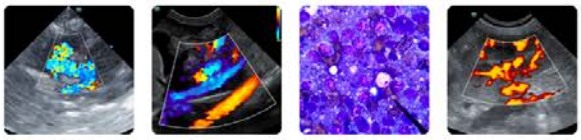


DATE

11/7/25

PATIENT

Simba Workman

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

10/20/16

WEIGHT

10.4 lbs

INTERPRETED BY

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

HOSPITAL NAME

Chadwell Animal Hospital

REFERRING VET

Dr. Olveri

INVOICE

71667

PRESENTING CLINICAL SIGNS

Patient History: 10/21/25 First seen here for lethargy, vomiting. Owner feels pet has lost weight (NO history to compare) ON PE- muscle wasting, sl dehydration, grade I/VI murmur. BW: mild anemia otherwise NR. Informed owner if continuing rec abd US. 11/6/25 Recheck exam - Lethargy, not eating more frequent vomiting/diarrhea. TX sq fluids/cerenia.

Current Medications: Cerenia 0.5ml sq 11/6/25
Labwork Results: Labwork attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Declined.
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 is normal in size but irregular in shape (likely due to previous infarct), measuring 4.13 cm. The cortex is of increased echogenicity, with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There are occasional small medullary mineralizations most consistent with non-obstructive nephroliths, and pyelectasia at 0.33 cm. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The right kidney is borderline small and irregular in shape, measuring 3.09 cm. The caudal pole appears hyperechoic and irregular with poor vascularity. There is 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 pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.45 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 0.59 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 (0.76 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 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.

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. Jejunum wall measures 0.18 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 left limb of the pancreas is prominent and mottled compared to the surrounding isoechoic mesentery. There is a somewhat poorly defined hypoechoic nodule in the left limb measuring 0.34 cm in diameter. There is no evidence of regional mesenteric inflammation or fluid. Prominent pancreatic duct noted.

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

- Decreased corticomedullary distinction in both kidneys with hyperechoic cortices, occasional small mineralizations, and cortical irregularities most consistent with previous infarcts. The caudal pole of the right kidney is very abnormal, possibly consistent with a previous infarct, fibrosis, or less likely a neoplastic lesion. There is mild pyelectasia of the left kidney.

- Pancreatic changes most consistent with chronic pancreatic remodeling and a hypoechoic nodule in the left limb – The nodule has the appearance most consistent with a lymphoid nodule. An early neoplastic lesion cannot be ruled out.

- Diffusely “ropey” small intestine with some areas exhibiting 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

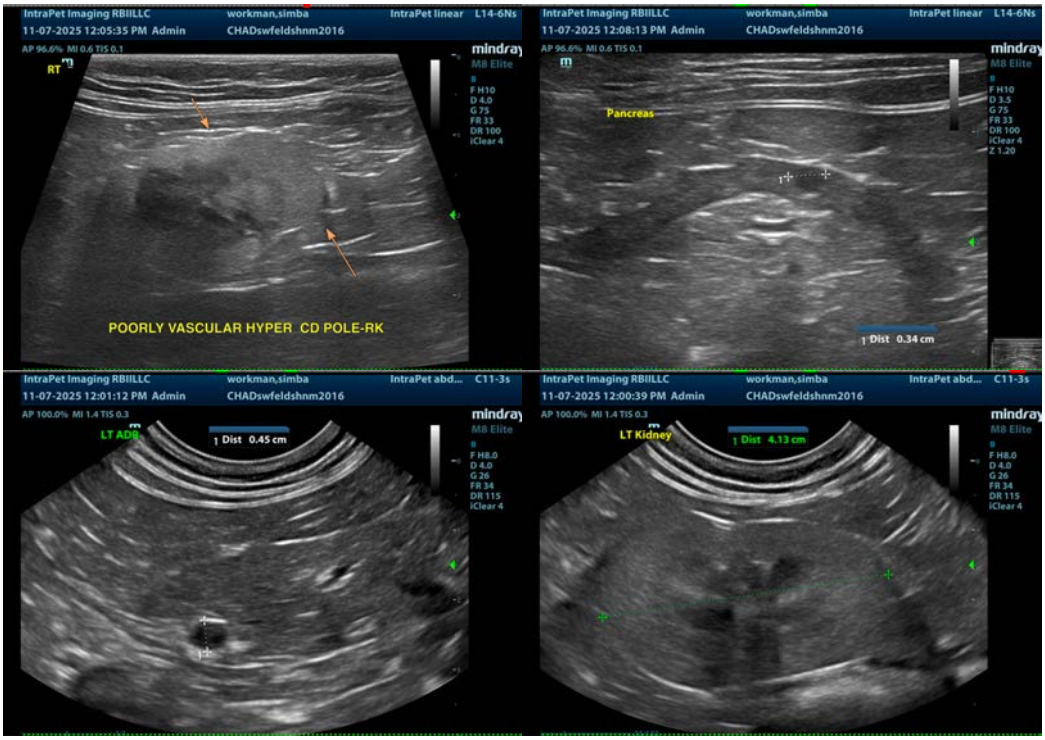
Both kidneys are very abnormal. Despite not being azotemic, consider a blood pressure, urinalysis +/-culture to further evaluate. The caudal pole of the right kidney is hyperechoic and poorly vascular. I suspect this is abnormal scarring/fibrosis, although continued monitoring is warranted for significant change in this region.

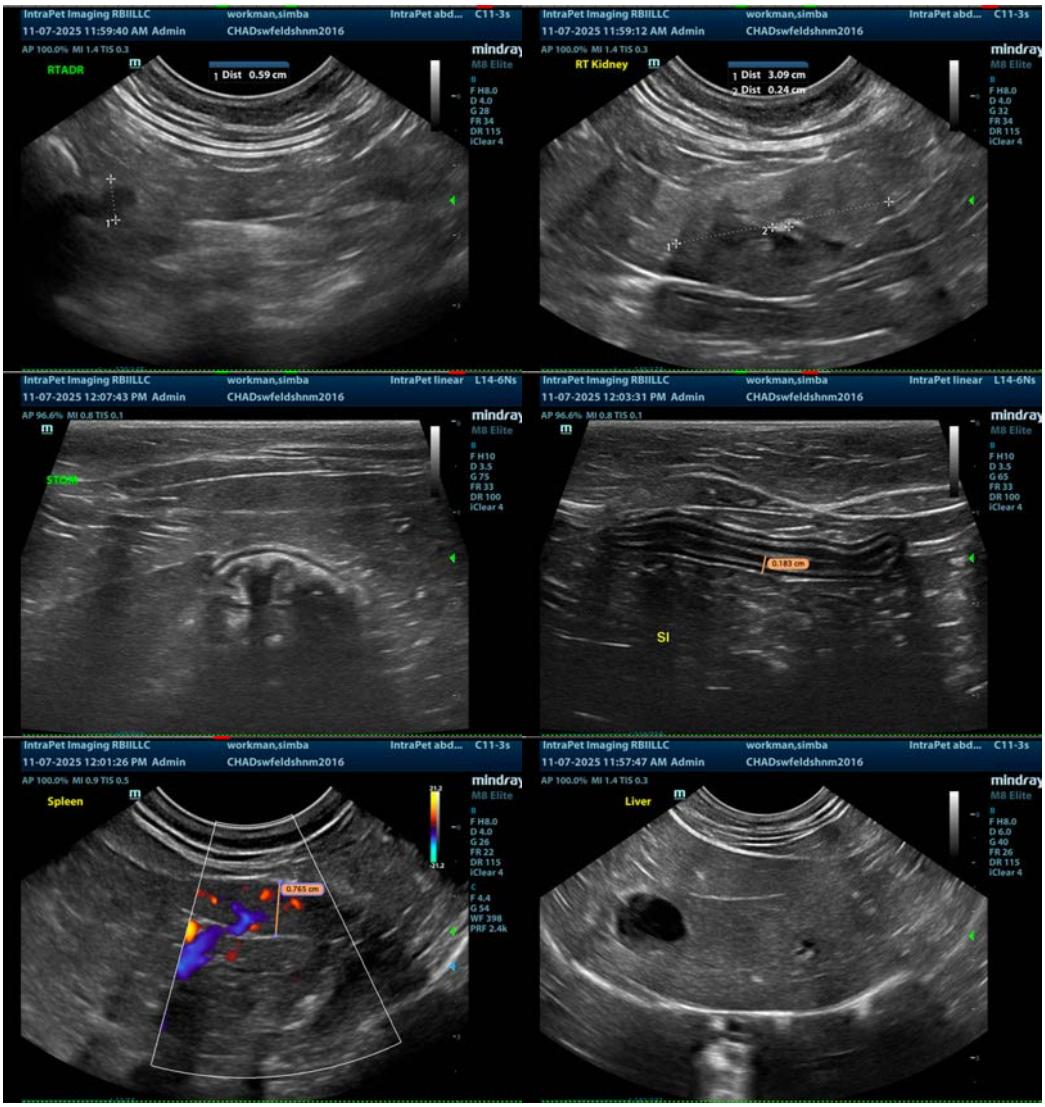
The pancreas is prominent with a hypoechoic nodule. I suspect this represents pancreatic remodeling and a lymphoid nodule but continued monitoring of the hypoechoic nodule is warranted (recheck in 2-3 months).

The small intestine appears somewhat “ropey”. This could be indicative of an underlying inflammatory enteropathy. Based on the vomiting and diarrhea reported, 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.

If GI symptoms are persistent, consider repeat imaging in the future, as biopsies of the GI tract may eventually be warranted.





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)
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