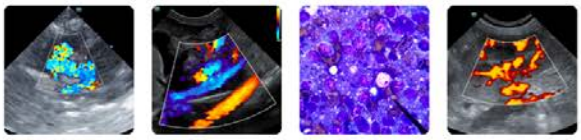


DATE

2/24/26

PATIENT

Minikitty Frank

SPECIES

Feline

BREED

DMH

SEX

Spayed Female

AGE

5/11/09

WEIGHT

7.8 lbs

INTERPRETED BY

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

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Willer

INVOICE

73222

PRESENTING CLINICAL SIGNS

Patient History: Mini kitty Murray is a 17-year-old female feline with a >10-year history of diabetes mellitus, previously well-managed on Prozinc insulin (2 units SC q12h) and diet. Recent medications include maropitant 4 mg PO q24h, budesonide 1 mg PO q24h, and cyanocobalamin with probiotic. Over the past four days, the patient developed inappetence, progressing to complete food refusal, with one episode of vomiting (water) and subsequent syringe feeding tolerated without further vomiting. Weakness, especially in the pelvic limbs, and one episode of inappropriate urination were noted.

Current Medications: Ondansetron, Unasyn, Cerenia, Potassium Chloride.
Labwork Results: Labwork attached.
Date of Previous IntraPet Ultrasound: 11/4/2025. See attached.
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 (4.06 cm) with pyelectasia at 0.46 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 (4.54 cm) with pyelectasia at 0.28 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 normal in size measuring 0.51 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 0.47 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 (0.68 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 large in size with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in 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. Visualized peristalsis appears appropriate. The muscularis layer of the small intestine is prominent and thickened throughout the small intestine. Jejunum wall measures 0.35 cm.

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 large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with moderate pancreatitis.

Free Abdomen
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Decreased corticomedullary distinction in both kidneys with bilateral pyelectasia – Pyelectasia of the kidneys could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.

- Pancreatic changes most consistent with chronic active pancreatitis.

- Large, hyperechoic liver – Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy. Findings could be consistent with a diabetic hepatopathy.

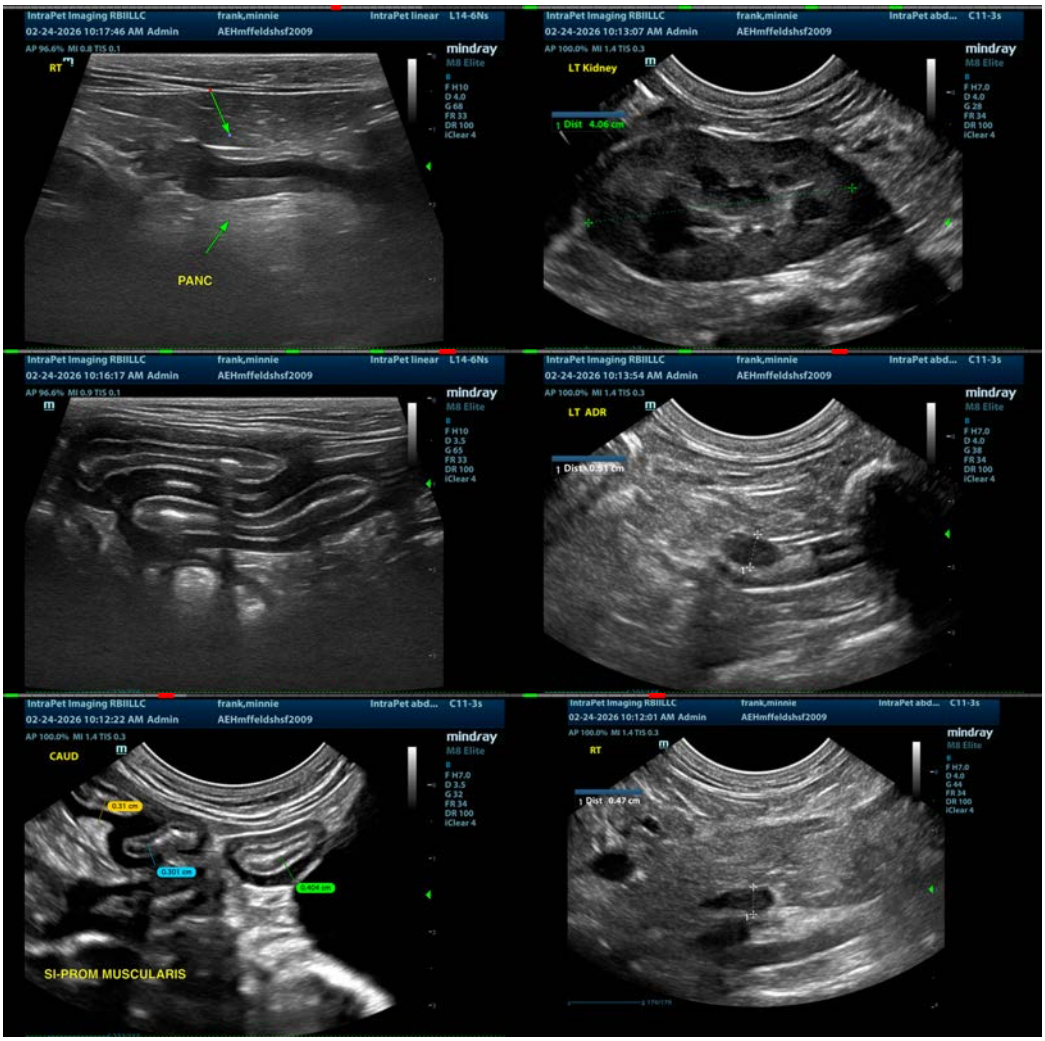
- Diffusely thickened small intestine with a prominent muscularis layer – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.

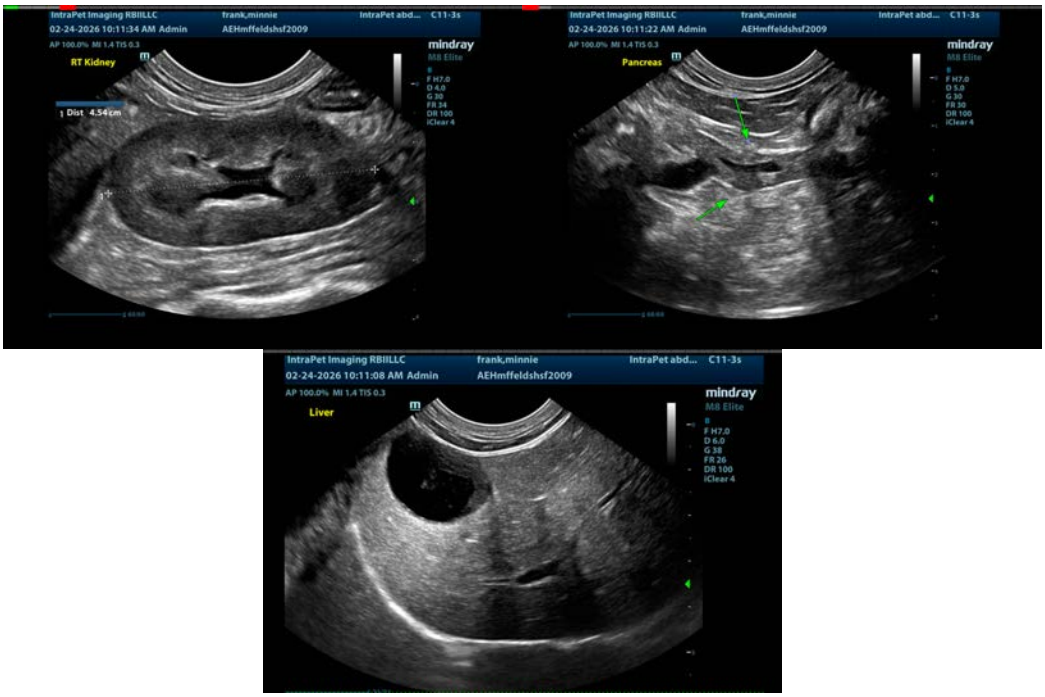
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Many of the changes visualized on today's exam appear similar to the previous exam from 11/2025. These include thickened small intestine with prominent muscularis layer, decreased corticomedullary distinction, pyelectasia in both kidneys, and a prominent pancreas. Subjectively, the pancreas appears slightly more prominent on today's exam, possibly indicative of a chronic active pancreatitis.

There is severe azotemia reported on lab work. This could represent prerenal azotemia or renal azotemia. Recommend diuresis as well as a urinalysis, culture and a blood pressure, looking for any evidence of pyelonephritis. An acute on chronic episode is suspected with concurrent severe dehydration and electrolyte derangements. Recommend treatment for hyperosmolar diabetes with short acting insulin and possibly a feeding tube if the patient does not start to eat once rehydrated.

If GI symptoms have progressed since the last evaluation, biopsies of the GI tract may eventually be warranted, or current inappetence could very well be due to the other metabolic issues occurring.





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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