. O first noticed 1st time over 1 month ago. Significant Weight Loss and Hematochezia.

**PATIENT**

Bo Bryan **Current Medications:** 1 packet of Forti flora daily starting 10/30.

**SPECIES**

Feline **Labwork Results:** Labwork attached, reported as: Laboratory findings: Mild, non-regenerative anemia, likely secondary to chronic illness and weight loss. Decreased total protein. Albumin is slightly lower than normal. Significant increase in globulins (inflammatory protein). Mildly low cholesterol, likely secondary to the low albumin. Complete blood count showed no increase in white blood cells and no changes in platelets. Organ function is otherwise normal: kidney values, liver values, and a specific pancreatic test were all normal. Fecal analysis was negative for parasites.

**BREED**

**Date of Previous IntraPet Ultrasound:** No previous.

**Sedation:** Not required to complete full diagnostic ultrasound.

**Stat Report:** Not requested.

**Imaging Performed by:** Rachel Brillhart, RDMS.

Norwegian Forest Cat

**SEX**

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

Neutered Male

**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.

**AGE**

5/29/19

**WEIGHT**

8.5 lbs

The left kidney has a normal shape and size (4.37 cm) with mild pyelectasia at 0.15 cm. Overall echogenicity is slightly hyperechoic with poor 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.

**INTERPRETED BY**

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

The right kidney has a normal shape and size (4.18 cm) with mild pyelectasia at 0.1 cm. Overall echogenicity is slightly hyperechoic with poor 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.

**HOSPITAL NAME**

Animal Care Center

**Adrenal Glands**

The left adrenal gland is normal in size measuring 0.50 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.

**REFERRING VET**

Dr. Beavers

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.

**INVOICE**

71533

**Spleen**

The spleen is subjectively normal in size (0.76 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 mildly heterogenous in echotexture with subtle, indistinct focal mottling. 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 appears dilated and tortuous, measuring 0.48 cm at the proximal common bile duct, tapering to 0.25 cm at the level of the duodenal papilla. No focal obstruction is visualized.

### ***Gastrointestinal***

The stomach contains minimal luminal contents. It measures at a normal thickness of 0.36 cm 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. The pylorus is somewhat prominent, measuring at 0.49 cm.

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 0.31 cm. Jejunum wall measures 0.22 cm. Visualized peristalsis appears appropriate. The duodenal papilla appears prominent, measuring at 0.39 cm. The muscularis layer is diffusely thickened.

The ileocecal junction is visualized and appears within normal limits. The ascending colon appears somewhat thickened with intact wall layering, measuring at 0.37 cm proximally. The descending colon at the level of the urinary bladder has a prominent wall measuring 0.22 cm with intact wall layering. Sections of colon are visualized with formed fecal material and gas shadowing distally.

### ***Pancreas***

The pancreas is large, hypoechoic and mottled with prominent pancreatic duct measuring 0.28 cm. There is no evidence of nodules or cystic lesions. There is surrounding inflammation most consistent with mild/moderate chronic pancreatitis.

### ***Free Abdomen***

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are occasional prominent cranial abdominal lymph nodes. A pancreaticoduodenal lymph node measures 0.55 cm in diameter. The omentum is hyperechoic around the pancreas.

## **ULTRASONOGRAPHIC FINDINGS**

- Age related changes visualized associated with both kidneys.
- Pancreatic changes most consistent with chronic pancreatic remodeling and chronic active pancreatitis.
- Heterogeneous liver – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.
- Dilated/tortuous bile duct – Dilation of the common bile duct could be consistent with a functional obstruction (i.e. primary hepatic disease resulting in hepatocellular swelling) or with an extrahepatic bile duct obstruction (ie. choledocholith, bile duct tumor, pancreatic disease, other).

- Mild small intestinal thickening 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.
- Thickened colon wall with intact wall layering – Findings are most consistent with colitis.
- Prominent cranial abdominal lymph node – Findings are most consistent with reactive lymph nodes. Early metastatic lymph nodes cannot be ruled out.

### INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The pancreas is very large and prominent in both limbs with a dilated pancreatic duct. Findings are most consistent with chronic pancreatitis and chronic pancreatic remodeling. Correlate with a PLI level and consider treatment for chronic pancreatitis.

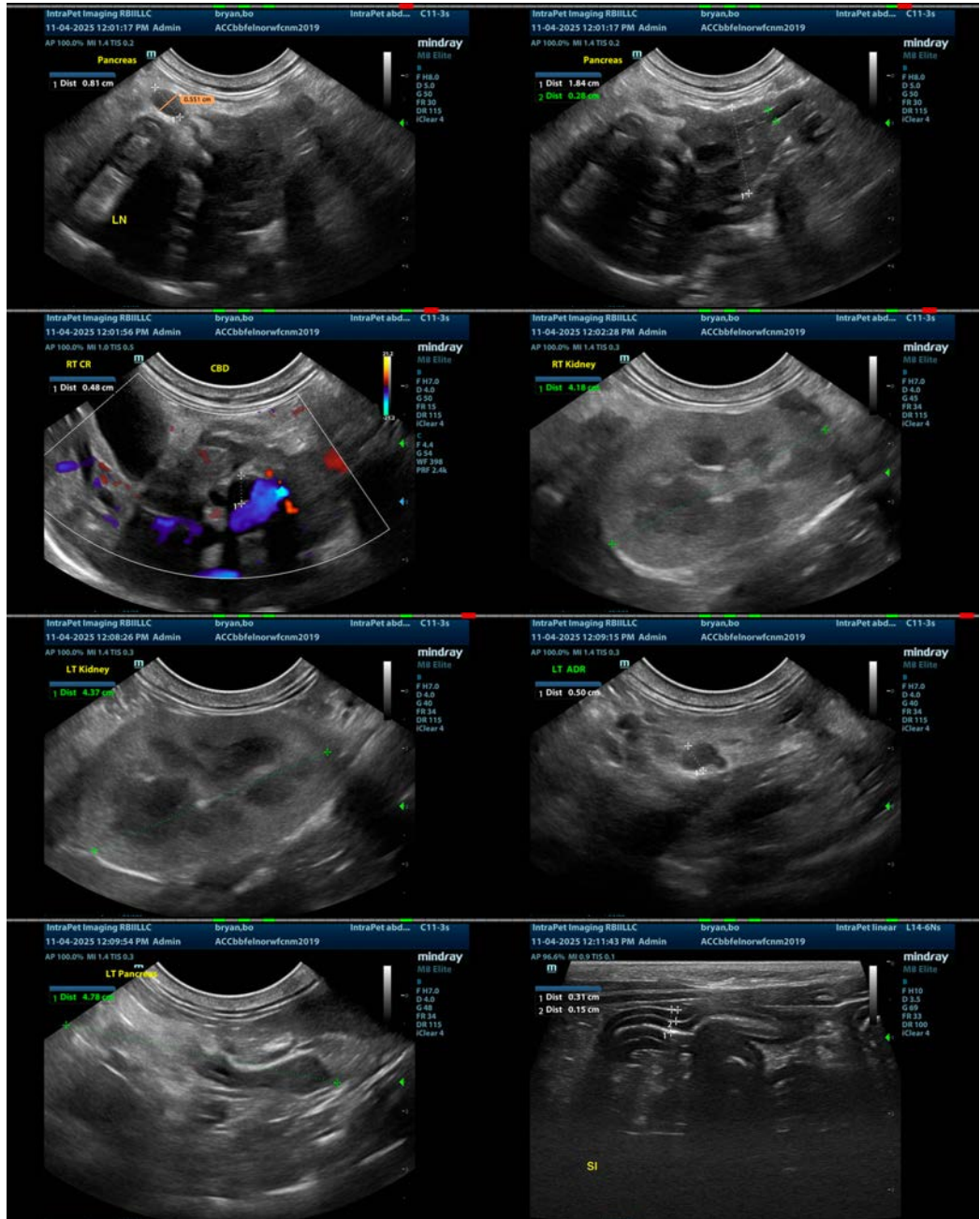
Additionally, the small intestine has a prominent muscularis layer, and the colon appears mildly thickened with intact wall layering. The bile duct is somewhat dilated and tortuous. Given the biliary changes, pancreatic and small intestinal changes, there could be concern for Triaditis. Consider the following:

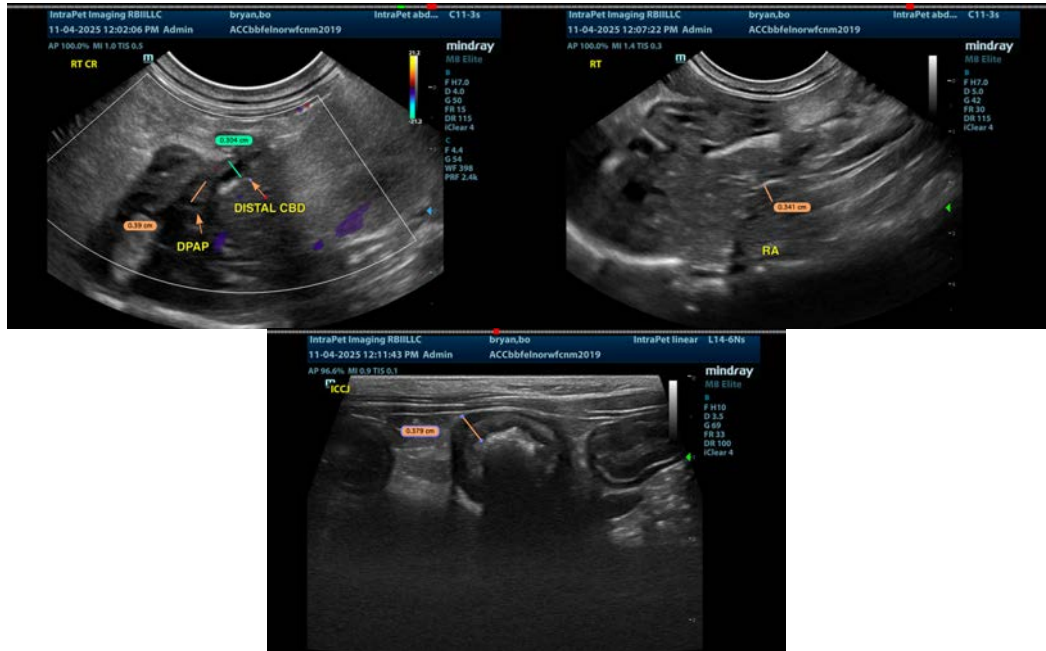
- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.
- Recommend a fine needle aspirate of the liver, looking for possible underlying round cell neoplasia, FIP, etc., as globulin levels are very elevated. Additionally, you could consider a protein electrophoresis.

Consider chronic Ursodiol therapy and treatment for cholangiohepatitis (Ursodiol, Denamarin, antibiotics).

If treatment for mild GI inflammation, cholangiohepatitis, and pancreatitis does not result in improvement, then biopsies of the GI tract, pancreas and liver may be warranted. Additionally, you could consider repeat imaging in the future to look for possible progression of today's lesions or the development of new lesions.







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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