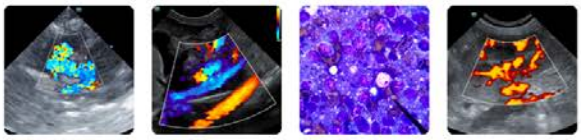




**DATE**

12/2/25

**PATIENT**

Tora Wouters

**SPECIES**

Feline

**BREED**

Siamese

**SEX**

Neutered Male

**AGE**

4/23/12

**WEIGHT**

11.6 lbs

**INTERPRETED BY**

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

**HOSPITAL NAME**

Perry Hall Animal Hospital

**REFERRING VET**

Dr. Hatzigiannakis

**INVOICE**

72259

## PRESENTING CLINICAL SIGNS

**Patient History:** Presented 11/26 as second opinion for chronic vomiting. Emesis has been clear and recent kibble ingestion. Noted grade 2/6 basilar systolic murmur on PE. Has also experienced weight loss. No other abnormalities noted. Hx of kidney disease, doesn't like to eat cat food or kidney food- prefers O's home made diets.

**Current Medications:** Gabapentin: 200mg 12 and 2 hours prior to visit
**Labwork Results:** Labwork not attached, reported as: CBC: elevated MCHC (36.7), monocytosis (0.553k), eosinophilia (3.413k). CHEM: elevated SDMA (15), Creat 2.0 (IRIS stage II). UA: cysto, usg 1.052, pH 6.5, 1+ protein, occ struvite crystals. T4: 2.4 WNL. Spec fPL: 3.0 WNL
**Date of Previous IntraPet Ultrasound:** No previous.
**Sedation:** Alfax/Torb.
**Stat Report:** Not requested.
**Imaging Performed by:** Stephanie Warga RDCS, RVT

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is moderately distended with mild primarily suspended 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 (4.01 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 pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.93 cm). Overall echogenicity is slightly hyperechoic with mildly reduced 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 0.38 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 0.47 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 (0.98 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 to mild fluid distension. Wall thickness is increased. Bowel loops follow a typical curvilinear path. Duodenum wall measures 0.32 cm. Jejunum wall measures 0.34 cm. Visualized peristalsis appears appropriate. The duodenum appears mildly to moderately fluid distended, most consistent with ileus. The jejunum appears severely thickened with a very prominent muscularis layer. Wall layering appears intact.

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 pancreas is mildly prominent and hypoechoic as 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. There is no significant lymphadenopathy. Occasional mesenteric lymph nodes are visualized, examples measure 0.32 cm and 0.33 cm. The omentum is generally of normal echogenicity.

## ULTRASONOGRAPHIC FINDINGS

- Suspended 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.
- Age related changes visualized associated with both kidneys.
- Diffuse thickening of the small intestine with a very 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.
- Mild mesenteric lymphadenopathy – Findings are most consistent with reactive lymphadenopathy.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

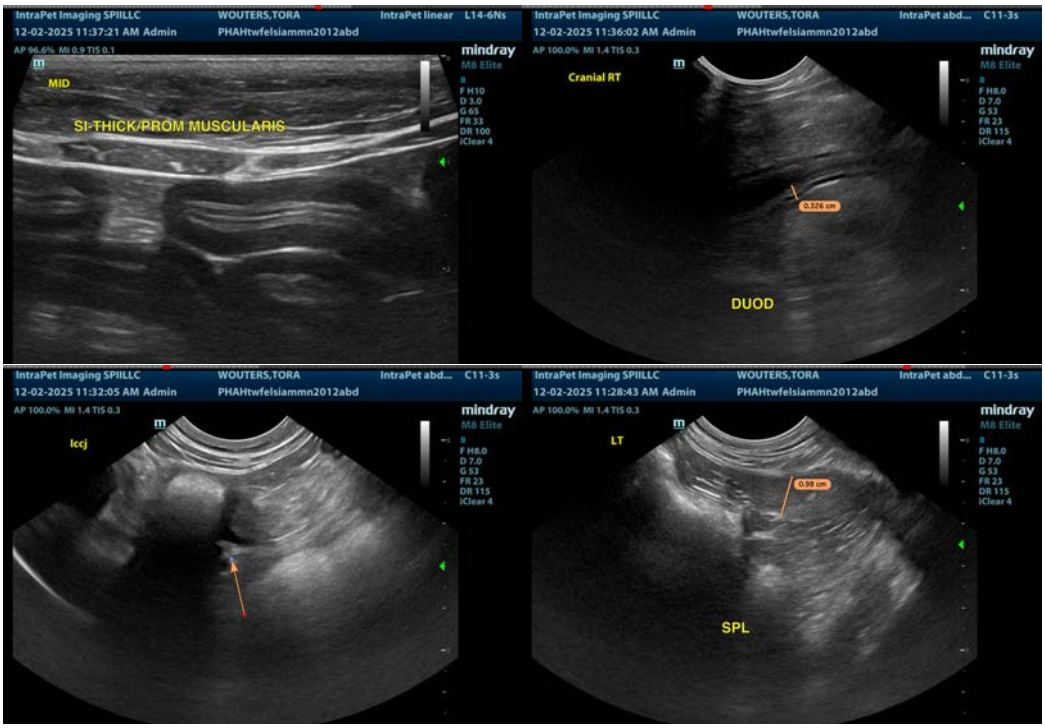
The jejunum is severely thickened with a very prominent muscularis layer. These changes are most consistent with severe inflammatory type change, although early neoplastic change cannot be ruled out.

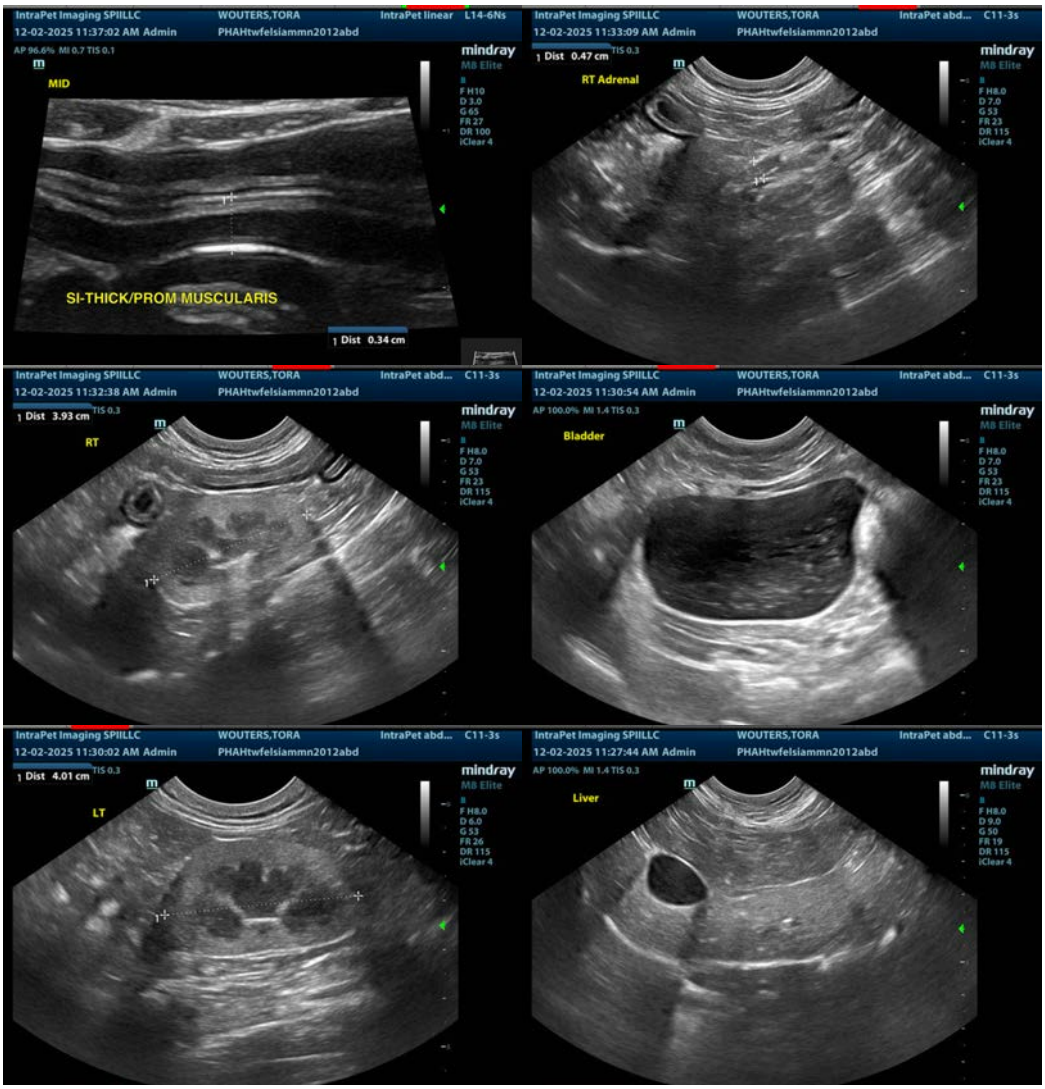
Both kidneys have mildly reduced corticomedullary distinction. The significance of this in the face of intact concentrating ability is uncertain.

Ideally, this pet should be on a hydrolyzed protein prescription diet. If this is not possible due to the patient's finicky appetite, then recommend a nutritionist consultation so that a homemade novel protein diet can be formulated (I've used University of Tennessee's nutrition consultation service previously).

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.

Based on the history provided and the appearance of the GI tract on today's exam, biopsies of the GI tract would be warranted, particularly if empirical therapy is not effective. Consider continued monitoring of the GI tract with ultrasound, looking for progressive thickening or loss of layering, which could indicate progression to a neoplastic process.






**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