PATIENT

Flame Hanson

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

14 years

WEIGHT

2.87 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Incline Veterinary Hospital

REFERRING VET

Dr. Kateryna Sovik

INVOICE

11614

DATE

4/1/2026

PRESENTING CLINICAL SIGNS

Significant weight loss noted by client; patient weighed 12 lbs at the time of a previous dental surgery, was 6.4 lbs at the last visit, and has continued to lose weight. The decline has been sharp since January. Appetite is decreased. Patient shows initial interest in food, will take a few bites, and then refuses to eat more. Has been tried on multiple diets, including GI Biome stew, which he refused. Currently eating a few bites of Friskies wet food and some treats. May have a preference for chicken flavor. Water intake is reported as steady and normal, not excessive. No vomiting or diarrhea reported. Urination is normal; he is walking to the litter box to urinate. Defecation: Client has not observed a bowel movement in a couple of days and is unsure of the last time he defecated. Energy level is significantly decreased; described as "mellow" and having lost a lot of "oomph". He is weaker than usual but is not hiding at home and maintains his routines, though at a slower pace. Client notes he sprawls out more when sleeping since the last visit. Hips were previously noted to be uncomfortable. Client feels there may be some slight improvement, but he still "walks weird". Bloodwork performed in January showed a normal T4 of 1.7 and an increased pancreatitis value, but was otherwise unremarkable.

Abnormal PE/Chem/CBC/UA Results: RBC 6.35 6.54 - 12.20 M/µL LOW HCT 26.8 30.3 - 52.3 % LOW HGB 8.6 9.8 - 16.2 g/dL LOW WBC 18.71 2.87 - 17.02 K/µL HIGH NEU * 16.09 2.30 - 10.29 K/µL HIGH EOS 0.01 0.17 - 1.57 K/µL LOW PLT 95 151 - 600 K/µL LOW PCT 0.16 0.17 - 0.86 % LOW CREA 0.7 0.8 - 2.4 mg/dL LOW ALB 2.0 2.3 - 3.9 g/dL LOW TBIL 3.9 0.0 - 0.9 mg/dL HIGH AMYL 1913 500 - 1500 U/L HIGH QPL 19.9 0.0 - 4.4 U/L HIGH - Progressive weight loss and hyporexia - r/o neoplasia, chronic inflammatory disease (IBD), chronic pancreatitis, organ dysfunction (renal, hepatic), constipation - Constipation (suspected) - r/o dehydration, pain/discomfort (e.g., anal sacculitis, orthopedic pain), dietary, obstruction - Lethargy/weakness - r/o systemic illness, pain, metabolic disease, malnutrition.

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. The cortex is increased in echogenicity and has hyperechoic cortical striations with poor corticomedullary distinction. 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 (4.12 cm). The cortex is increased in echogenicity and has hyperechoic cortical striations with poor corticomedullary distinction. 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.

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The right adrenal gland is normal in size measuring 0.52 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 (1.0 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. There is a small, hypoechoic nodule visualized in the parenchyma measuring 0.29 cm.

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.

The visualized areas of duodenum (0.25 cm), jejunum (0.28 cm) and ileum have a uniform diameter with minimal fluid distension. Wall thickness is increased (enter measurement if given). Bowel loops follow a typical curvilinear path. Some areas have reduced detail of wall layering. Visualized peristalsis appears appropriate. The muscularis layer is very prominent throughout the small intestine.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. 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 visible/mildly mottled in the left limb. 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 revealed a moderate amount of free abdominal fluid. There are large, irregular mesenteric lymph nodes visualized. Examples measure 1.75 cm x 4.03 cm, and 1.06 cm x 2.13 cm. The omentum is irregular and hyperechoic.

PRIMARY FINDINGS

- Age related changes visualized associated with both kidneys.
- 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 but seems unlikely to be causing a current issue. Recommend continued monitoring.

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- Small, hypoechoic nodule in the liver. Significance of this is uncertain. At this time its likely too small to easily sample. Recommend continued monitoring with ultrasound.
- Diffusely thickened small intestinal 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
- Large, irregular mesenteric lymph nodes. Findings are concerning for neoplastic lymph nodes although highly reactive lymph nodes cannot be ruled out.

SECONDARY 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. Recommend urinalysis and culture.
- Pancreatic changes consistent with mild pancreatic remodeling.

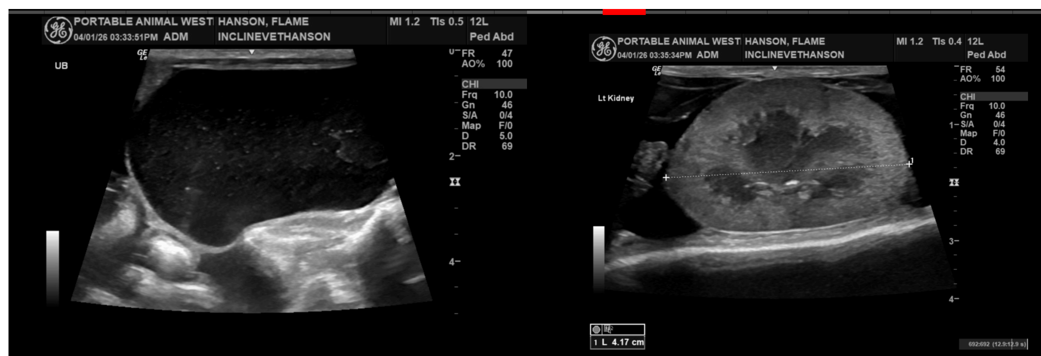
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine appears diffusely thickened with a very prominent muscularis layer. Additionally, there are large, irregular mesenteric lymph nodes. Recommend a fine needle aspirates of the mesenteric lymph nodes for cytologic evaluation. The small intestinal changes are most consistent with inflammatory type change but neoplastic change can have a very similar appearance, and with lymph node change this is a concern. If a diagnosis cannot be made based on evaluation of the lymph node, ultimately, biopsies of the small intestine may be necessary. Consider the following:

HYPOALLERGENIC DIET AUTOTEXT k3-ha

- 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.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.



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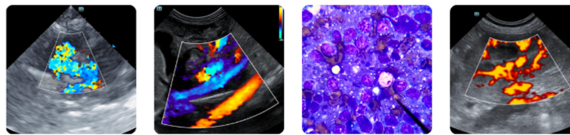
pawsonography@gmail.com
530-786-8340



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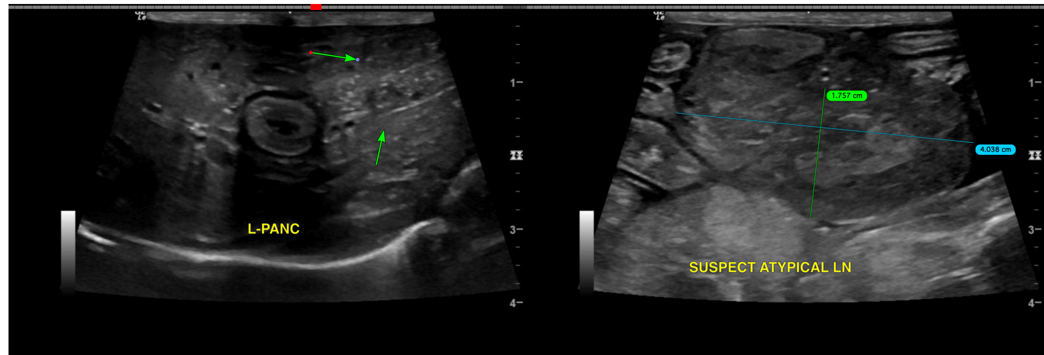

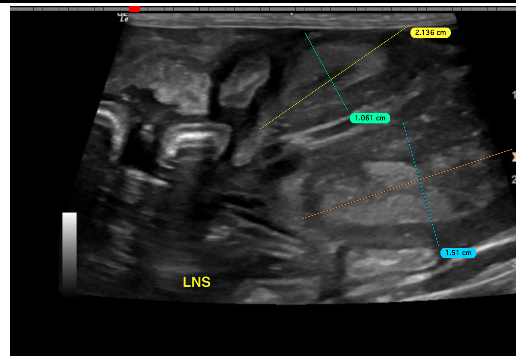

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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