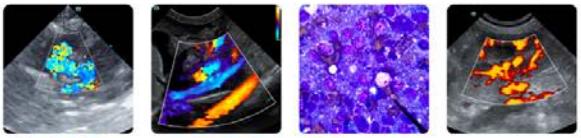


PATIENT

Bella Pinto

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed Female

AGE

6 Years

WEIGHT

7.7 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Meghan Morse, LVT, CVT

HOSPITAL NAME

All Animal Veterinary Services

REFERRING VET

Dr. Acworth

INVOICE

71604

DATE

11/5/25

PRESENTING CLINICAL SIGNS

Not eating or drinking x 4 days Bloodwork WNL, dehydration, thickened colon Current meds: Cerenia, Convenia

Abnormal PE/Chem/CBC/UA Results: Increased cholesterol

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mild primarily suspended and dependent echogenic 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 (3.26 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 (3.57 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 0.27 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 0.35 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.

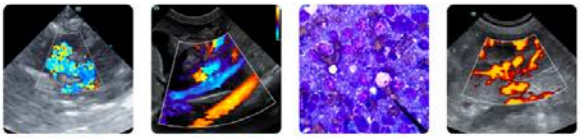
Spleen

The spleen is subjectively normal in size (0.72 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. Duodenum wall measures 0.33 cm. Jejunum wall measures 0.23 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized. The proximal ascending colon appears somewhat thickened with intact wall layering, measuring at 0.40 cm. Distal to the ileocecal junction the colon wall appears more thickened with slightly reduced detail of wall layering, measuring up to 0 .47 cm. There is a moderate amount of shadowing intraluminal gas and fecal material that interferes with visualization in some regions. There are some areas distally that appear thickened as well. At the level of the distal descending colon the colon wall appears normal.

Pancreas

The pancreas is prominent, hypoechoic and mottled in the body and 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. There is no evidence of a significant diffuse lymphadenopathy, but there is a cluster of large hypoechoic lymph nodes near the ileocecal junction. Examples measure 0.64 cm x 0.60 cm and 0.82 cm x 0.58 cm. The omentum is hyperechoic around the ileocecal junction and some areas of the colon.

ULTRASONOGRAPHIC FINDINGS

- Suspended and dependent echogenic debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.
- Pancreatic changes most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.
- Thickened proximal ascending colon with some areas distally exhibiting mild thickening as well – Findings are most consistent with severe colitis or early neoplastic disease.
- Scant free fluid and a localized lymphadenopathy at the ileocecal junction – Findings are most consistent with highly reactive or early neoplastic lymph nodes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Correlate with radiographs to better determine the amount of stool present in the colon. Some sections of proximal colon appear significantly thickened. Many areas exhibit thickening with intact wall layering, although it can be diminished in some areas. These changes could be consistent with severe localized colitis/inflammation or early neoplastic change. If a safe window for sampling is available, you could

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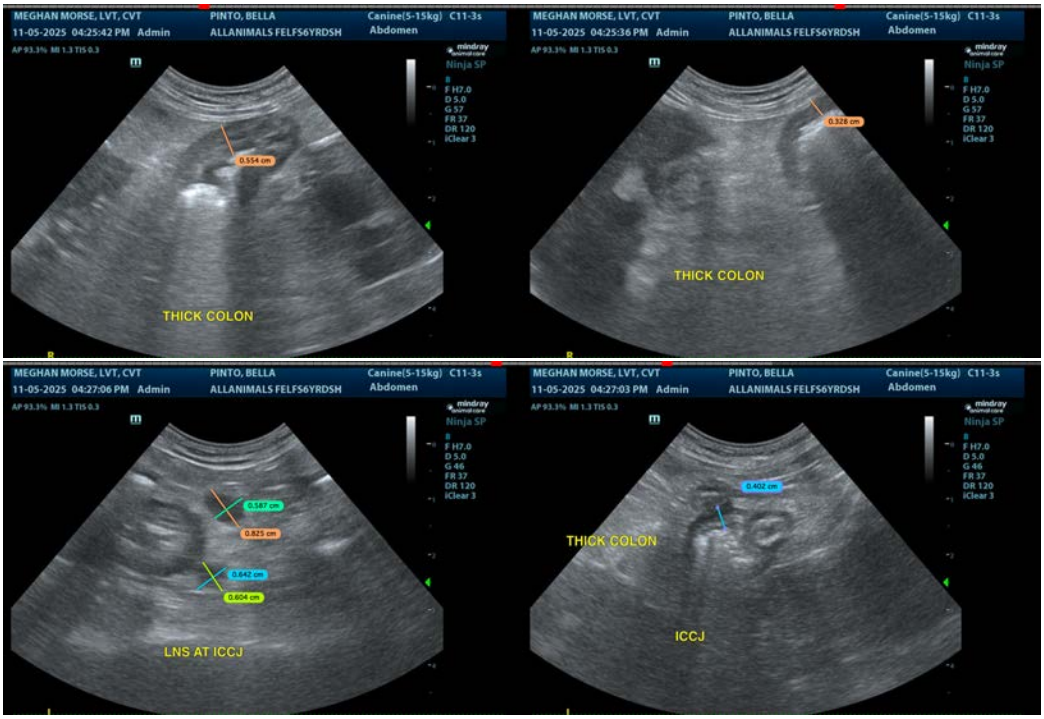
consider a fine needle aspirate of some of the thicker areas of colon wall, or a lymph node at the ileocecal junction. If cytologic sampling is not possible and symptoms are persistent despite treatment for colitis, then surgical biopsies may be warranted. Possible differentials could include inflammatory change (colitis, FIP, granulomatous colitis, etc.) or possibly neoplastic change. If not already done, recommend fecal testing and empirical deworming.

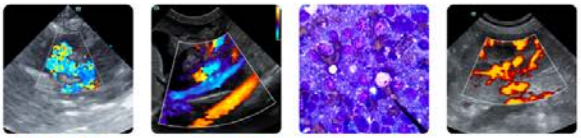
The pancreas appears somewhat prominent in the right limb and body. This could be secondary to inflammation from the colon in this region or could be due to mild pancreatitis as well. A GI panel to Texas A&M could be considered to evaluate a quantitative fPLI, TLI, cobalamin and folate, looking for evidence of small intestinal disease, exocrine pancreatic insufficiency, etc.

Recommend significant supportive care, possibly including a feeding tube if the patient continues not to eat.

There are some areas where there is shadowing intraluminal material visualized within the bowel. These areas are not accompanied by an obstructive pattern, so colon is suspected but retained small intestinal material/foreign material cannot be ruled out.



New Jersey Mobile
FUELED BY SONOPATH VETERINARY ULTRASOUND



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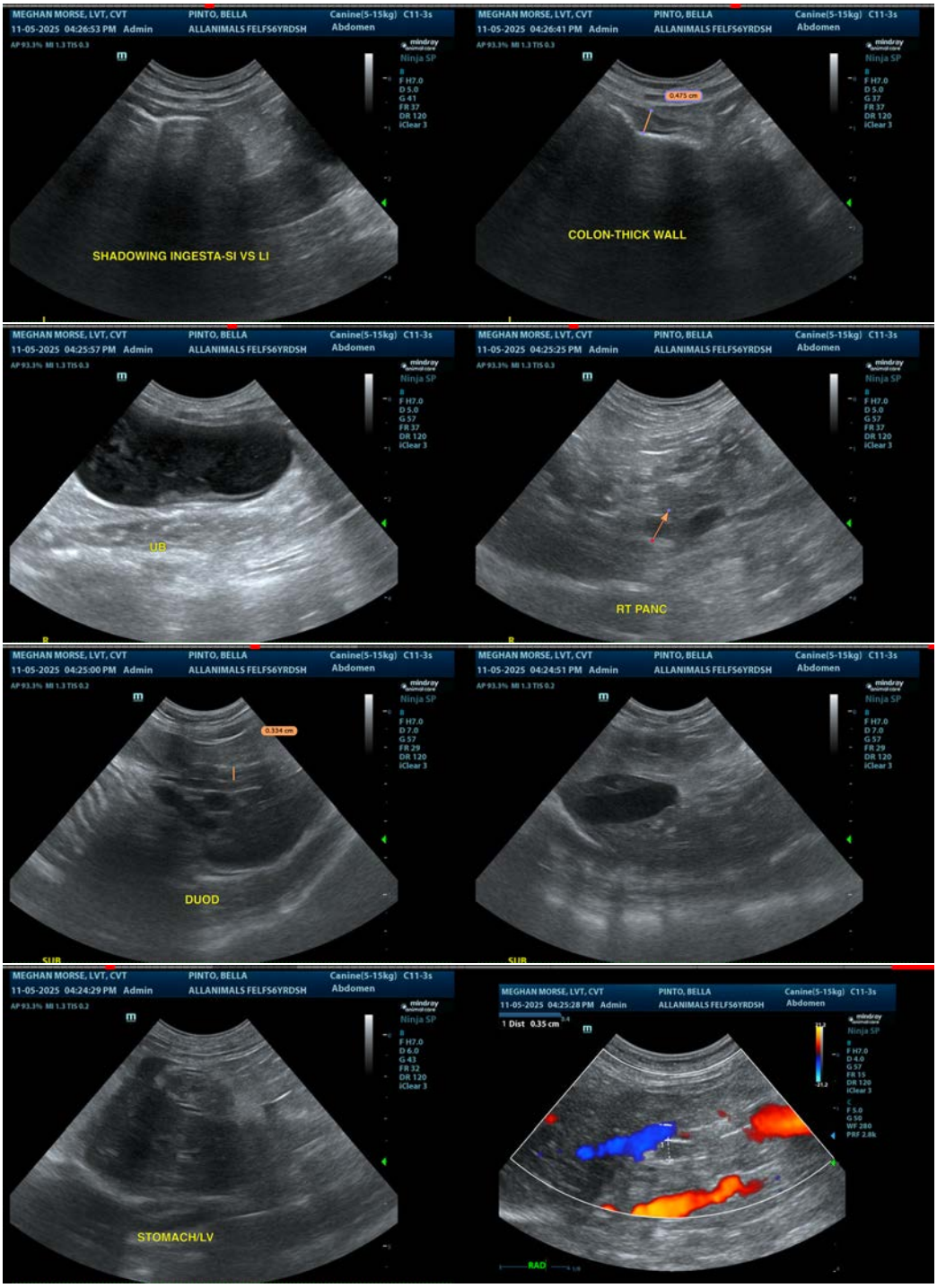

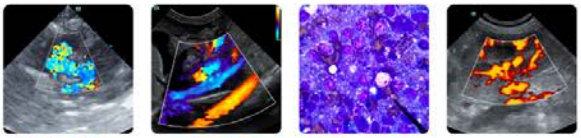

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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