PATIENT

Spaz Hoffman

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

13 years

WEIGHT

2.77 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Peavine Animal Hospital

REFERRING VET

Dr. Baggett

INVOICE

11302

DATE

2/12/2026

PRESENTING CLINICAL SIGNS

- Senior on 12/1/25 showed calcium 11.9, history of diarrhea chronic. heart murmur 4/6 L systolic murmur. hypercalcemia panel showed 1.66 ionized calcium. <0.50 parathyroid hormone. vomiting chronic.
- Working diagnosis: lymphoma. vit d toxicity, ideopathic

Abnormal PE/Chem/CBC/UA Results: Ionized calcium 2.66, parathyroid hormone <0.50, calcium 11.9, retic 20, eos 1.362, plat 599, creat. kin. 4,602pH 5.5, urine protein 2+, 3+ calcium oxalate dihydrate.

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 (2.99 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 (3.42 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 region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.3 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 (0.7 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 0.27 cm 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 0.43 cm in diameter and the jejunum measured 0.26 cm in diameter. Visualized peristalsis appears appropriate. The muscularis layer is diffusely thickened and prominent.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with non-formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The area of 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 a mild/moderate mesenteric lymphadenopathy with iso- to slightly hypoechoic mesenteric lymph nodes. Eamples measure 1.4 cm x 1.98 cm, 0.83 cm and 0.39 cm. A lymph node near the ileocecal junction measures 0.34 cm. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- 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.
- Mild/moderate mesenteric lymphadenopathy. Findings are most consistent with highly reactive or early neoplastic lymph nodes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine is mildly diffusely thickened with a prominent muscularis layer. These changes are most consistent with inflammatory type change but early neoplastic change cannot be ruled out. If not already done, recommend 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.

If symptoms are persistent despite making these changes, biopsies of the GI tract would likely be

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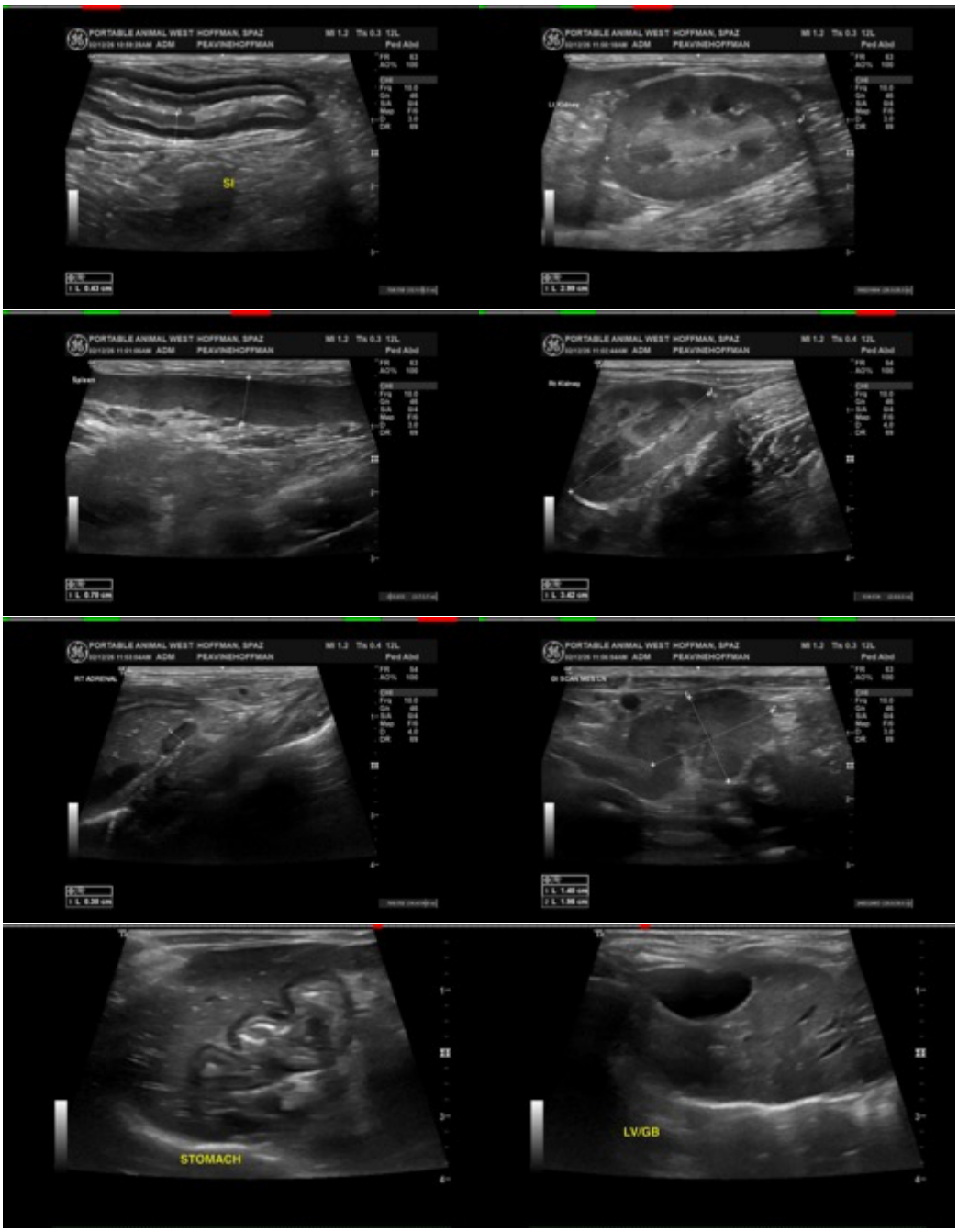
necessary to further evaluate. A fine needle aspirates of a large mesenteric lymph node could be considered (if a safe window for sampling is available) but this may be challenging as they are only moderately increased in size.

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

The hypercalcemia is most consistent with either idiopathic hypercalcemia or secondary to an underlying neoplastic process (transitioning GI lymphoma?)



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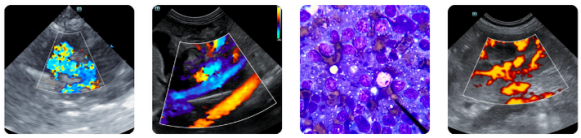
530-786-8340



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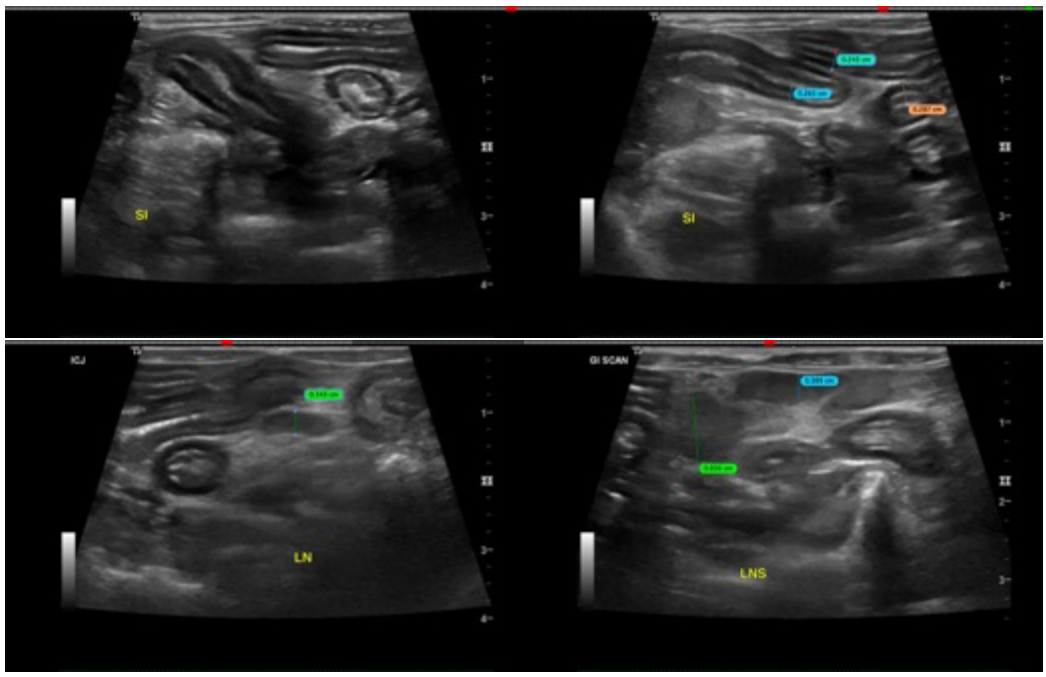

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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