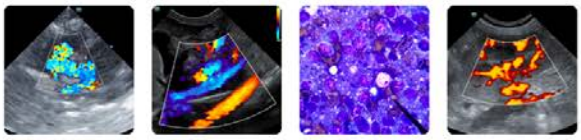


DATE

12/4/25

PATIENT

Dennis Gaskin

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

10/21/12

WEIGHT

3.21 kg

INTERPRETED BY

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

HOSPITAL NAME

Eastern Animal Hospital

REFERRING VET

Dr. Perez

INVOICE

72363

PRESENTING CLINICAL SIGNS

Patient History: Chronic hyporexia since July 2025. Weight loss more dramatic within the last month (0.59 kg). Now chronic intermittent vomiting since October 27th.

Current Medications: Started miratax today.
Labwork Results: Labwork attached, reported as: Sent out BW/UA today.
Most recent labs: 9/26/25- ALT 152, CREA 1.9; CBC: suspected bands; UA 1.037 2 WBC/HPF, RBC > 50/HPF, rods present and suspect cocci.
AXR: 9/26/25- Radiographic Conclusions/Recommendations: Gastric foreign bodies (possibly bones). These may be able to dissolve and pass on their own. The appearance of the small intestine within the mid to caudal abdomen could be due to functional ileus, infiltrative disease, or less likely, early mechanical obstruction. Abdominal ultrasound could be considered for further evaluation and to further evaluate the patient's chronic hyporexia. After amoxicillin course x 7- 10/06/2025- UA: USG 1.039, cocci suspected present but negative urine culture
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Rachel Brilhart, RDMS.

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 (4.15 cm). The cortex is of increased echogenicity 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 is normal in size. It slightly bulges at the caudal pole where there is an expansile hypoechoic, slightly echogenic, poorly vascular region measuring 1.78 cm x 1.8 cm in the sagittal view. The cortex is of increased echogenicity. 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 0.42 cm at the caudal pole, with occasional pinpoint mineralizations. 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 0.44 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 large with rounded margins, measuring 1.16 cm. 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 increased. Bowel loops follow a typical curvilinear path. Some areas have reduced detail of wall layering. Jejunum wall measures 0.27 cm. Duodenum wall measures 0.30 cm. Visualized peristalsis appears appropriate. The muscularis layer is diffusely prominent in the jejunum, and there are focal sections of bowel that appear more significantly thickened with reduced detail of wall layering. In these areas the bowel wall measured up to 0.43 cm in 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 right limb of the pancreas is prominent and mottled 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
There is scant free fluid. There is a moderate/severe mesenteric lymphadenopathy. Examples of lymph nodes in this region measure 1.35 cm x 2.77 cm, 2.12 cm x 0.84, 0.73 cm x 0.39 cm, and 0.82 cm x 1.34 cm. The omentum is diffusely hyperechoic.

PRIMARY FINDINGS

- Large, rounded spleen – Possible differentials could include anatomic variation (large cat), congestion, splenitis, lymphoid hyperplasia, or infiltrative neoplasia.

- Expansile, hypoechoic, echogenic, poorly vascular region at the caudal pole of the right kidney – Possible differentials could include an echogenic cyst, an abscess, an early mass lesion, etc.

- Diffusely thickened small intestine with prominent muscularis layer and focal sections of bowel with more severe thickening and loss of layering – Findings are highly concerning for infiltrative neoplasia. Severe inflammatory disease is possible.

- Moderate/severe mesenteric lymphadenopathy – The moderate mesenteric lymphadenopathy could be concerning for a neoplastic process, although you can see significant lymphadenopathy in some cases of autoimmune/inflammatory disease, infectious disease(tick born disease-such as

bartonella, fungal infections, FIP (cats)) etc. A fine needle aspirate with cytology is recommended for further evaluation.

SECONDARY FINDINGS

- Mild suspended echogenic debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.

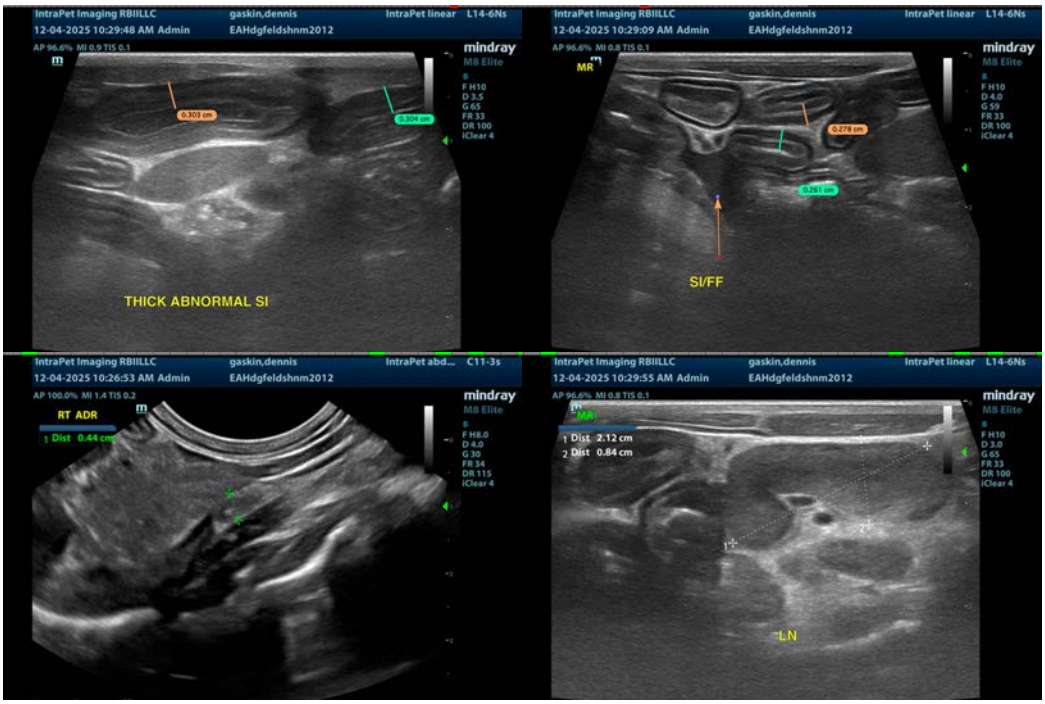
- Pancreatic changes most consistent with pancreatic remodeling in both limbs.

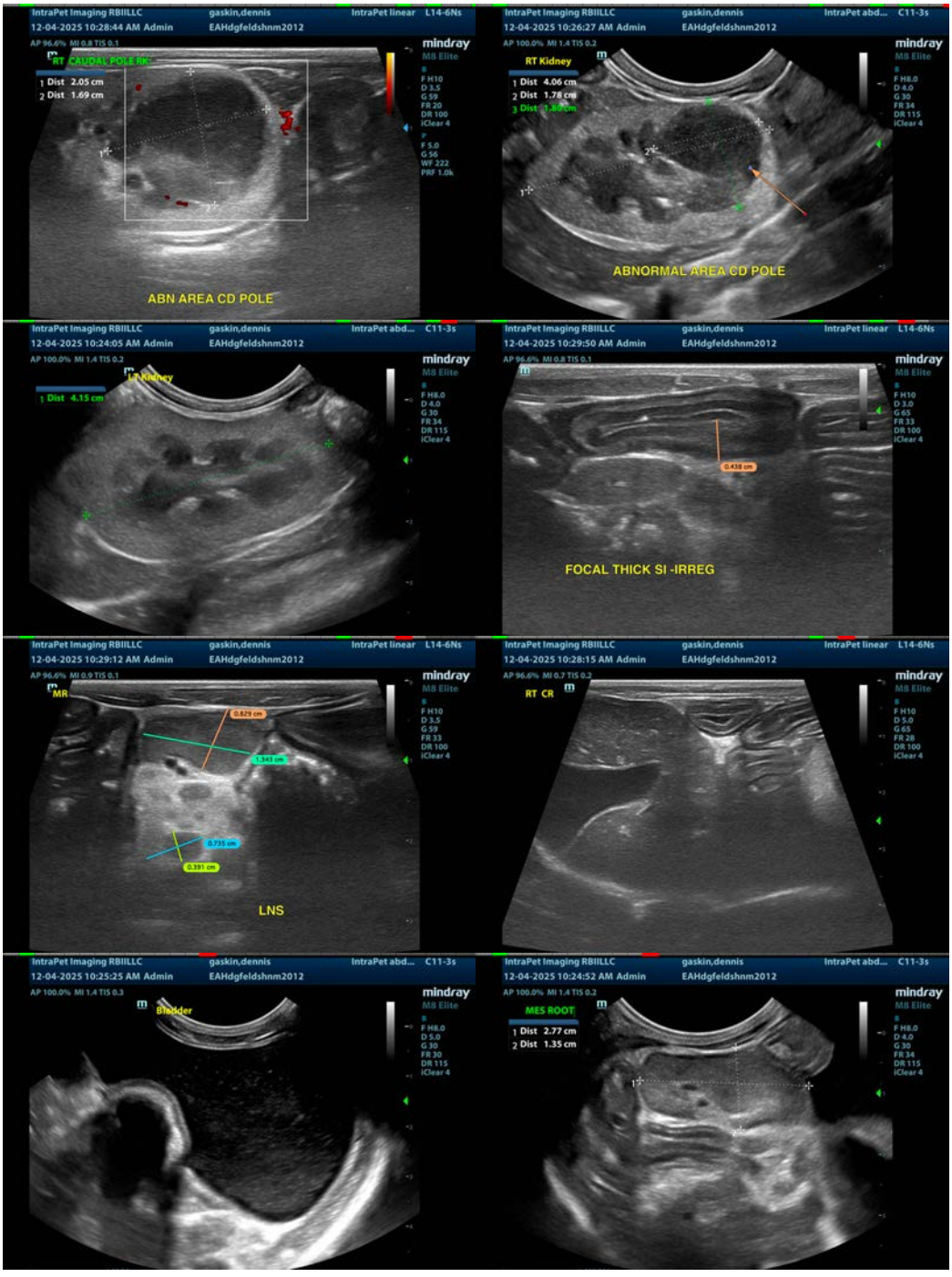
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The combination of the severely enlarged mesenteric lymph nodes, the large spleen, and the thickened bowel with loss of layer is highly concerning for multicentric round cell neoplasia, although a definitive discrete mass effect is not visualized. Recommend a fine needle aspirate of a mesenteric lymph node for cytologic evaluation.

Additionally, there is an atypical hypoechoic region associated with the caudal pole of the right kidney. This is poorly vascular and appears somewhat expansile with echogenic hypoechoic appearance surrounded by a hyperechoic cortex. Options to further evaluate could include a fine needle aspirate (provided coagulation parameters and blood pressure are normal) or continued following with ultrasound (recheck in 4-6 weeks).

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

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RT CAUDAL POLE RK
1 Dist 2.05 cm
2 Dist 1.69 cm
ABN AREA CD POLE
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RT Kidney
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2 Dist 1.78 cm
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FOCAL THICK SI -IRREG
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IntraPet linear L14-6Ns
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MR
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1.343 cm
0.735 cm
0.391 cm
LNS
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RT CR
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12-04-2025 10:25:25 AM Admin
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Bladder
IntraPet Imaging RBIILLC
gaskin,dennis
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MES ROOT
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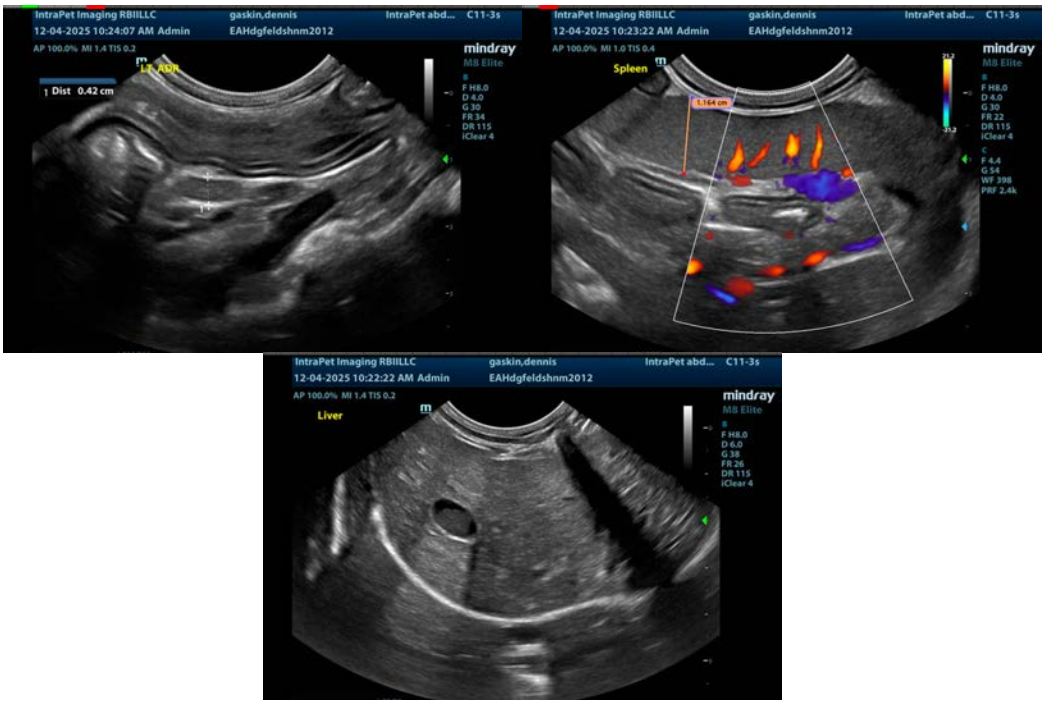
2 Dist 1.35 cm



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.

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