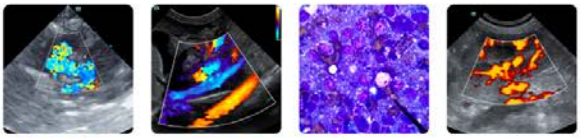


PATIENT

David Bowie Hearts Rescue

SPECIES

Feline

BREED

DSH

SEX

Male

AGE

11 Years

WEIGHT

12.7 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Kerri Becker

HOSPITAL NAME

Millburn Veterinary Hospital

REFERRING VET

Dr. Rotside

INVOICE

72287

DATE

12/3/25

PRESENTING CLINICAL SIGNS

Wt loss.
Abnormal PE/Chem/CBC/UA Results: ALB-2.4 Glob-6.1

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 (3.83 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 (3.75 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.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.35 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 0.37 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.

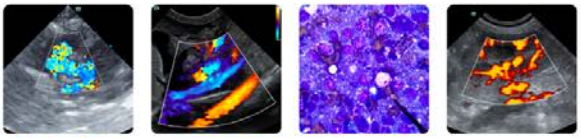
Spleen

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.



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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. Jejunum wall measures 0.18 cm. Visualized peristalsis appears appropriate. Some sections of small intestine appear segmentally thickened with a prominent muscularis layer. An example measures 0.22 cm.

Sections of colon are visualized with formed fecal material and gas shadowing distally. The descending colon is prominent and thickened, visualized from caudal to the left kidney at the level of the urinary bladder measuring up to 0.62 cm with significantly reduced wall layering.

Pancreas

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

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is no evidence of a diffuse lymphadenopathy. In the cranial abdomen caudal to the stomach there is a focal hypoechoic mass effect measuring 1.16 cm x 1.72 cm, most consistent with a large lymph node, although a mass effect involving the pancreas, bowel, etc. cannot be ruled out. The omentum is hyperechoic around the cranial abdominal mass and the thickened colon wall.

ULTRASONOGRAPHIC FINDINGS

- Age related changes visualized associated with both kidneys.
- Segmental thickening of the small intestine with 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.
- Severe thickening/irregularity and reduced detail of wall layering of the descending colon – Findings are concerning for infiltrative neoplasia, although severe colitis is possible.
- Cranial abdominal mass lesion – Findings are most concerning for an enlarged lymph node, although a pancreatic mass lesion or bowel mass lesion cannot be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The descending colon appears severely thickened and irregular with reduced detail of wall layering/absent wall layering. Recommend a fine needle aspirate of the colon wall.

Additionally, in the cranial abdomen caudal to the stomach there is a large, hypoechoic mass effect most consistent with an abnormal lymph node. This is in the region of the pancreas and bowel, so an association between these structures cannot be ruled out. Consider fine needle aspirate for cytologic

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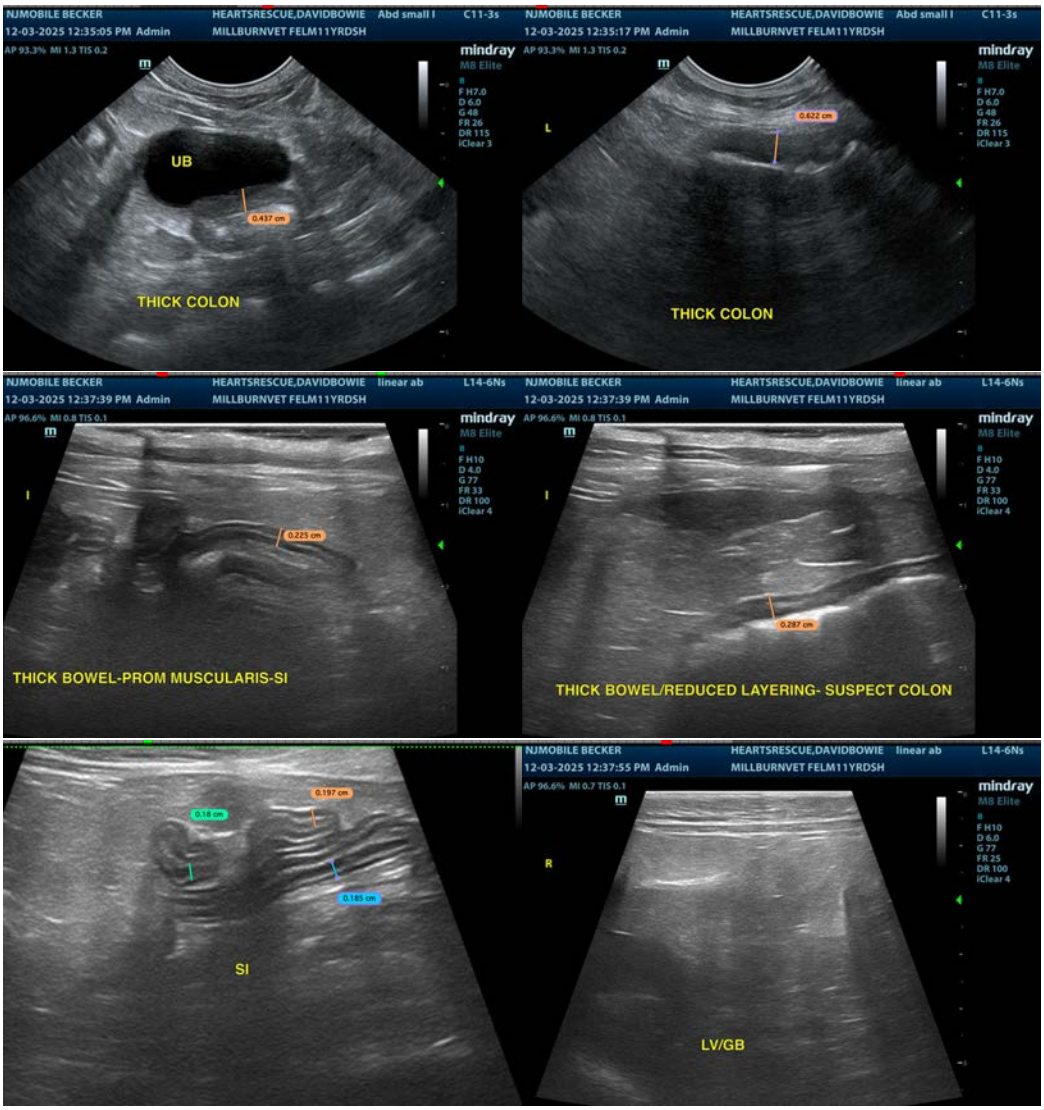
evaluation.

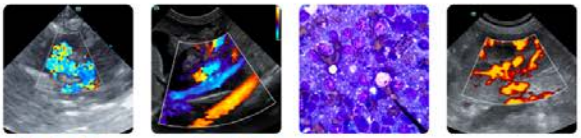
There are some sections of small intestine that appear more significantly thickened with prominent muscularis layer. These changes are most consistent with significant inflammatory type change or possibly even early neoplastic change.

If cytologic diagnosis cannot be obtained, surgical biopsies may need to be considered.

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



New Jersey Mobile
FUELED BY SONOPATH VETERINARY ULTRASOUND



Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath www.SonoPath.com info@sonopath.com 800.838.4268

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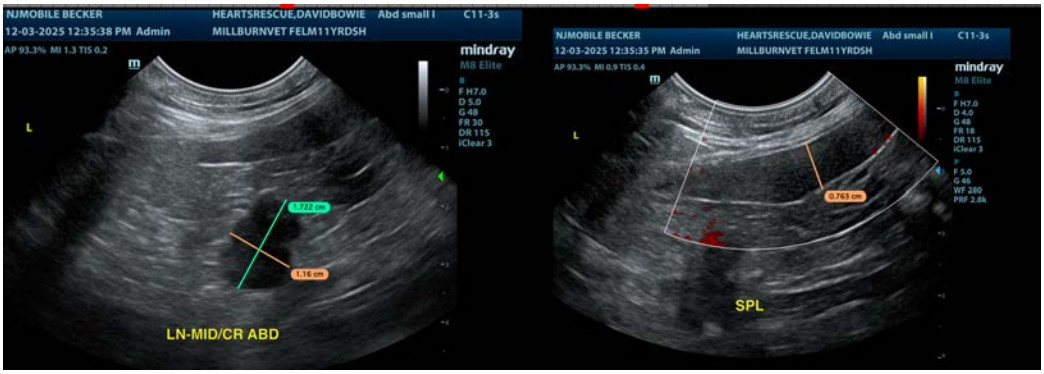

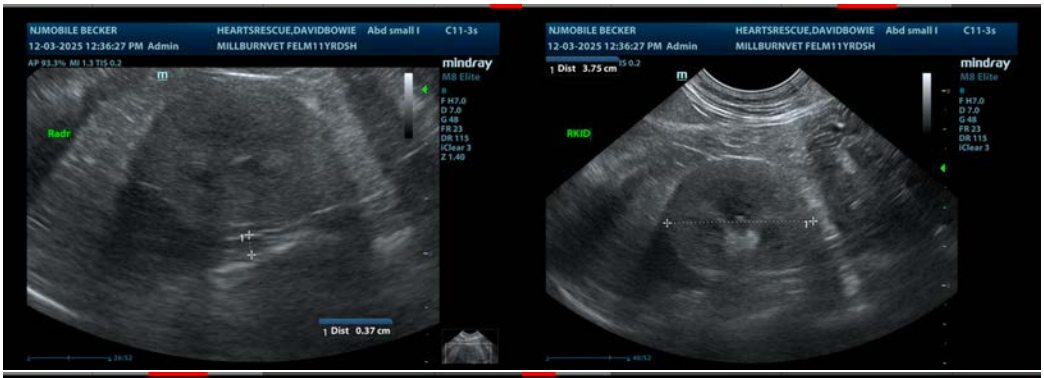

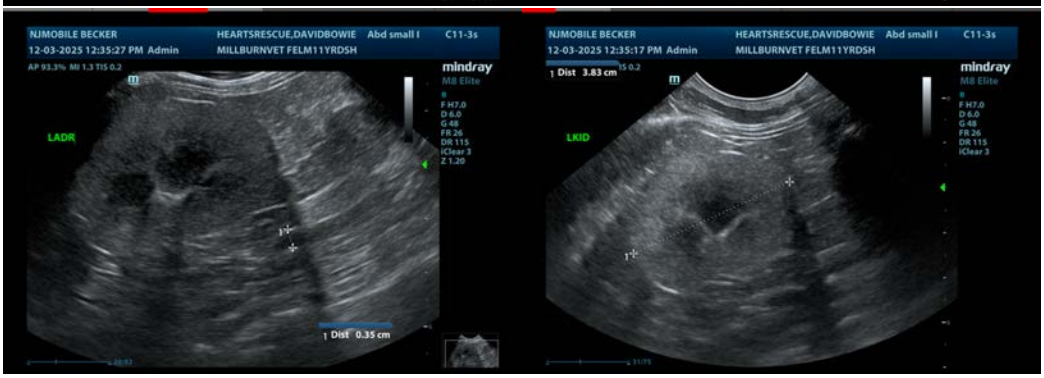

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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