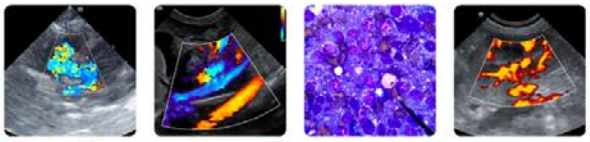


PATIENT

Bill Young

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

16 Years

WEIGHT

6.1 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Gira

HOSPITAL NAME

Argo Vet

REFERRING VET

Dr. Leung

INVOICE

72271

DATE

12/2/25

PRESENTING CLINICAL SIGNS

Pertinent History Presented in clinic for decreased appetite and PU/PD. Bloodwork showed elevated Precision PSL and decreased SDMA. Suspect pancreatitis, admitted for IVF treatment, analgesia, appetite stimulant, and anti-emetic injection. Prescribed cerenia, mirtazapine, aventi gi essential, and buprenorphine. Patient would not eat over the weekend and declined high valued food as well. No improvement seen.

Abnormal PE/Chem/CBC/UA Results: PrecisionPSL 56 U/L 826 SDMA 9.0 ug/dL <15.0

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 (4.37 cm). Overall echogenicity is slightly hyperechoic with mildly reduced corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is a thin, hyperechoic line separating the cortex and medulla, most consistent with medullary rim sign. 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 (4.65 cm). Overall echogenicity is slightly hyperechoic with mildly reduced corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is a scant pocket of free fluid adjacent to the right kidney. 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 0.38 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 0.33 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.

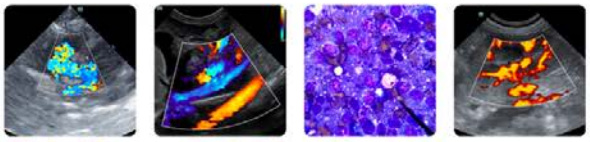
Spleen

The spleen was not clearly 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.



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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 0.22 cm. Jejunum wall measures 0.23 cm. Visualized peristalsis appears appropriate. There are some segments of small intestine that appear more significantly thickened, measuring up to 0.40 cm with a prominent muscularis layer.

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. The descending colon appears somewhat thickened with intact wall layering, measuring at 0.33 cm.

Pancreas

The pancreas is large, prominent, hypoechoic and mottled. The pancreatic duct is prominent in the left limb measuring at 0.21 cm.

Free Abdomen

There is scant free fluid noted. There are occasional prominent lymph nodes. An example of a jejunal lymph node measures 0.29 cm. The omentum is generally of normal echogenicity.

PRIMARY FINDINGS

- Age related changes visualized associated with both kidneys.
- Prominent, hypoechoic, mottled pancreas – Changes are consistent with chronic pancreatic remodeling and likely chronic active pancreatitis.
- Moderate gallbladder debris – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting. Incidental gall bladder debris is less common in cats.
- Prominent small intestine with segmental thickening and 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.
- Scant free abdominal fluid and occasional prominent mesenteric lymph nodes.

SECONDARY FINDINGS

- Spleen not visualized – Findings could be consistent with an absent spleen or small, contracted spleen.

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- Mild medullary rim sign visualized associated with both kidneys – Clinical significance uncertain, can be seen in normal patients and in cases of ethylene glycol toxicity, FIP, chronic interstitial nephritis, and leptospirosis.

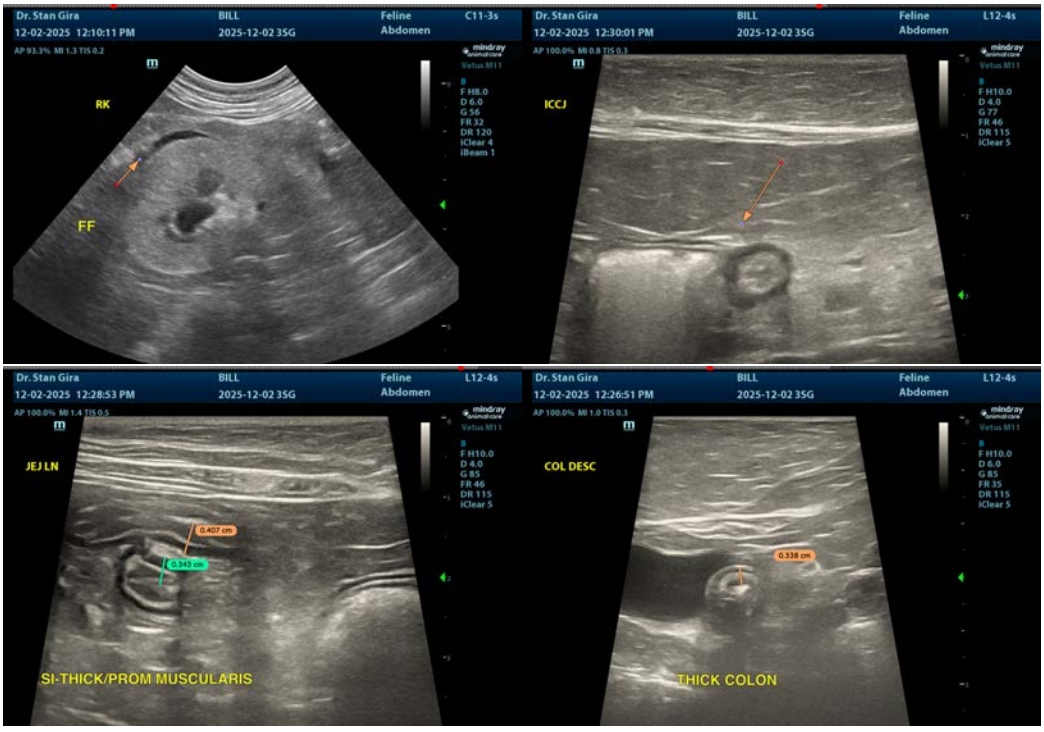
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The pancreas is very prominent, hypoechoic and irregular. Changes are consistent with pancreatic pathology and pancreatic remodeling. Based on the symptoms described, chronic active pancreatitis is suspected.

Additionally, the small intestine exhibits segmental thickening and prominent muscularis layer, concerning for a possible concurrent enteropathy. Consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate, looking for additional evidence of a concurrent enteropathy.

There is a moderate amount of debris visualized associated with the gallbladder with no evidence of significant inflammation or wall thickening. This is atypical for a cat, and there could be some concerns for early Triaditis. Correlate with current lab work, looking for liver enzyme elevations, etc. If this is a concern, you could consider chronic Ursodiol therapy in addition to treatment for an enteropathy and pancreatitis.

Consider placement of a feeding tube if anorexia is persistent, as this may be necessary to get this individual back on its feet and on a selected diet, etc. If symptoms are persistent, GI biopsies may be warranted. If surgical biopsies are obtained, consider biopsy of the pancreas at the same time.



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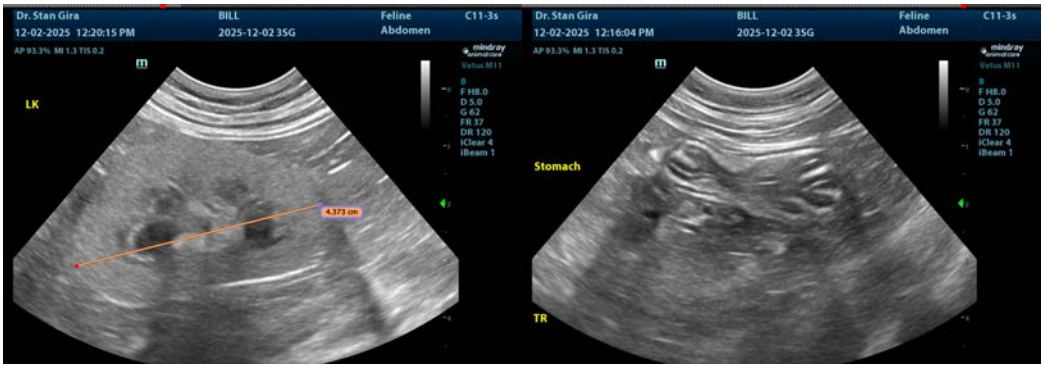

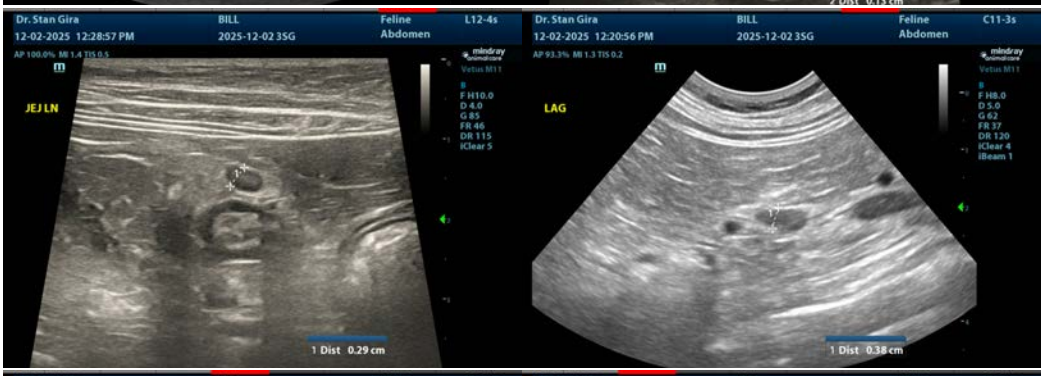

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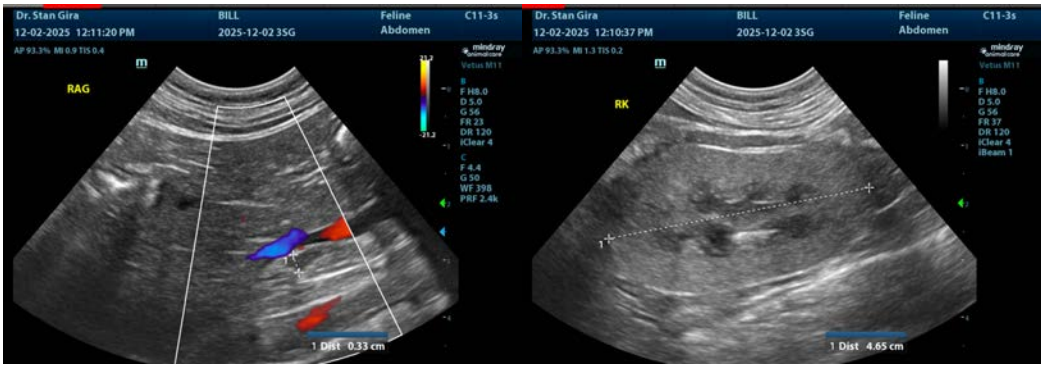

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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