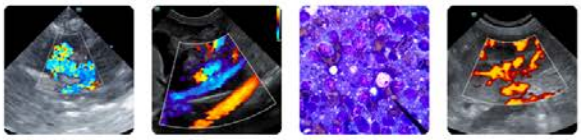


DATE

11/7/25

PATIENT

Bella Frearson

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

8/20/15

WEIGHT

14.3 lbs

INTERPRETED BY

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

HOSPITAL NAME

Hickory Veterinary Hospital

REFERRING VET

Dr. Snyder

INVOICE

71668

PRESENTING CLINICAL SIGNS

Patient History: 10/21/2025 - seen for vomiting - tx ondansetron, cerenia, gabapentin and select protein diet (rabbit) – Did very well until today - stopped eating and vomited small bits of white foam 5 times.

Current Medications: Cerenia 12mg SID, ondansetron, gabapentin
Labwork Results: Labwork not attached, reported as: Initially high ALT 411 and low K+ 2.6, CBC NSF - - UA - unremarkable, lat rad - thickened SI.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Rachel Brilhart, RDMS.

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 (3.84 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 (3.92 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 0.56 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 0.50 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 (0.85 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. There is a moderate amount of non-organized echogenic debris. 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 increased. Bowel loops follow a typical curvilinear path. Duodenum wall measures 0.34 cm. Jejunum wall measures 0.37 cm. Visualized peristalsis appears appropriate. The small intestine appears significantly diffusely thickened with a severely thickened muscularis layer. The duodenum appears corrugated.

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 right limb of the pancreas is prominent and mottled compared to the surrounding isoechoic mesentery. 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 consistent with mild pancreatic remodeling.
- Diffusely thickened small intestine with a severely thickened 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

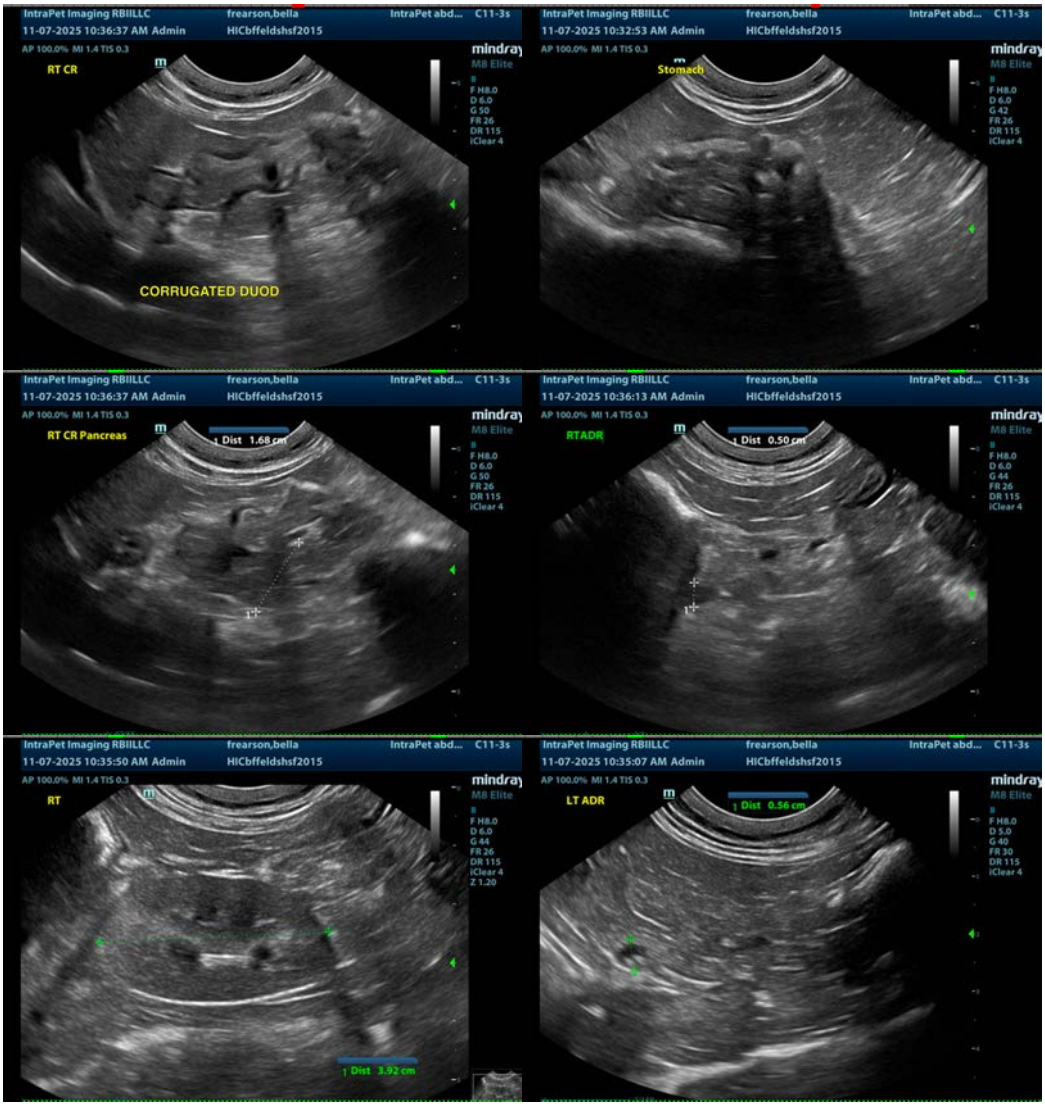
The small intestine is diffusely thickened with a very thickened muscularis layer. These changes are most consistent with severe inflammatory change or early neoplastic change. Additionally, the duodenum appears somewhat corrugated. If vomiting is persistent, consider reevaluation of the duodenum, looking for any progressive change. Additionally, recommend the following:

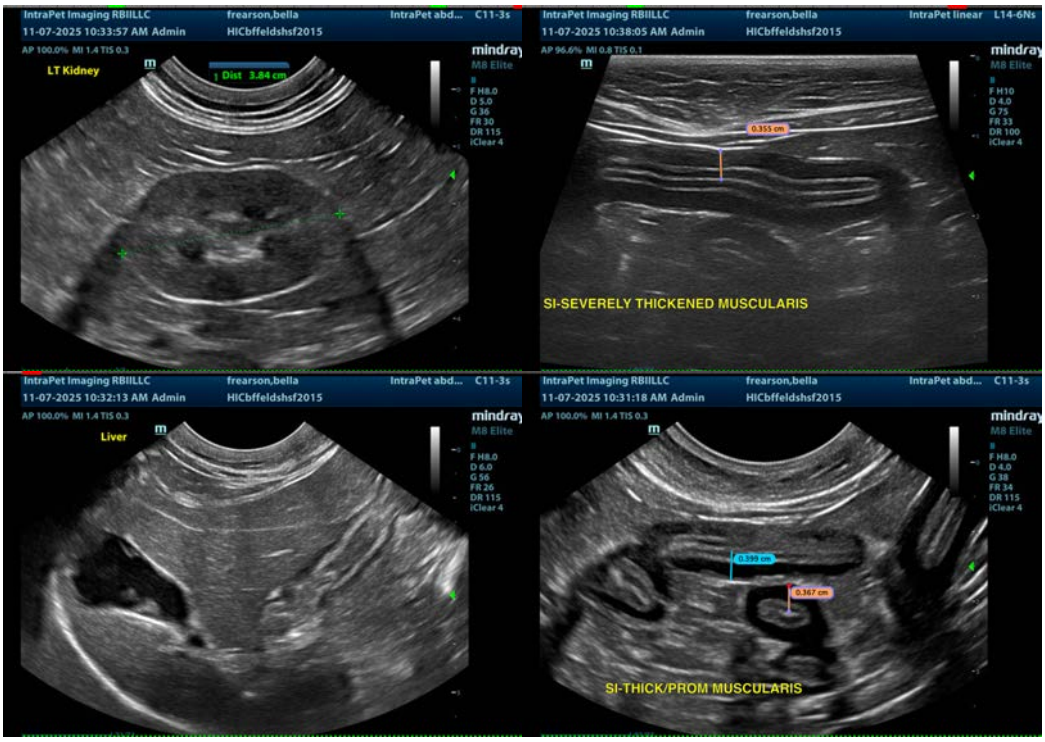
- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.

Per the history, a diet change has already been made. An obvious cause for the relapse in symptoms is uncertain. Recommend symptomatic treatment. Additionally recommend reevaluation of the liver values. Elevation in ALT could reflect a reactive hepatopathy secondary to liver disease or a primary hepatopathy, in which case a liver function test +/- a fine needle aspirate of the liver may be warranted (possibly looking for round cell neoplasia or similar).

If symptoms are persistent, eventually biopsies of the GI tract may be necessary +/- a biopsy of the liver.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement (disregard if this has already been done).





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