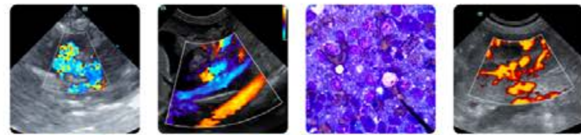


PATIENT

Ebony Wimmer

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

~14 Years

WEIGHT

7.3 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Shari Reffi, CVT

HOSPITAL NAME

Mt. Bethel Animal Hospital

REFERRING VET

Dr. Stevans

INVOICE

74424

DATE

4/14/26

PRESENTING CLINICAL SIGNS

BCS 2/9; weight loss, cachectic, recurrent dh+. No current medications.
Abnormal PE/Chem/CBC/UA Results: WBC-25; Neuts-21.175; Monos-1.175

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 (3.64 cm). The cortex is increased in echoechogenicity, with poor 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 (4.15 cm) with a small cortical cyst visualized measuring 0.34 cm. The cortex is increased in echoechogenicity, with poor 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 0.42 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 0.45 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.

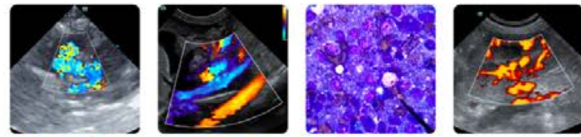
Spleen

The spleen is subjectively normal in size (0.63 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 hypoechoic nodule visualized towards the caudal aspect of the liver measuring 0.53 cm.

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.



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Gastrointestinal

The stomach contains mild fluid. 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 0.29 cm. Jejunum wall measures 0.20 cm. Visualized peristalsis appears appropriate. There are some sections of small intestine that appear somewhat "ropey" with segmental thickening of the muscularis layer. A more prominent section measures up to 0.34 cm. The distal ileum is slightly prominent, measuring at 0.30 cm.

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 prominent, mottled, and hypoechoic in both limbs. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

There is no free fluid. There is a mild diffuse mesenteric lymphadenopathy with hypoechoic, slightly irregular lymph nodes. Examples measure 0.34 cm x 1.6 cm, 0.44 cm, and 0.25 cm in width. The omentum is generally of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

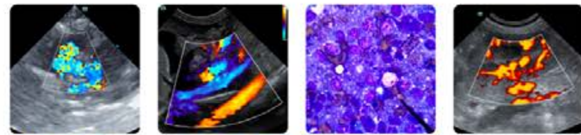
- Decreased corticomedullary distinction in both kidneys – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.

- Pancreatic changes most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.

- Hypoechoic nodule in the liver – This could represent a benign or neoplastic lesion. Recommend continued monitoring with ultrasound +/- a fine needle aspirate.

- Segmental areas of "ropey" small intestine 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.

- Mild/moderate mesenteric lymphadenopathy – Findings are most consistent with reactive lymphadenopathy. An early neoplastic process cannot be ruled out.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No definitive focal lesions are visualized associated with the small intestine. Some areas appear more thickened and mildly “ropey” with a prominent muscularis layer, but wall layering is intact. Findings could be consistent with a primary enteropathy.

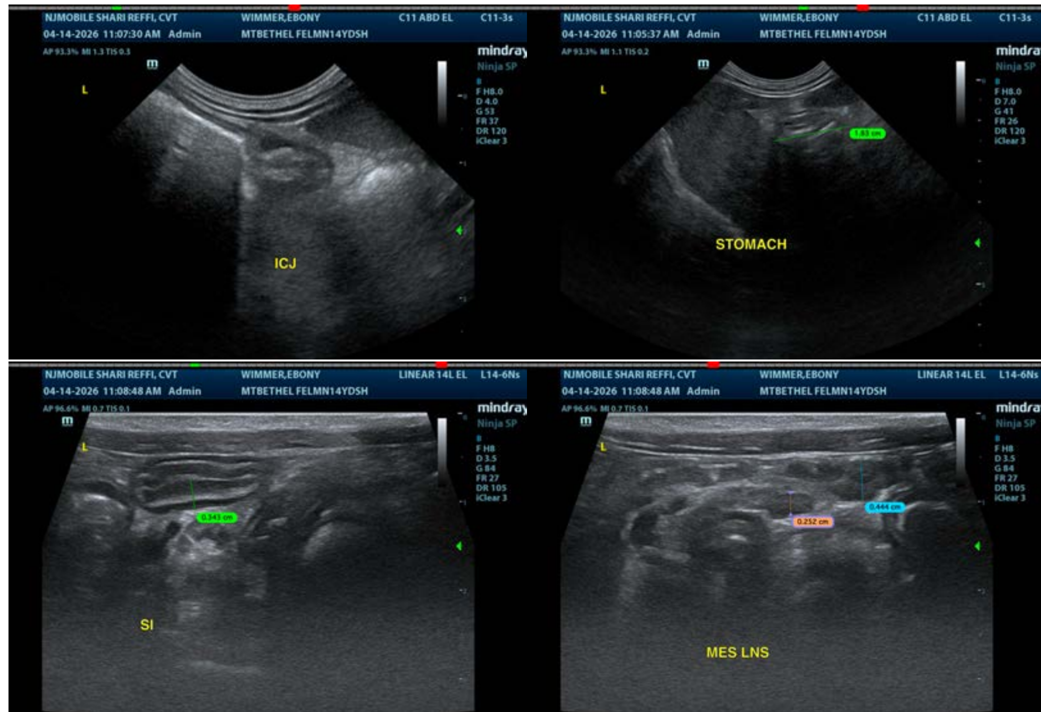
Additionally, both limbs of the pancreas are somewhat prominent. Correlate with a PLI level, looking for evidence of active chronic pancreatitis. Consider the following:

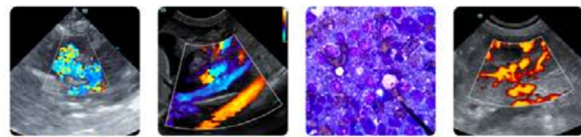
- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.

Both kidneys have significantly reduced corticomedullary distinction and are hyperechoic. Correlate these findings with lab work and a urinalysis +/- urine culture to assess urine concentrating ability, etc. A blood pressure may be indicated.

If symptoms are persistent despite taking these measures, ultimately surgical biopsies of the GI tract and mesenteric lymph nodes may be warranted. Prior to this, consider repeat evaluation, looking for possible progression of today’s lesions or the development of new lesions.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement (disregard if this has already been done).





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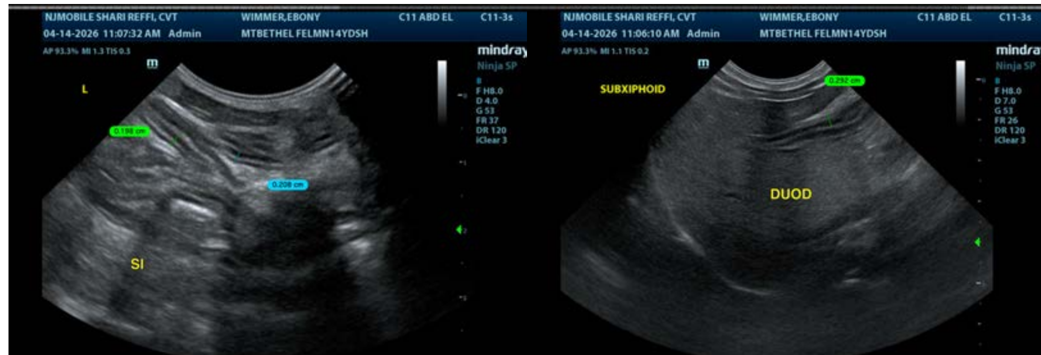

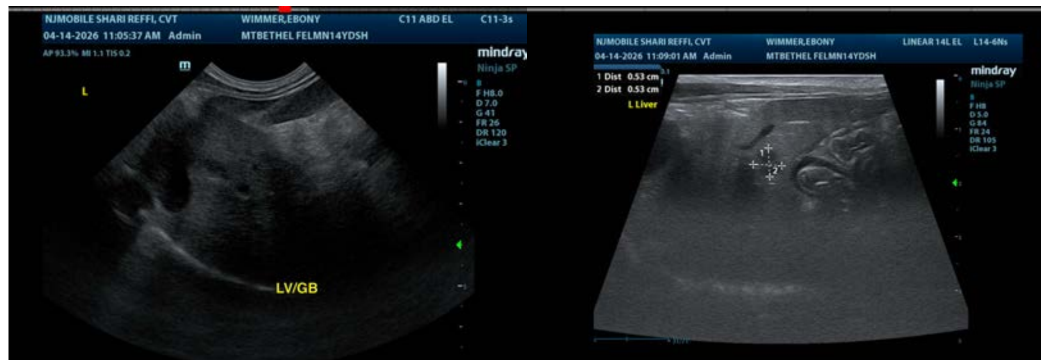

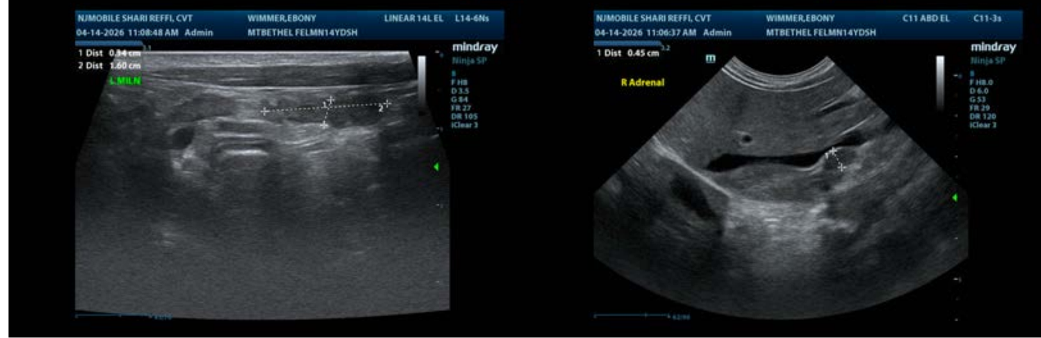

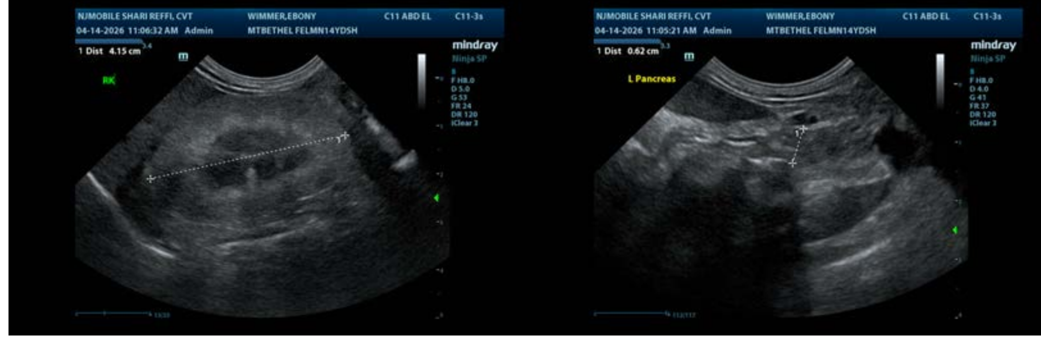

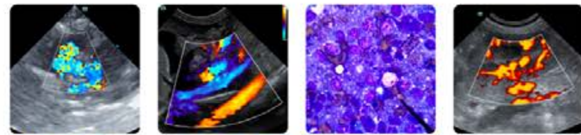

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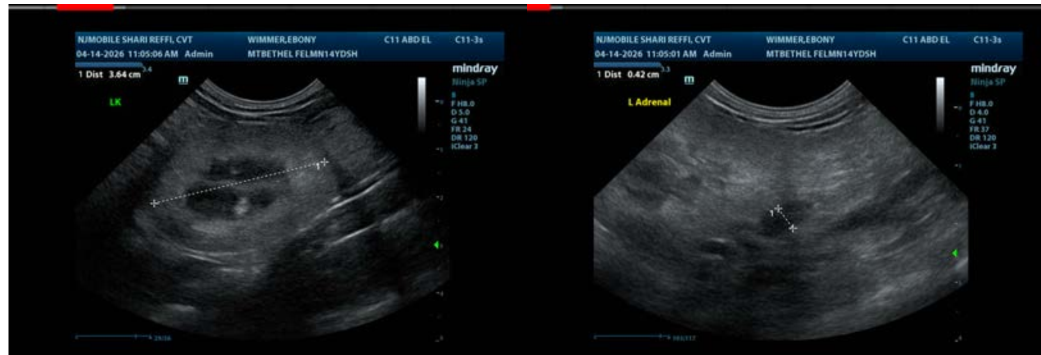

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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