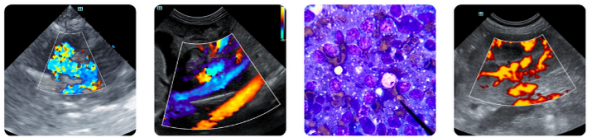


PATIENT

Karl Bowen

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

11 years

WEIGHT

4.9 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Lacovides

HOSPITAL NAME

Tuxedo Animal Hospital

REFERRING VET

Dr. Anderson

INVOICE

10863

DATE

12/4/2025

PRESENTING CLINICAL SIGNS

October 14/2025 came in for weight loss and excessive drinking Owner noted that the weight loss started in the summer of 2025 Is outside all summer Diet is 1 can of wet food a day, some dry food and sometimes treats/snacks 26% weight loss (was 6.7kg in March 2024 and went down to 4.92kg in October 2025) Cat eats well. BM unknown (outdoor cat) T4 : 22 Urine cytology 1.022 no proteinuria CBC/Chem 17 : Stage 1 IRIS Occult UTI – NEG.

Abnormal PE/Chem/CBC/UA Results: CBC: WBC 13.28 x10e9/l (2.87-17.02) Neut 10.6 (2.3-10.29) CHEM: BUN 12.7 mmol/l (5.7-12.9) Crea 126 umol/l (71-212) UA: usg 1.022 TT4 normal.

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 (3.89 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 (4.01 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 0.49 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.

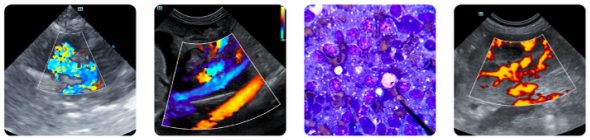
The right adrenal gland is normal in size measuring 0.41 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (1.04 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.



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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 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 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. The duodenum measured 0.26 cm in diameter and the jejunum measured 0.21 cm in diameter. Visualized peristalsis appears appropriate. Theres segmental areas of small intestine which have more pronounced thickening of the 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. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is prominent and mottled in the left limb. 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 are occasional prominent mesenteric lymph nodes. The lymph node near the ileocecal junction measures 0.38 cm. A jejunal lymph node measures 0.29 cm. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Pancreatic changes most consistent with chronic pancreatic remodeling +/- mild chronic pancreatitis.
- Segmental thickening of the small intestine with some areas exhibiting a thickened 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 reactive lymphadenopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There are some sections of small intestine which appear somewhat thickened with a prominent muscularis layer. These are inflammatory type changes. Although, an early neoplastic process cannot be ruled out. Recommend further evaluation for a primary enteropathy.

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)

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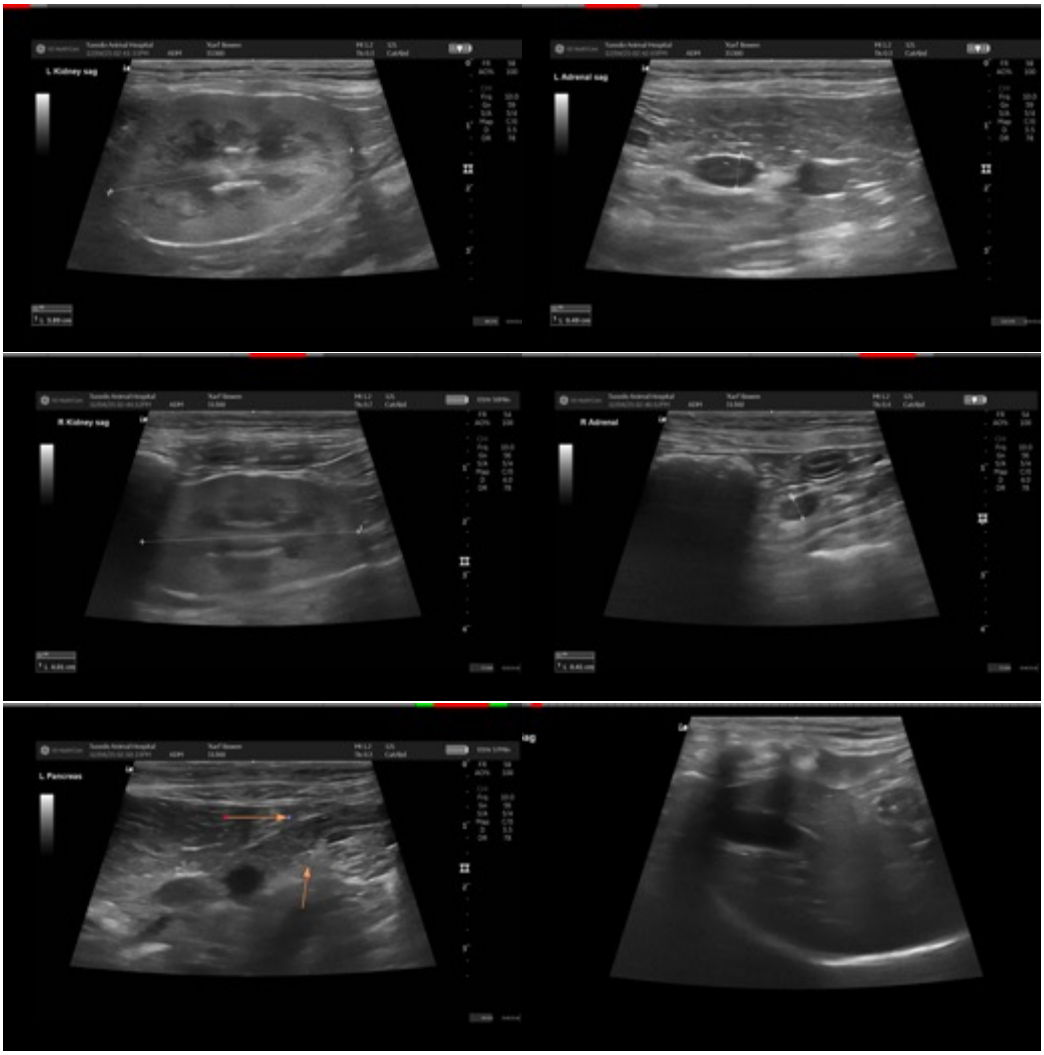
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.

If weight loss is persistent recommend obtaining biopsies of the GI tract for further evaluation.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.

Prior to obtaining biopsies, you could consider repeat imaging looking for the progression of today's lesions.



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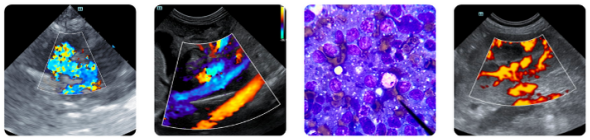

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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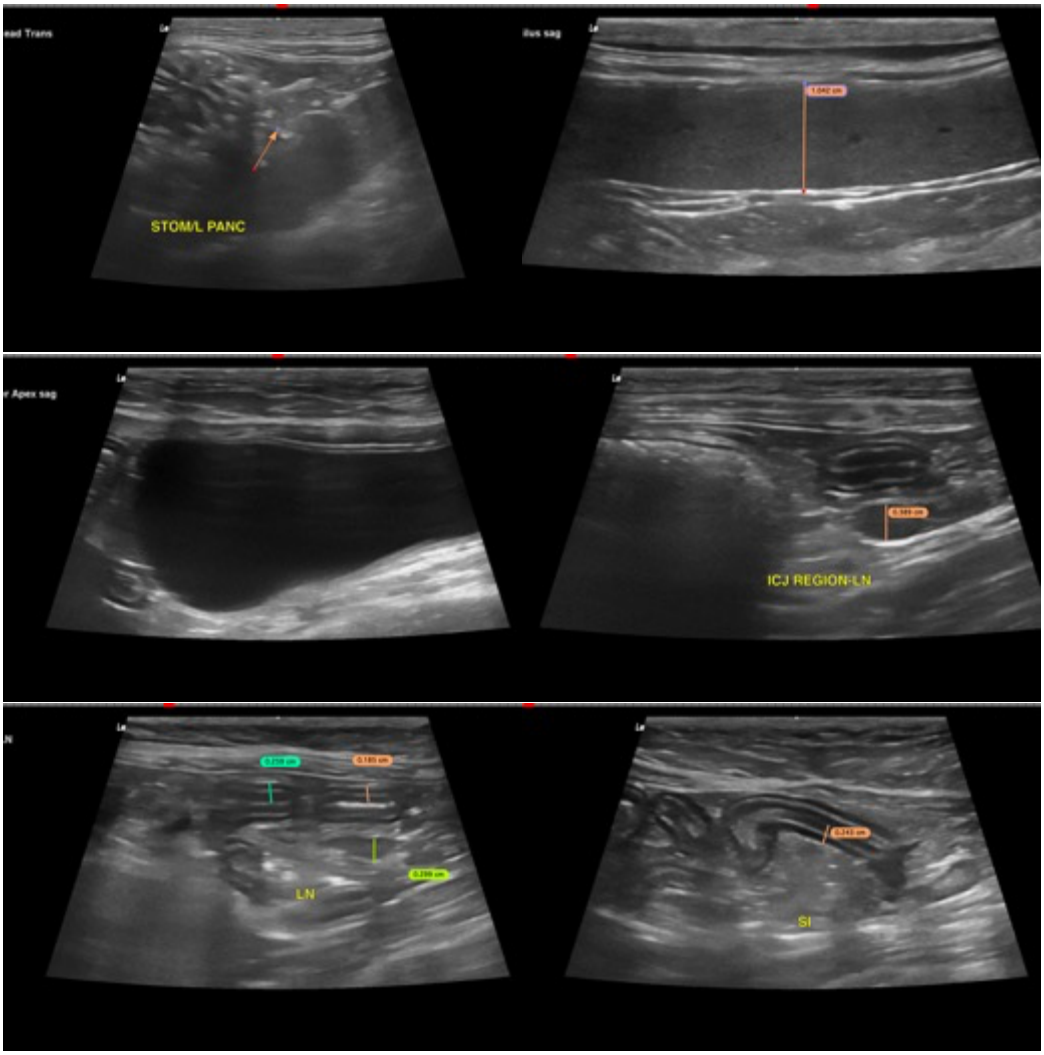

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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