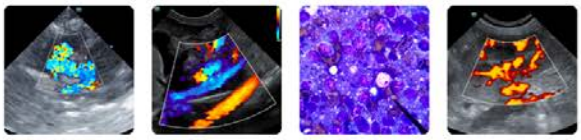




**DATE**

12/9/25

**PATIENT**

Christopher McCormack

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

10/11/11

**WEIGHT**

6.9 lbs

**INTERPRETED BY**

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

**HOSPITAL NAME**

Chadwell Animal Hospital

**REFERRING VET**

Dr. Oliveri

**INVOICE**

72437

## PRESENTING CLINICAL SIGNS

**Patient History:** 11/11/25 New Patient: presented for chronic URI and vomiting for "two weeks: Severe dental disease, 10^% dehydrated, muscle wasting, Grade II/VL murmur.

**Current Medications:** Cerenia, Clavamox
**Labwork Results:** Labwork attached, reported as: BW: anemia, increased WBC (29K)
Rads: increased radiopacity cranial abd, thickened stomach
**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 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 (3.8 cm) with pyelectasia at 0.17 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.9 cm) with pyelectasia at 0.30 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 “plump” measuring 0.58 cm. 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 “plump” measuring at 0.68 cm. 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 (0.62 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 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. Duodenum wall measures 0.36 cm. Jejunum wall measures 0.27 cm. Visualized peristalsis appears appropriate. Some sections appear more prominent and thickened with slightly reduced detail of wall layering and a prominent muscularis layer.

The ileocecal junction was visualized and appears within normal limits. Sections of colon are visualized with non-formed fecal material and gas shadowing distally. In the descending colon there is a section of prominent/thickened colon wall measuring up to 0.41 cm (normal areas measured at approximately 0.11 cm) with reduced detail of wall layering in this region.

### *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. A prominent lymph node near the colon is visualized measuring 0.32 cm.

## ULTRASONOGRAPHIC FINDINGS

- Age related changes and mild pyelectasia noted associated with both kidneys – Pyelectasia of the kidney(s)could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.

- Bilaterally “plump” hypoechoic adrenals – The adrenal glands are both large with no significant structural abnormalities. This is most likely a benign-age related change. This can be caused by chronic stress/concurrent illness etc… If signs of cushings disease are present (diabetes, thin skin etc..) pituitary dependent cushings could be considered but is much less likely.

- Segmental thickening of the small intestine with some corrugation in areas exhibiting mildly reduced detail of wall layering – Findings are most consistent with significant inflammatory type change. Early neoplastic change cannot be ruled out.

- Focal thickening of the descending colon – Findings could be consistent with severe gastritis or early neoplastic change.

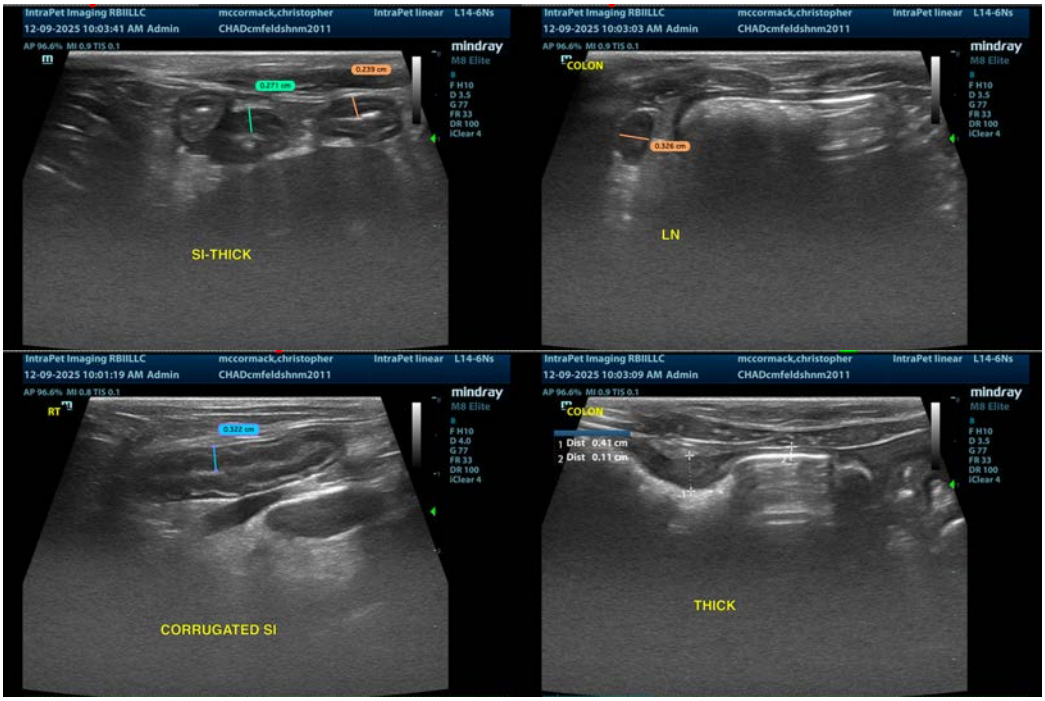
- Prominent colic lymph nodes – Findings could be consistent with a highly reactive or early neoplastic lymph node.

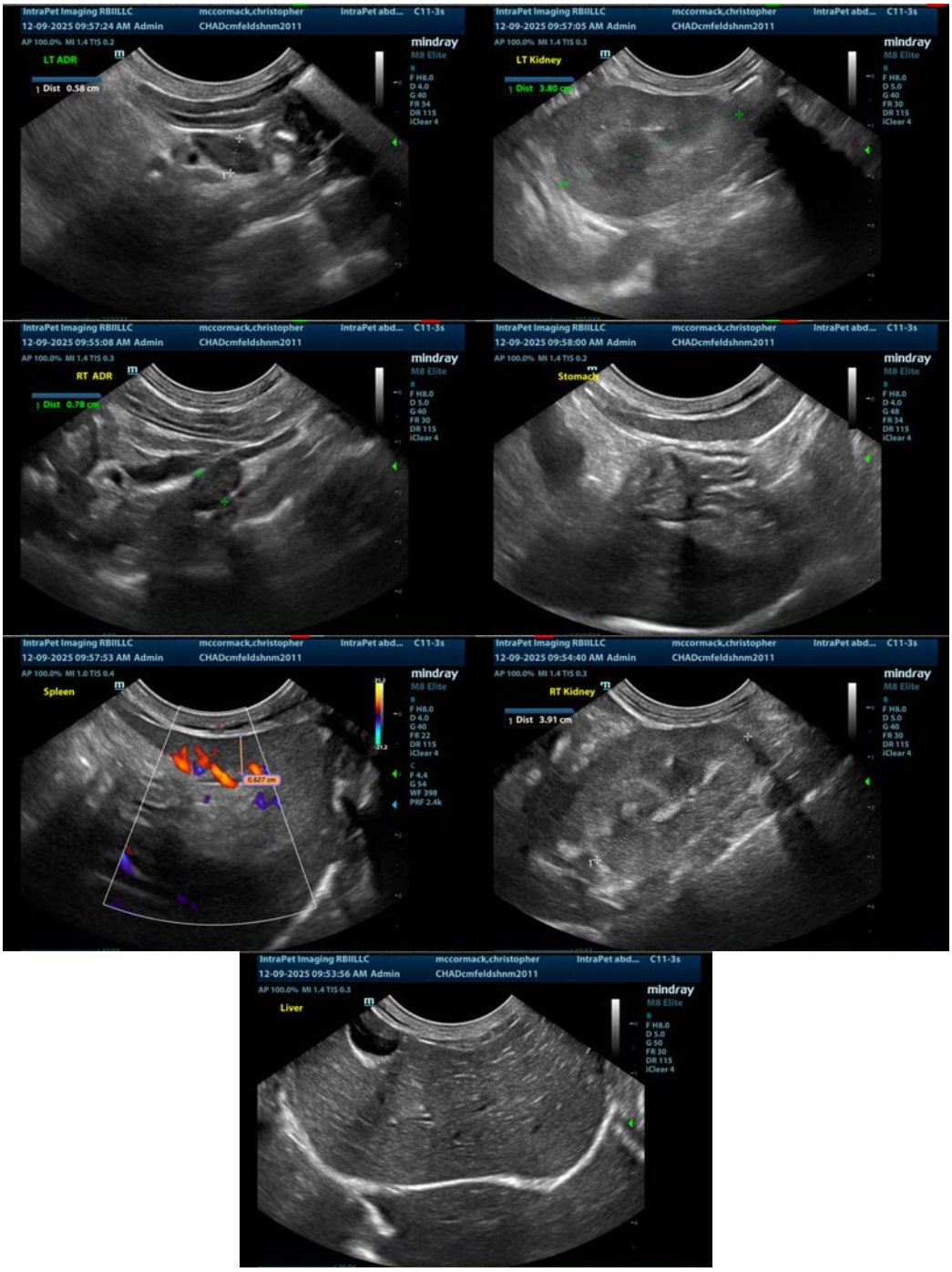
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is generalized mild thickening of the small intestine with some areas exhibiting a prominent muscularis layer. Additionally, there are some areas that appear more segmentally/severely affected, possibly consistent with a chronic enteropathy with an acute exacerbation. Recommend non-specific treatment for enteritis and a non-specific enteropathy with the following:

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- 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.
- Recommend nausea medications, supportive care, etc. as needed.

If symptoms are persistent, it is likely that biopsies of the GI tract would be necessary to further evaluate. Based on the appearance of today's scan, diarrhea would be suspected, so an upper and lower GI endoscopy could be warranted. Additionally, you could consider parasite screening and empirical deworming. If symptoms are persistent, you could also consider repeat imaging in the future (4-6 weeks), looking for the progression of today's lesions or a more discrete focal lesion.

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Liver
mindray
M8 Elite

**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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