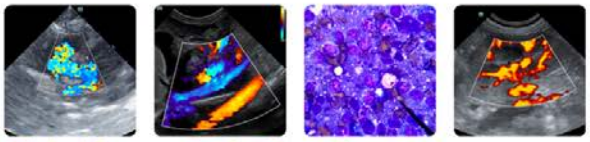


PATIENT

Marlowe Hall

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

12 Years 8 Months

WEIGHT

9.4

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Sarah Green

HOSPITAL NAME

Healing Spirit Animal Wellness

REFERRING VET

Dr. Sarah Green

INVOICE

72745

DATE

12/23/25

PRESENTING CLINICAL SIGNS

History of progressive weight loss, occasional vomiting, no diarrhea. Generally eating well. Prior episodes of suspected hepatic lipidosis 1/2023 and 5/2024

Abnormal PE/Chem/CBC/UA Results: Mild generalized muscle atrophy, unkempt coat, abdomen not overtly painful on exam. ALP=71 (12-59) U/L, cholesterol=79 (91-305) mg/dL remainder of chemistry, CBC, T4, fPL WNL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with a large amount of 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 (3.7 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 (3.87 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 0.37 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.

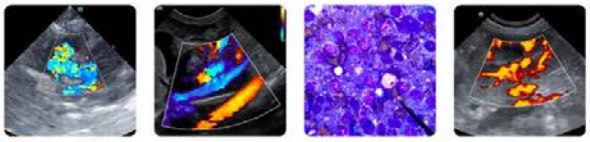
The right adrenal gland is normal in size measuring 0.43 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is normal in size and shape, measuring 0.59 cm, and mildly mottled. The blood flow through the hilus and splenic parenchyma appears normal. There are occasional hyperechoic nodules visualized within the parenchyma, examples measure 0.47 cm and 0.44 cm.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is mildly heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.



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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 bile duct is slightly prominent and measures at the upper end of normal at 0.19 cm.

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. Some sections of the gastric wall appear slightly more prominent with intact wall layering, measuring at 0.49 cm.

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. Some areas have reduced detail of wall layering. Duodenum wall measures 0.34 cm. Jejunum wall measures 0.36 cm. Visualized peristalsis appears appropriate. The small intestine appears diffusely thickened with a diffusely prominent muscularis layer. Some focal section of bowel appear more significantly thickened with reduced detail of wall layering, measuring up to 0.47 cm.

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 area of the pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

There is scant free fluid present. There is a mild mesenteric lymphadenopathy with clusters of hypoechoic, prominent mesenteric lymph nodes. Examples measure 0.53, 0.66, and 0.57 cm. The omentum is mildly diffusely hyperechoic.

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.
- Mildly mottled spleen with hyperechoic nodules – The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis. The hyperechoic nodules have the appearance most consistent with benign myelolipomas, although other differentials are possible.
- Mildly heterogeneous liver – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.
- Mildly thickened gastric wall with intact wall layering - Findings could be consistent with artifact, mild gastritis, or less likely early infiltrative disease.

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- Diffusely thickened small intestine with a prominent muscularis layer and some areas displaying more significant thickening with reduced detail of wall layering. Findings are concerning for early neoplastic change or severe inflammatory change.
- Prominent mesenteric lymph nodes – Findings are most consistent with reactive lymph nodes, although early neoplastic change cannot be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine appears diffusely thickened with a prominent muscularis layer. There are some sections of bowel that have mild fluid distention, and others that exhibit more significant thickening with reduced detail of wall layering. These changes are concerning for early infiltrative change (round cell neoplasia, other), although severe inflammatory disease cannot be ruled out at this time. Biopsies would likely be necessary to definitively differentiate.

There are clusters of prominent mesenteric lymph nodes, but these currently have somewhat of a reactive appearance. If progressive enlargement occurs, a fine needle aspirate could be considered for cytologic evaluation.

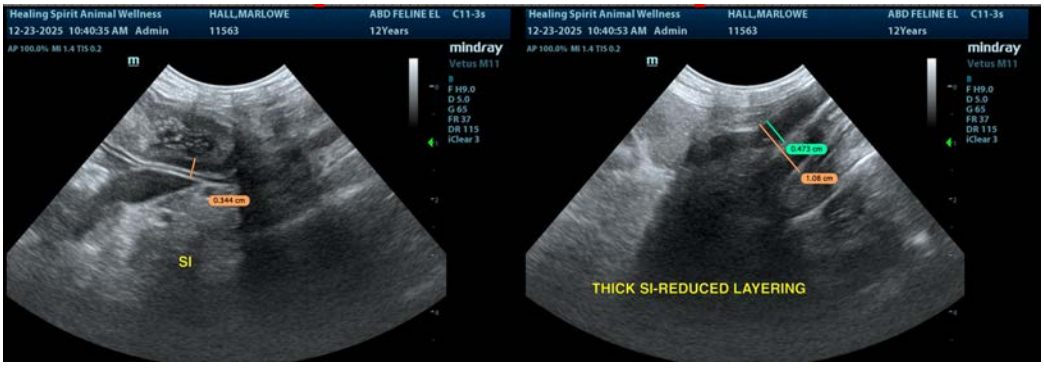
The liver appears mildly heterogeneous. This is a subjective finding. If liver enzyme values continue to rise, you could consider a fine needle aspirate of the liver (provided coagulation parameters are normal).

Additionally, the spleen is somewhat mottled but not enlarged. The hyperechoic nodules noted are most consistent with benign myelolipomas. Recommend continued monitoring of the spleen. If there is progressive change, consider a fine needle aspirate.

There is echogenic debris in the urinary bladder. Correlate with urinalysis +/- culture.

Consider symptomatic treatment for gastroenteritis along with a hydrolyzed protein prescription diet. Consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate, looking for a B12 deficiency, etc. Ideally, biopsies of the GI tract should be considered to further evaluate and look for sampling of more thickened/abnormal sections of bowel. If this is not an option, consider conservative treatment for inflammatory bowel disease and repeat imaging in the future, looking for the progression of today's lesions, as an early neoplastic process is a significant concern.

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



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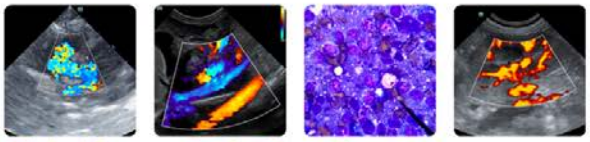

Clinical Sonography & Telecytology
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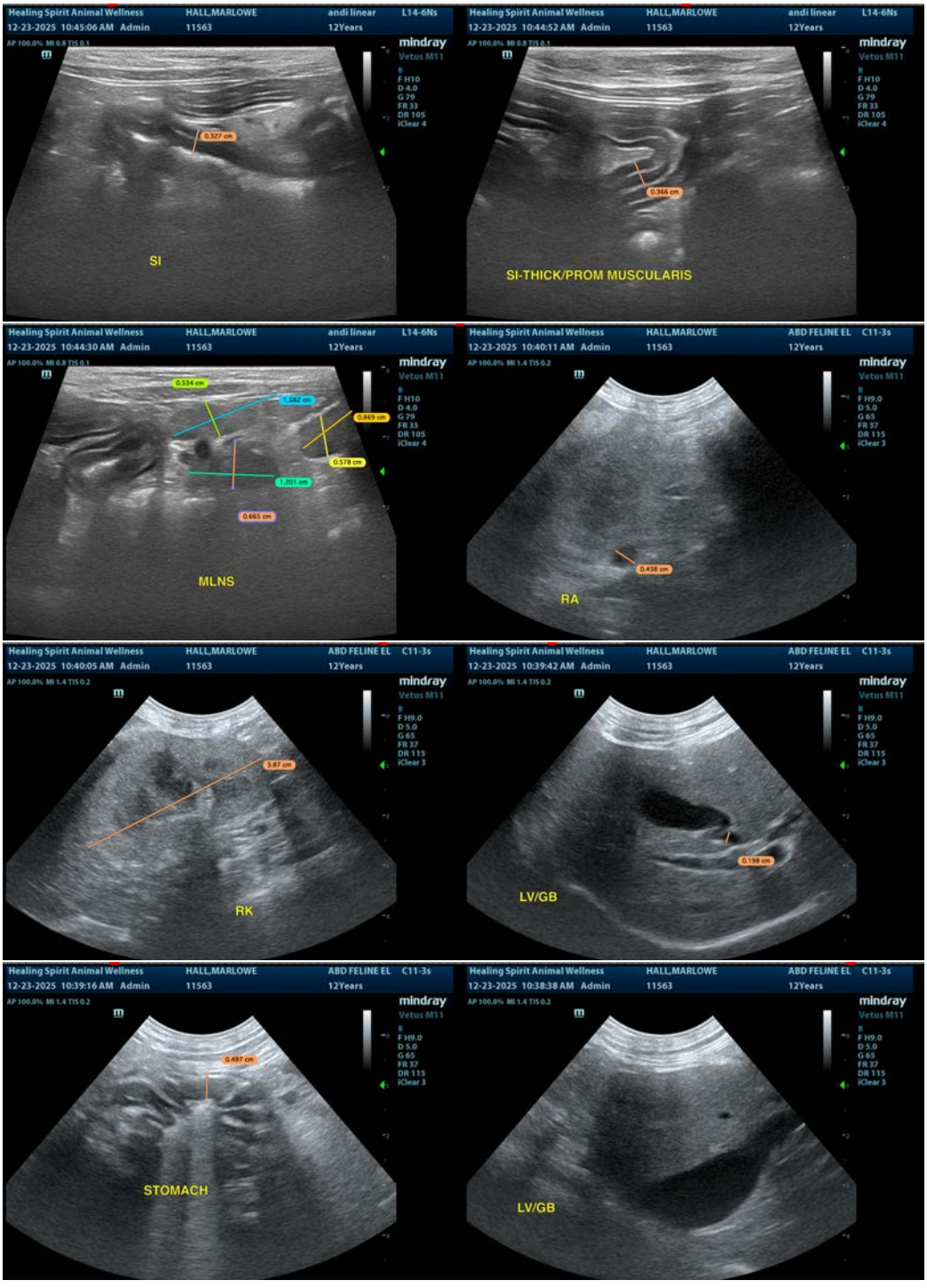

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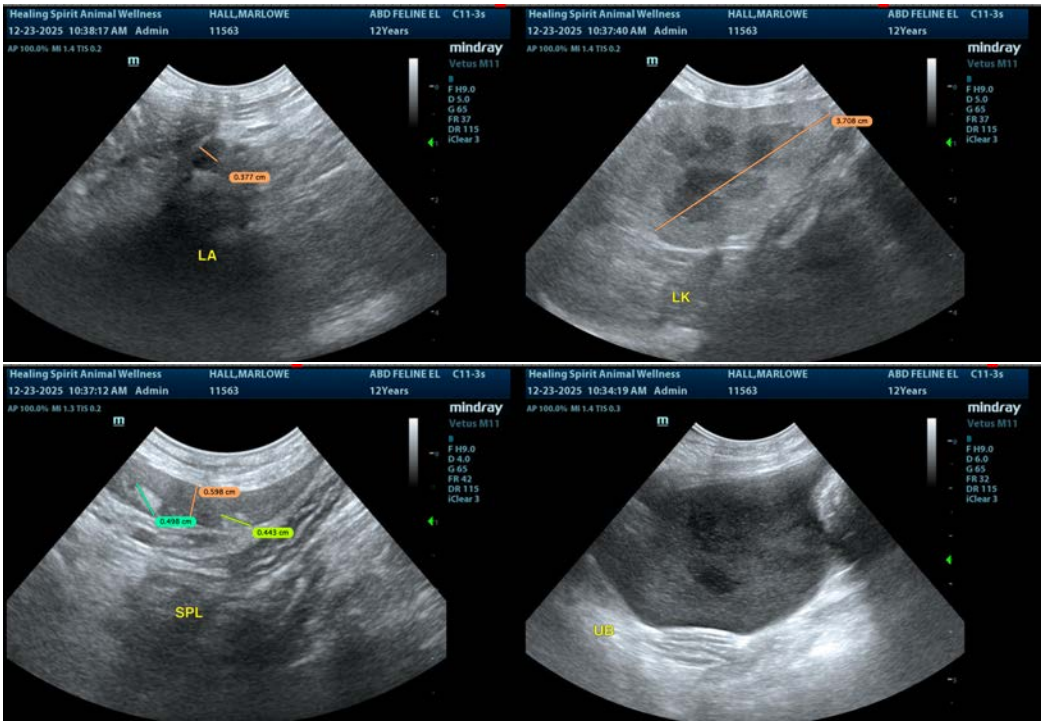

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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