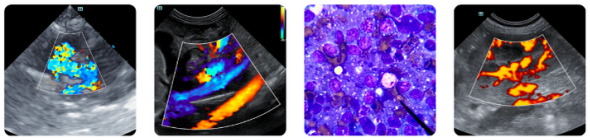


PATIENT

Sebastian Brenner

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered Male

AGE

14 years 8 months

WEIGHT

13 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Megan Bray

HOSPITAL NAME

Taylorsville Veterinary Clinic

REFERRING VET

Dr. Megan Bray

INVOICE

11242

DATE

4/5/2026

PRESENTING CLINICAL SIGNS

- Patient is new to us, referred for a diagnostic ultrasound. Previous medical record notes- patient presented on 2/2/26 for decreased appetite and hiding. Owner did bring 2 kittens into the house in December. Grade 2/6 heart murmur. Patient is still not eating well despite the use of Mirtazapine.

Abnormal PE/Chem/CBC/UA Results: From previous clinic: Eosinopenia (stress), plt 127 (clots noted in sample), SDMA 18, Tbil 1.4 (sample was significantly hemolyzed), T4 WNL, fPL WNL. Noted borderline proteinuria with a USG of 1.019.

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 has a normal shape and size (3.76 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 (3.77 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 are pinpoint non-obstructive mineralizations noted. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

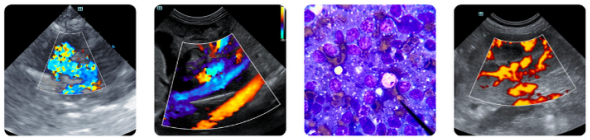
The left adrenal gland is plump in size measuring 0.55 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is plump in size measuring 0.6 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 (0.75 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There's a hyperechoic irregular nodule visualized in the parenchyma most consistent with a benign myelolipoma measuring 0.31 cm.

Liver



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The liver is subjectively large/normal in size with smooth peripheral margins. The parenchyma is mildly 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 significantly distended and appears somewhat folded. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are moderate at this time. The cystic duct is significantly dilated with a large amount of mucoid debris. This extends into a dilated proximal bile duct with mucoid debris which is dilated distally at the level of the duodenal papillae. No definitive obstruction is visualized.

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 0.27 cm in diameter and the jejunum measured 0.28 cm in diameter. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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 mild/moderate pancreatitis in both limbs. The pancreatic duct is prominent in the right limb of the pancreas.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a cluster of large, hypoechoic rounded lymph nodes visualized in the mid abdomen measuring 0.87 cm x 0.61 cm, and 1.19 cm x 0.71 cm. This is sounded by reactive mesentery. Additionally, there's mildly reactive mesentery in the cranial abdomen in the region of the pancreas.

PRIMARY FINDINGS

- Pancreatic changes consistent with chronic active pancreatitis.
- Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- Large, folded gallbladder with a prominent cystic and proximal bile duct with debris. Findings are concerning for cholecystitis.
- Diffusely thickened/ropey small intestine with a prominent muscularis. The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma

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- Focal cluster of large, hypoechoic mesenteric lymph nodes. Findings are concerning for highly reactive or neoplastic lymph nodes.

SECONDARY FINDINGS

- Bilaterally plump adrenals. Significance of this is uncertain. This could be normal for a large cat or a sick/stressed cat. Additionally, early pituitary dependent hyperadrenocorticism is possible.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The pancreas appears prominent, hypoechoic, and mottled in both limbs with some mild surrounding reactive mesentery, most consistent with pancreatic inflammation. Correlate with PLI level and recommend treatment for chronic pancreatitis.

The liver appears subjectively, mildly hyperechoic. This could be normal in an overweight cat but given the stressful history, concern for early lipidosis could be present. If this is suspected, consider a liver function test +/- a fine needle aspirate of the liver.

The gallbladder is prominent and somewhat folded with a dilated cystic and common bile duct with debris. Findings are concerning for cholecystitis. Consider chronic ursodiol therapy, denamarin and antibiotics. Recommend continued monitoring.

The small intestine is diffusely thickened with a prominent muscularis layer. These changes are mostly consistent with an inflammatory enteropathy (IBD) but early neoplastic change cannot be ruled out. Additionally, there is a cluster of large rounded hypoechoic mesenteric lymph nodes which is somewhat concerning for a possible early neoplastic process. Consider a fine needle aspirate for cytologic evaluation.

The changes involving the biliary tract, pancreas and Gi tract could be consistent with triaditis, additionally round cell neoplasia can have this presentation.

If symptoms are persistent despite treatment for pancreatitis and possibly early IBD (hydrolyzed protein prescription diet, GI panel to Texas A&M for a qualitative fPLI/TLI, cobalamin, and folate, etc) then consider repeat imaging of the abdomen looking for the development of new lesions or the progression of today's lesions as eventually biopsies of the GI tract, liver, pancreas and LNs may be warranted.

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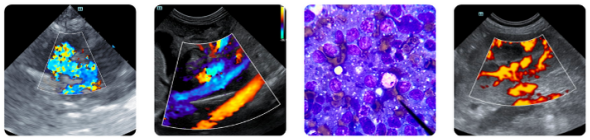

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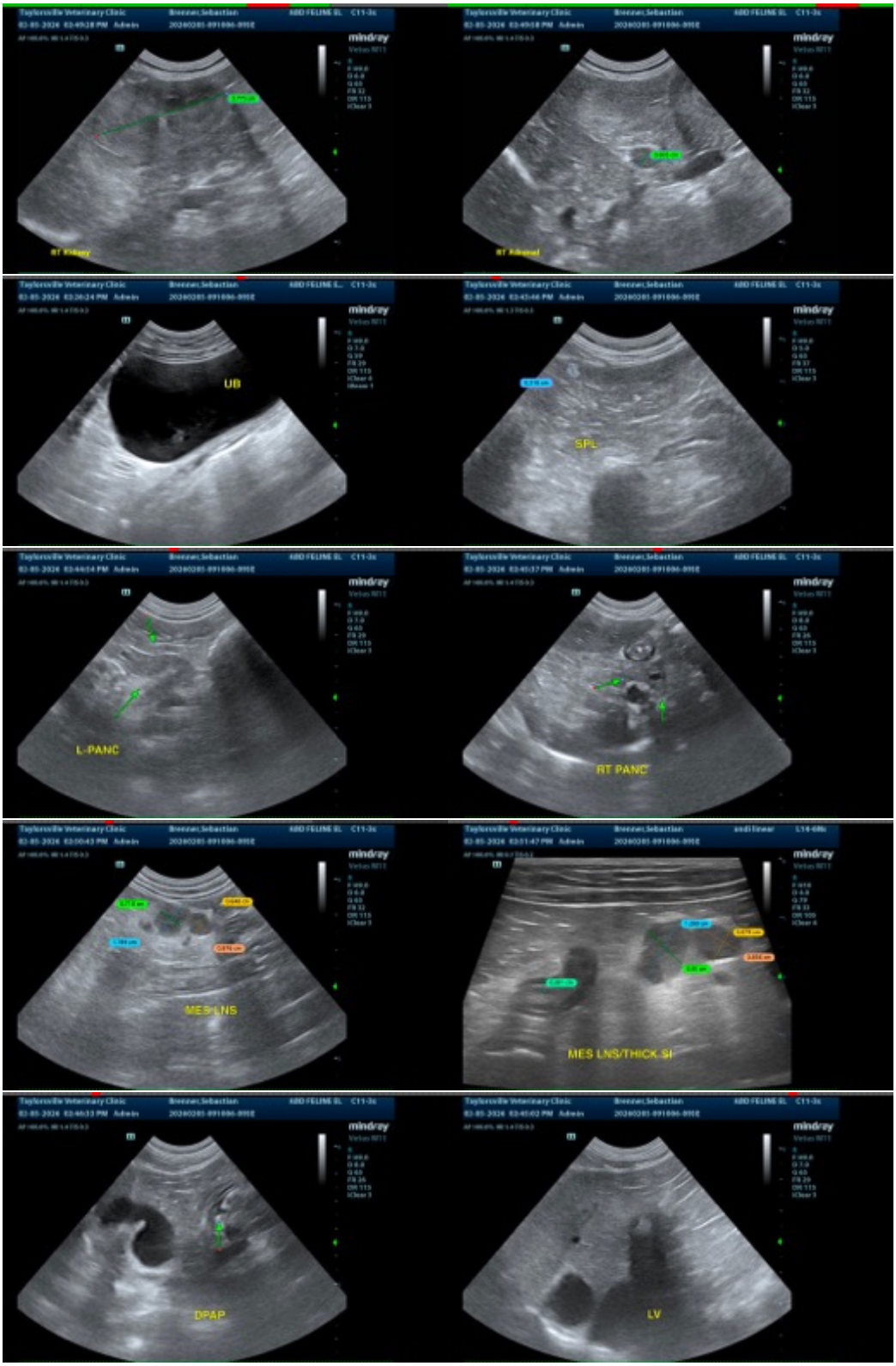

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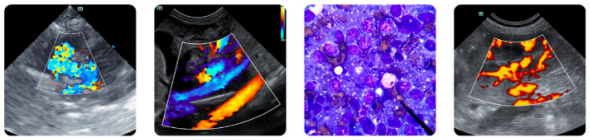

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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