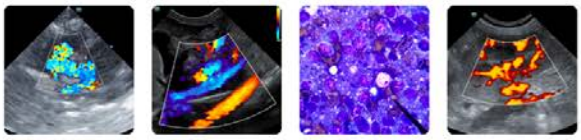


DATE

3/5/26

PATIENT

Max Stanley

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

2/6/13

WEIGHT

10 lbs

INTERPRETED BY

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

HOSPITAL NAME

Essex Middle River Veterinary Center

REFERRING VET

Dr. Stoll

INVOICE

73449

PRESENTING CLINICAL SIGNS

Patient History: Unintentional weight loss despite normal appetite. Potentially diarrhea in litter box, but multi-cat household (cannot confirm Max is having diarrhea). PE: BCS 3/9 (weight loss 4.4 lbs since 2023), moderate generalized muscle wasting, mild-moderate dental disease (mild-moderate calculi, mild gingivitis). No auscultable heart murmur over growling/hissing. Extremely fractious.

Current Medications: Owner understands that Max will need Gabapentin 100mg PO and injectable sedation for advanced diagnostics.
Labwork Results: Labwork attached, reported as: CBC: Mono 1.35 (H); rest WNL. Chem17 with Lytes: WNL Total T4: WNL. UA: Struvite 1-5/hpf; rest WNL. ProBNP: 423 (H)
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Alfaxan.
Stat Report: Not requested.
Imaging Performed by: Stephanie Warga RDCS, RVT.

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, or masses. In the dependent portion of the urinary bladder there is a small amount of mineralized sandy 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 (4.02 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 0.36 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 0.46 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 (1.05 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. There is a moderate amount of non-organized echogenic debris. 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.

Some of 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. Some areas have reduced detail of wall layering. Jejunum wall measures 0.21 cm. Visualized peristalsis appears appropriate. There are some loops of small intestine that appear more significantly thickened with the impression of reduced detail of wall layering, measuring up to 0.31 cm.

The ileocecal junction was visualized and appears prominent and thickened. The ascending colon wall measures at 0.29 cm with slightly reduced detail of wall layering and surrounding reactive mesentery. The distal colon appears normal, measuring at 0.20 cm.

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 pancreatitis.

Free Abdomen
Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are occasional prominent mesenteric lymph nodes. A colic lymph node is visualized measuring 0.40 cm x 0.99 cm. A mesenteric lymph node is visualized measuring 0.31 cm x 0.87 cm. The omentum is hyperechoic in the mid abdomen around the thickened sections of bowel as well as at the ileocecal junction and around the pancreas.

ULTRASONOGRAPHIC FINDINGS

- Dependent mineralized debris visualized in the urinary bladder – Recommend urinalysis and culture.
- Pancreatic changes most consistent with chronic active pancreatitis.
- Moderate gallbladder debris – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting. Incidental gall bladder debris is less common in cats.
- Segmental thickening and reduced detail of wall layering of the small intestine – Findings are most consistent with severe inflammatory or early neoplastic change.
- Thickened proximal ascending colon with reduced detail of wall layering and surrounding inflammation – Findings are most consistent with severe inflammation or early neoplastic change.

- Occasional prominent mesenteric lymph nodes – At this time the lymph nodes are most consistent with reactive lymph nodes, but early metastatic lymph nodes cannot be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

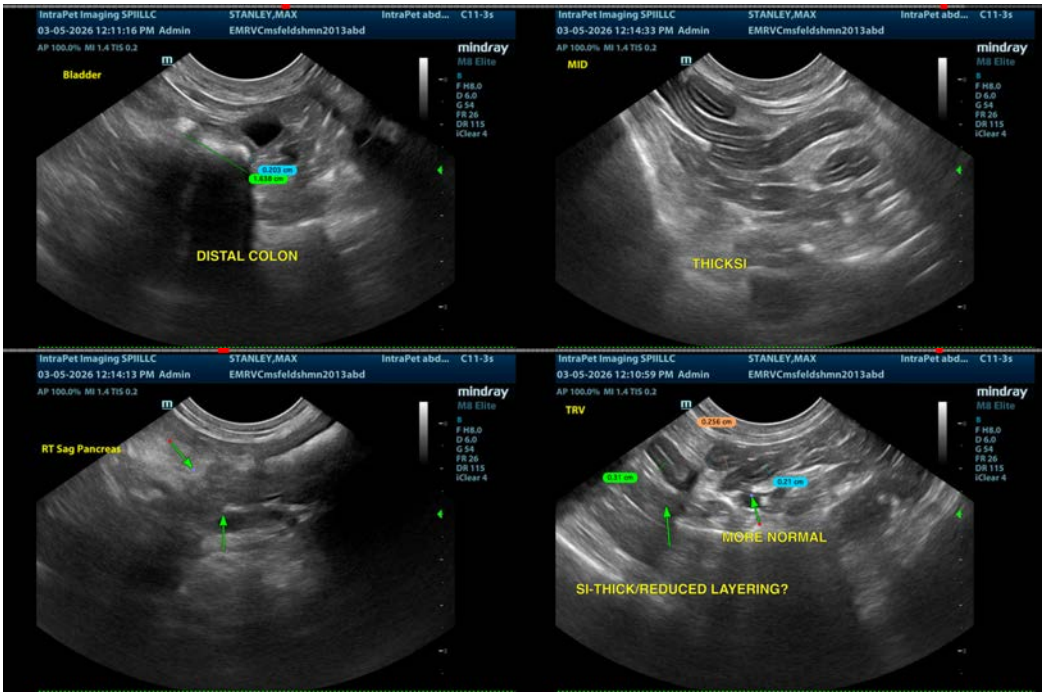
There is segmental thickening of the small intestine with some areas exhibiting reduced detail of wall layering. These areas of bowel appear to have some reactive mesentery. This is similar to the appearance of the proximal ascending colon, which appears thickened with reduced detail of wall layering. These findings are concerning for early infiltrative neoplasia (round cell neoplasia) but severe inflammatory disease/IBD is also possible. The borderline low albumin reported is suspicious for an early protein losing enteropathy.

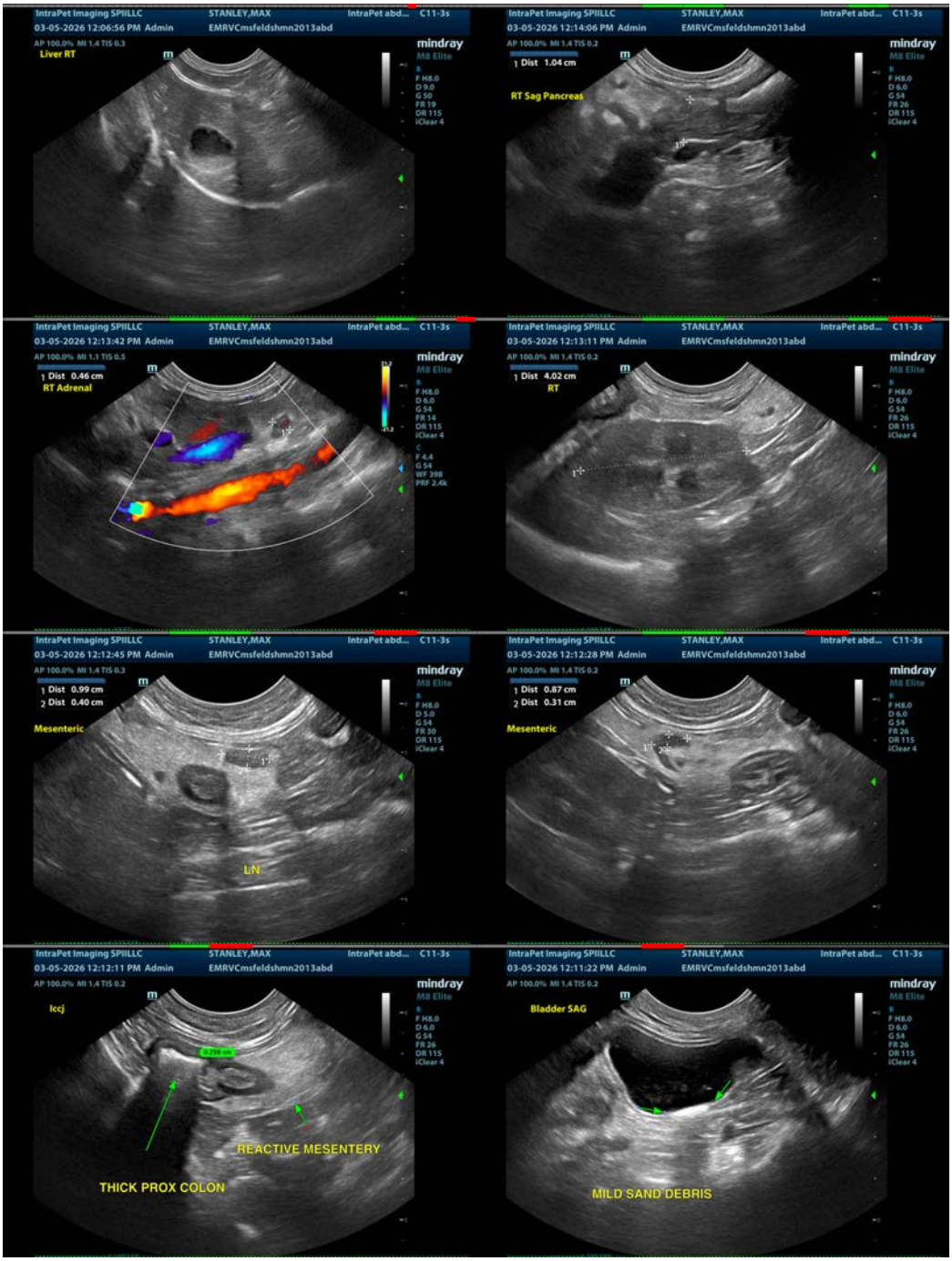
The pancreas is prominent and hypoechoic in both limbs with some reactive mesentery particularly in the right cranial abdomen. Correlate with PLI level and consider empirical treatment for pancreatitis.

For initial therapy, you could consider 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.

Ideally, consider biopsies of the GI tract for further evaluation. If this is not an option and there is no response to the aforementioned therapy, steroid therapy may need to be considered.

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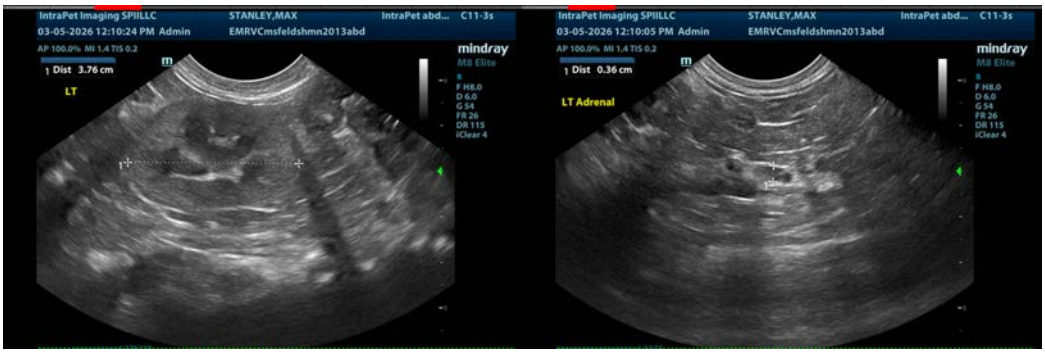

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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