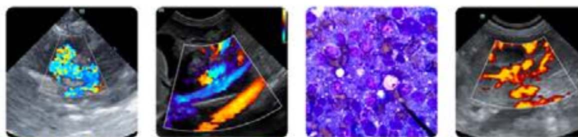


PATIENT

Pippy McKee

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

6 Years

WEIGHT

8.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Mary Pearce

HOSPITAL NAME

Chambersburg Animal Hospital

REFERRING VET

Dr. Mary Pearce

INVOICE

73413

DATE

3/4/26

PRESENTING CLINICAL SIGNS

Chronic intermittent vomiting that is usually self-limiting, and normally will continue to eat despite the vomiting. This time, complete anorexia was noted along with vomiting. Cerenia was given PO last night. No diarrhea, normal BM observed this morning. Previous workup including BW/radiographs performed with no significant concerns. O elected to pursue ultrasound and GI panel d/t recurrence of vomiting.

Abnormal PE/Chem/CBC/UA Results: 3/4/26: In house pancreatic lipase 0.8 (0-4.4) normal. UA: USG >1.050, pH 6.5, 30mg/dL protein, otherwise normal, quiet sediment, no evidence of UTI. Pending urine protein:creatinine ratio, pending B12/folate/TLI. 12/15/25: HCT 39.7%, WBC normal, PLT low but slow draw suspect artifact. Chem and lytes normal. Radiographs found spondylosis, otherwise unremarkable thorax and abdomen.

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 (3.37 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 (3.62 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 0.39 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.

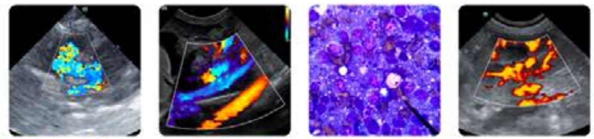
The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

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. 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.



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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 mild fluid distention in the region of the pylorus. 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. The pylorus and the proximal duodenum appear somewhat fluid distended with no evidence of a focal lesion.

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 0.34 cm. Jejunum wall measures 0.26 cm. Visualized peristalsis appears appropriate. Some areas of small intestine appear somewhat segmentally fluid distended, with some areas exhibiting a prominent muscularis layer.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. The proximal colon appears significantly fluid distended with non-formed fecal material. 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

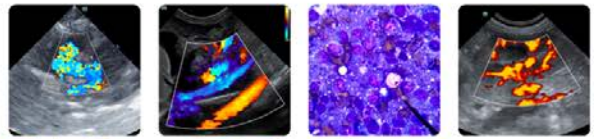
Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is no significant lymphadenopathy. Occasional prominent mesenteric lymph nodes are visualized. An example measures 0.38 cm and 0.35 cm. The omentum is of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Mild suspended echogenic debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.
- Segmental areas of small intestine that exhibit a prominent muscularis layer and fluid distention – Findings are suggestive of inflammatory type change/enteritis/ileus. An unseen focal lesion cannot be ruled out.
- Mild reactive lymphadenopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There are some sections of small intestine that appear segmentally “ropey” with a prominent muscularis layer. Some of these areas have mild to moderate fluid distention, and the pylorus and proximal duodenum appear mildly to moderately fluid distended. These findings are most consistent with inflammatory type change (possibly a chronic enteropathy with an acute exacerbation/enteritis?). An unseen focal lesion cannot be definitively ruled out but seems less likely. Consider the following:



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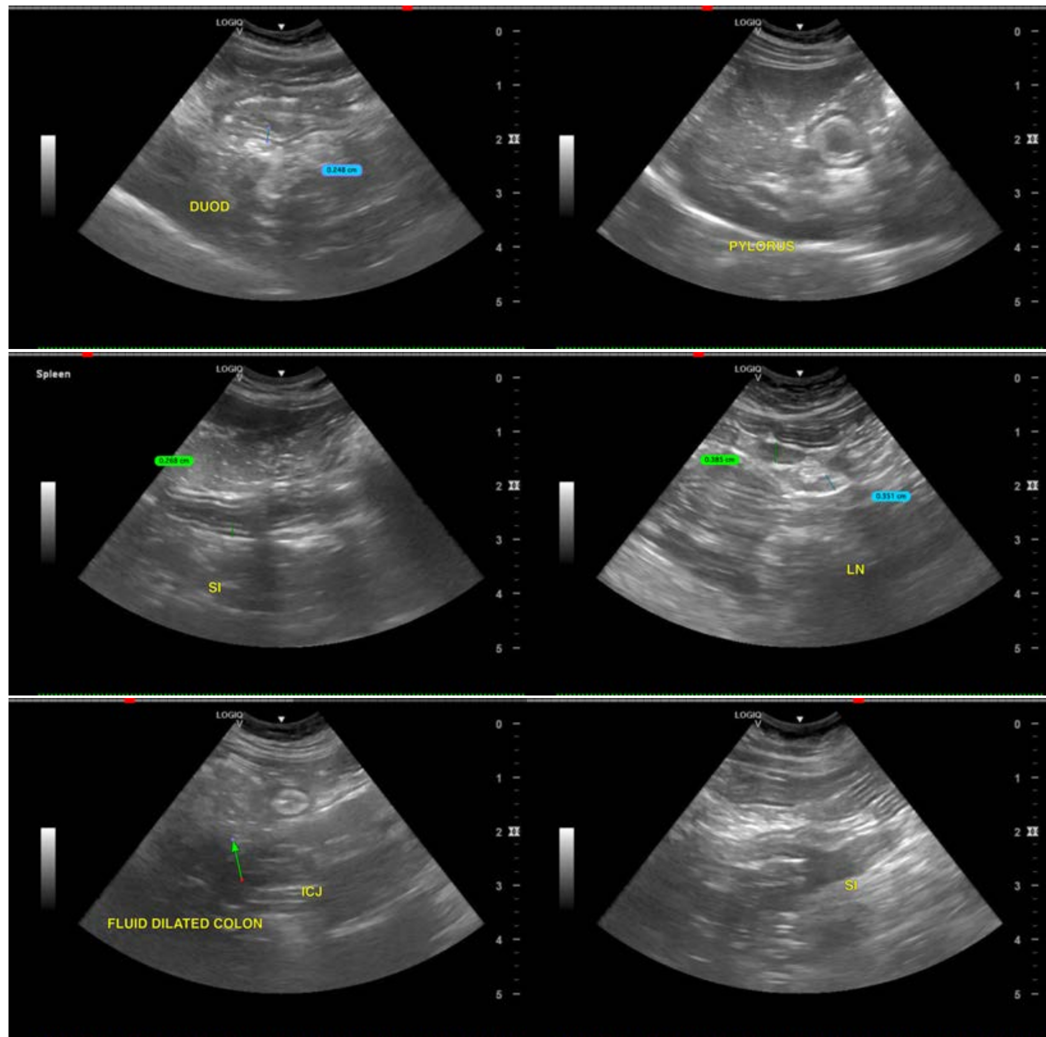
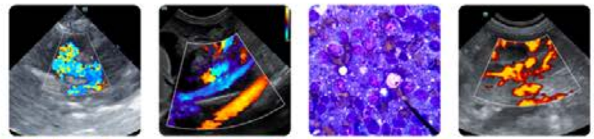
- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease. (I believe this is currently pending)
- Recommend chronic probiotic therapy.

If a PLI level is significantly elevated, consider concurrent treatment for pancreatitis, although no evidence of significant pancreatic inflammation is observed.

If symptoms are persistent despite taking these measures, ultimately biopsies of the GI tract would be recommended. Additionally, you could consider repeat imaging, looking for the development of a new lesion or progression of today's lesion.





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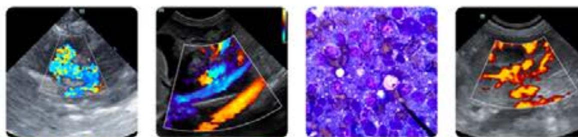

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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