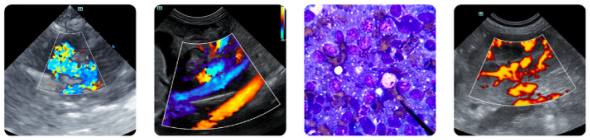

PATIENT

Calypso Spring

SPECIES

Feline

BREED

DLH

SEX

MN

AGE

11 years 8 months

WEIGHT

15.38 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Lucas Budden

HOSPITAL NAME

Frontier Veterinary Hospital

REFERRING VET

Dr. Lucas Budden

INVOICE

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2/10/2026

PRESENTING CLINICAL SIGNS

- Clinical signs: Overgrooming of abdomen and chronic vomiting.
- History: History of chronic vomiting (2-3x/month hair or bile) and overgrooming of abdomen. Ultrasound to assess for potential intraabdominal cause of overgrooming/vomiting. Abdominal ultrasound performed in 2021 due to persistently elevated ALT revealed Mild renomegaly, mineralized foci within the hepatic parenchyma, diffusely moderately hyperechoic pancreas.
- Current medications: Revolution Plus.

Abnormal PE/Chem/CBC/UA Results: Physical exam: BCS 9/9, abdomen comfortable on palpation, patch of alopecia from overgrooming caudal/ventral abdomen, severe dental calculus, multiple FORLs found on oral exam Lab work: GI panel pending cbc/chem 1/6/26 Creatinine high 1.6 Lymphocyte low 1185 Remainder of CBC/CHEM normal Senior panel 9/25/25 Albumin high 4 Creatinine high 1.6 SDMA high 15.3 Remainder of CBC/CHEM normal Thyroid normal 1.4 FEL V/FIV negative/negative HWT negative PT/PTT normal/normal USG 1.053 pH 7.5 Protein 1+ Fat droplets 2-3.

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 is normal/borderline large size (4.65 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/borderline large size (4.64 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.

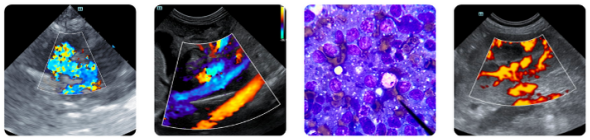
Adrenal Glands

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 0.33 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 (0.72 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.



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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. There are rare pinpoint mineralizations visualized in the parenchyma. 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. The duodenum measured 0.3 cm in diameter and the jejunum measured 0.33 cm in diameter. Visualized peristalsis appears appropriate. The small intestine appears diffusely thickened with a prominent muscularis layer.

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 both limbs. 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 some prominent, hypoechoic jejunal lymph nodes visualized with surrounding reactive mesentery. An example measures 0.64 cm. The omentum is of normal uniform echogenicity.

PRIMARY FINDINGS

- Large suspended echogenic debris in the urinary bladder. The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus. Recommend urinalysis and culture
- Pancreatic changes most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.
- Diffusely thickened small intestine with a 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
- Large, hypoechoic mesenteric lymph nodes. Findings are most consistent with highly reactive or early neoplastic lymph nodes.

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SECONDARY FINDINGS

- Occasional pinpoint mineralizations in the liver. This appears stable from the previous exam 2021.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine appears diffusely thickened and “ropey” with a prominent muscularis layer. These changes are most consistent with significant inflammatory type change, although early neoplastic change cannot be ruled out. Additionally, there are large hypoechoic mesenteric lymph nodes which are surrounded by reactive mesentery most consistent with highly reactive lymph nodes, although early neoplastic changes cannot be ruled out. Consider the following:

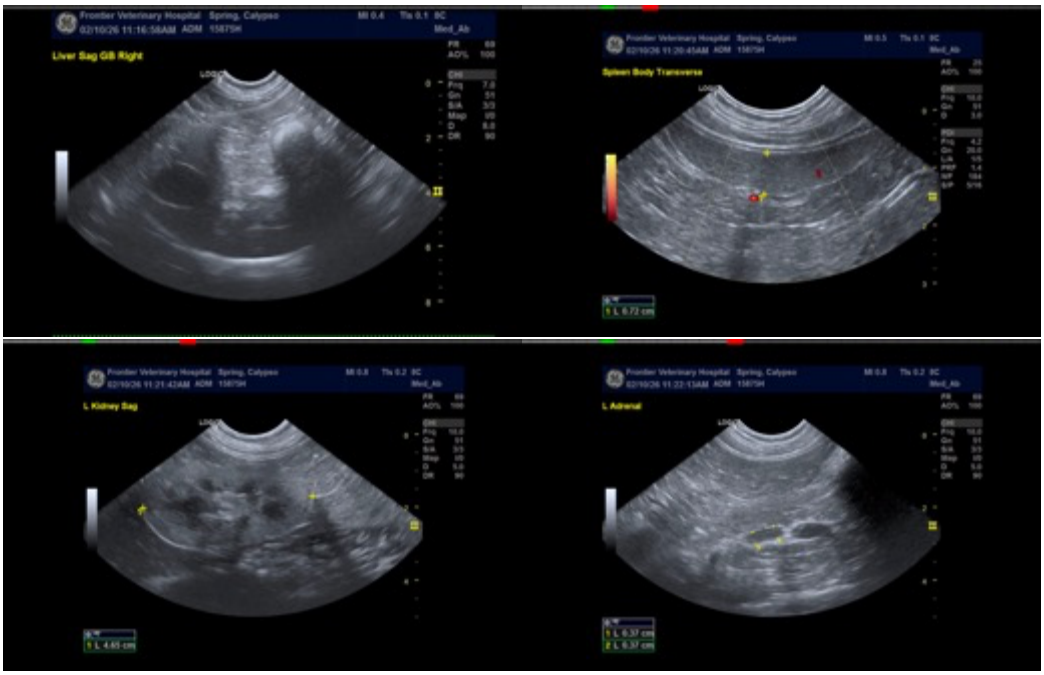
- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks.)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- I believe this is currently pending, recommend chronic probiotic therapy.

If a safe window for sampling is available you could consider a fine needle aspirate of a mesenteric lymph node, although these may be challenging to sampling if they’re not severely enlarged.

If symptoms are persistent despite taking the above steps, biopsies of the GI tract +/- lymph nodes may be warranted.

Additionally, you could consider repeat imaging in the future looking for the progression of today’s lesions.

Recommend empirical treatment for chronic pancreatitis and evaluation of a quantitative PLI level.



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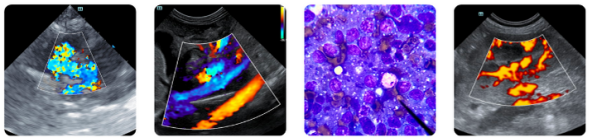

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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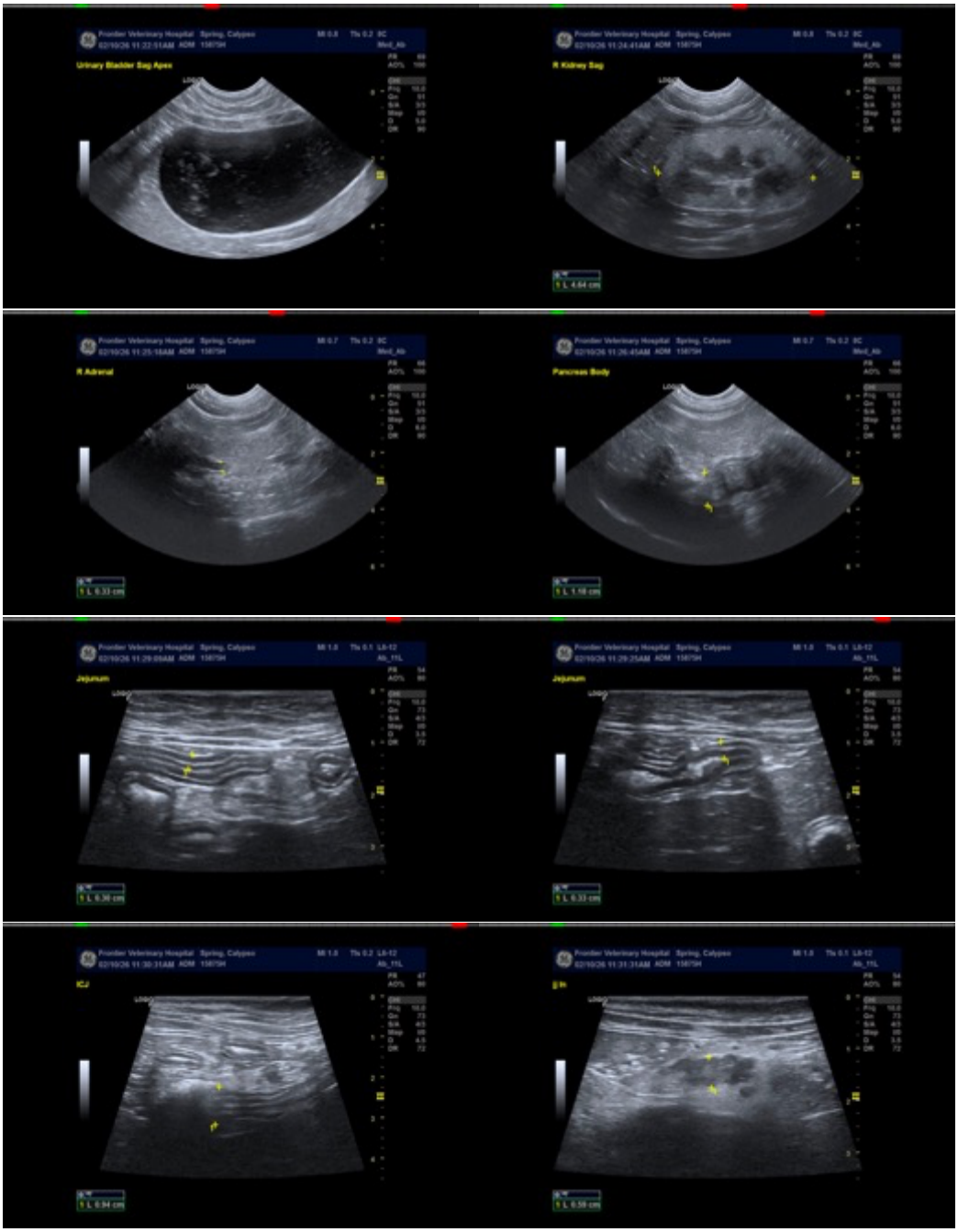

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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