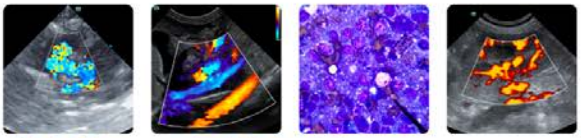

PATIENT

Bear Walbrecht

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

13 Years 4 Months

WEIGHT

7 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Rebecca Hamilton

HOSPITAL NAME

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REFERRING VET

Dr. Katara

INVOICE

73954

DATE

3/24/26

PRESENTING CLINICAL SIGNS

IBD vs. Lymphoma vs other? Weight loss and diarrhea

Abnormal PE/Chem/CBC/UA Results: Labs WNL as of 3/16/26

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 (3.36 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 (3.96 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 left adrenal gland is normal in size measuring 0.28 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.

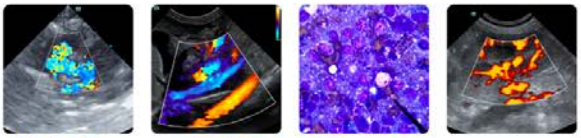
Spleen

The spleen is subjectively normal in size (0.78 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 subjectively mildly overdistended with anechoic fluid. The wall of the gall bladder is not thickened and has a smooth mucosal surface. The bile duct is somewhat dilated and tortuous, measuring at 0.31 cm distally at the level of the duodenal papilla.



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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 0.25 cm. Jejunum wall measures 0.30 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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. Descending colon wall measures at 0.17 cm.

Pancreas

The pancreas is prominent and mottled compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is mild peripancreatic inflammation visualized in the cranial abdomen. Findings are most consistent with pancreatic remodeling and possible mild pancreatitis.

Free Abdomen

There is scant free fluid present. There are some prominent mesenteric lymph nodes, an example measures 0.47 cm x 0.97 cm. The omentum is diffusely hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- Pancreatic changes most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.
- Dilated/tortuous bile duct – Dilation of the common bile duct could be consistent with a functional obstruction (i.e. primary hepatic disease resulting in hepatocellular swelling) or with an extrahepatic bile duct obstruction (ie. choledocholith, bile duct tumor, pancreatic disease, other).
- Mildly thickened/ropey small intestine – The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).
- Prominent mesenteric lymph node and hyperechoic reactive mesentery – Findings are most consistent with reactive lymph nodes. Early neoplastic change cannot be definitively ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is the impression of generalized mesenteric inflammation with some prominent lymph nodes and prominent pancreas. The small intestine appears mildly diffusely thickened with prominent wall layering, most consistent with inflammatory type change, although early neoplastic change cannot be ruled out. Consider the following:

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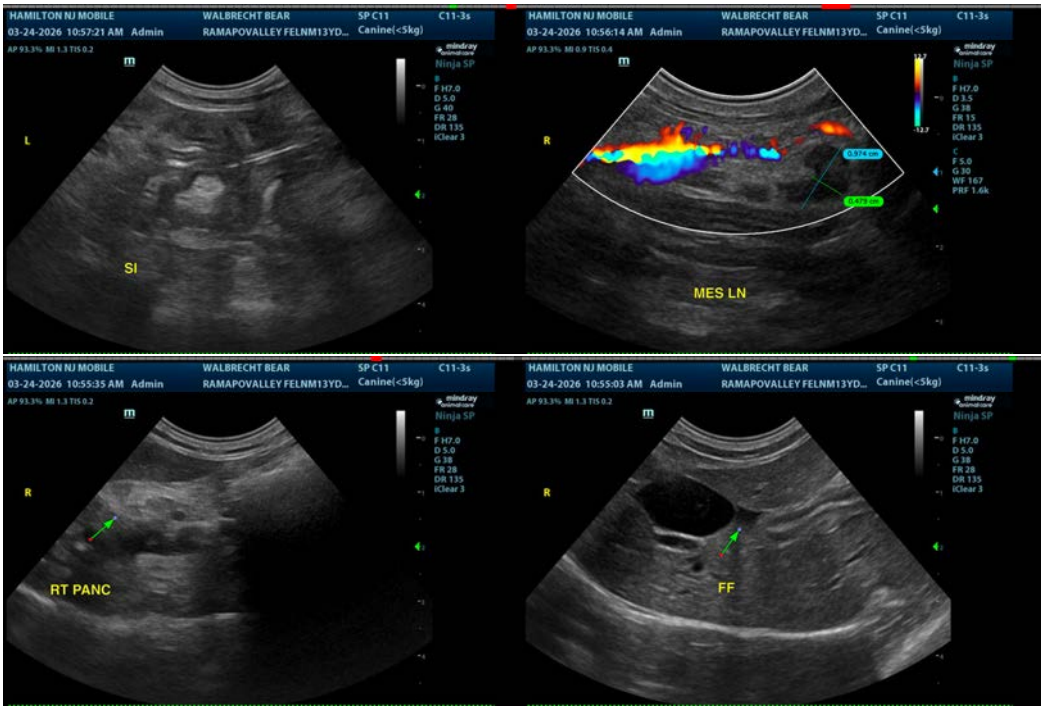
- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.

If the PLI level is significantly elevated, recommend concurrent treatment for chronic pancreatitis.

The bile duct is dilated and somewhat tortuous with no evidence of a focal lesion. Findings could be seen with active or previous cholangiohepatitis, cholecystitis, etc. Given the pancreatic and GI changes, additionally mild Triaditis could be a factor. You could consider a fine needle aspirate (particularly if liver enzyme elevations are present) and/or Ursodiol therapy and a course of antibiotics along with treatment for pancreatitis and mild IBD (dietary changes, etc.).

If symptoms are persistent or progressive, ultimately biopsies of the GI tract may be warranted. Additionally, you could consider repeat imaging in the future, looking for possible progression of today's lesions or the development of new lesions.



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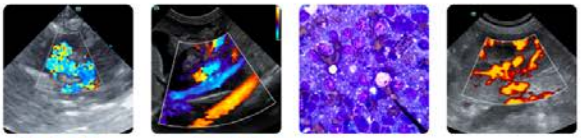

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath www.SonoPath.com info@sonopath.com 800.838.4268

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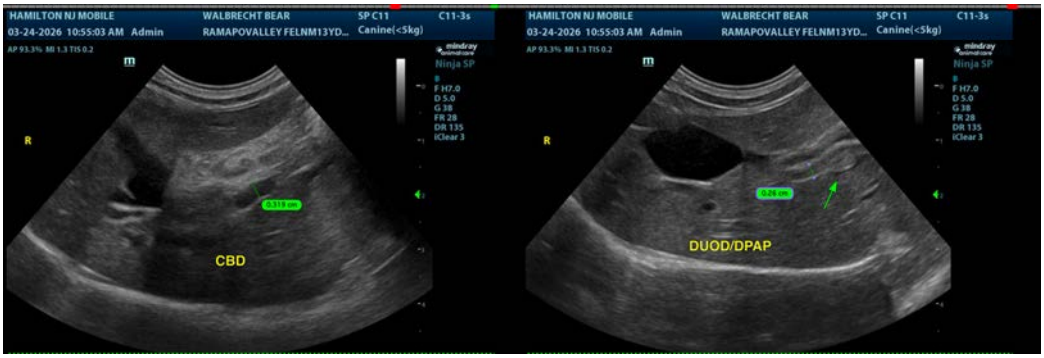

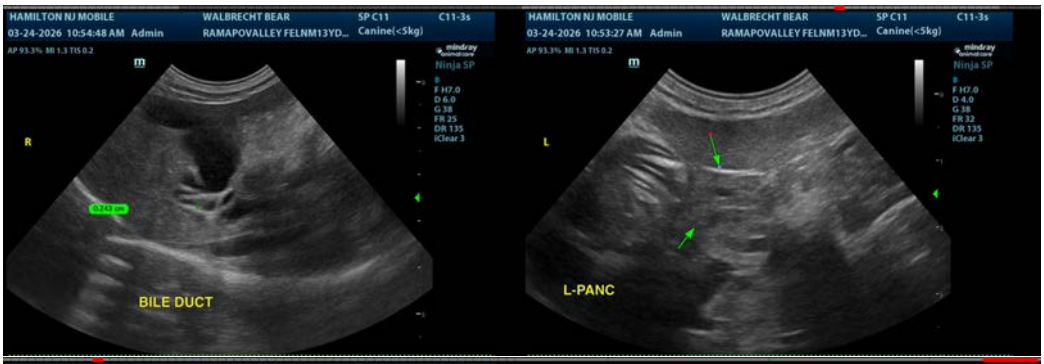

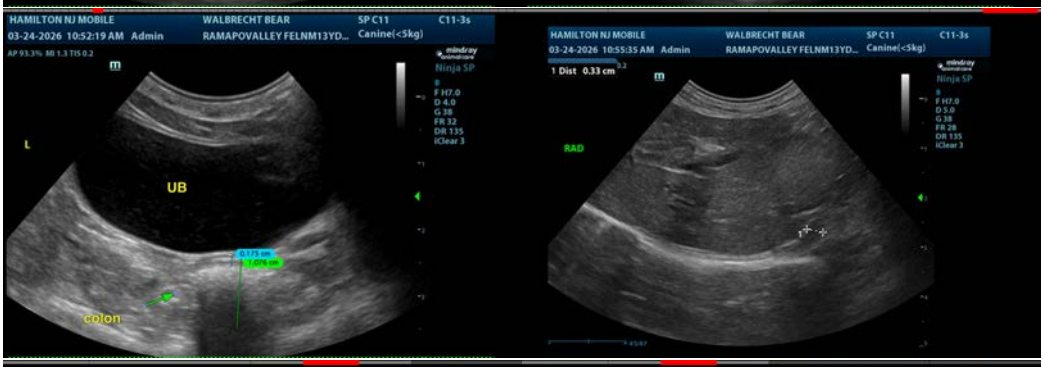

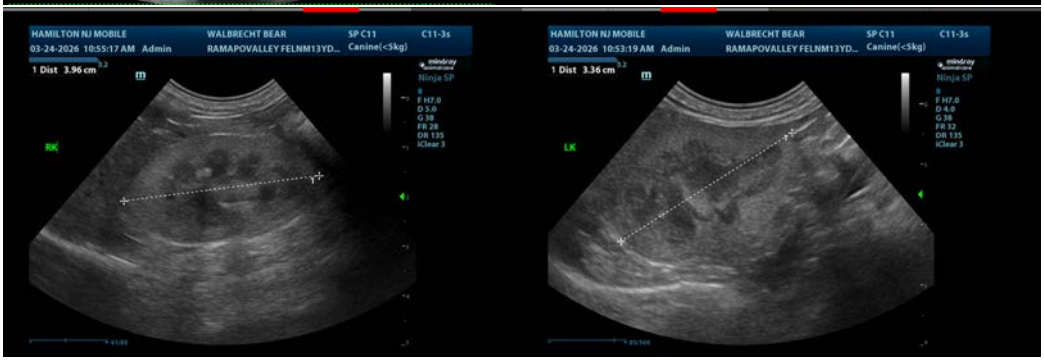

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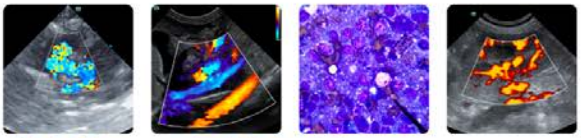

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com