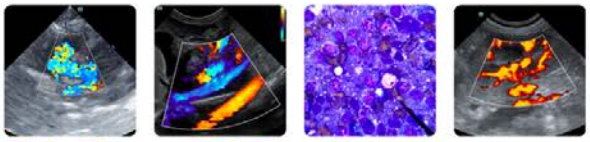


PATIENT

Filbert Long

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

14 Years

WEIGHT

8.3 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Mary Pearce

HOSPITAL NAME

Chambersburg Animal Hospital

REFERRING VET

Dr. Dawn Eckert

INVOICE

74792

DATE

4/29/26

PRESENTING CLINICAL SIGNS

Decreased & intermittent appetite since 04-24-26, no vomiting noted, chronic soft stool. Hyperthyroid, no methimazole given since 04-24-26 d/t not eating. Weight loss of 1-2 lb since late 2025. No PU/PD noted. Previously evaluated in 2024 for weight loss and intermittent v+/dh. US with internist found enlarged mesenteric LNs (reactive on cytology), mild intestinal thickening, enlarged pancreas. Poss. endoscopic biopsies performed but no record of it available. GI panel 2024 - B12 <150, cobalequin tablets started but discontinued d/t pt resistance. Episode of decreased appetite in 09-2025, bloodwork showed T4 elevation likely d/t missed doses of methimazole. Bw nsf in 12-2025.
Main concern to reevaluate intestines/LNs, concern for IBD vs. neoplasia. Further investigate kidneys, concern for occult renal disease.

Abnormal PE/Chem/CBC/UA Results: PE: General muscle loss, BCS 2-2.5/5, arthritic changes on exam & rads, no obvious intestinal thickening or abdominal masses on palpation, UB small/soft. Previous hx of gr IV/VI murmur w/ normal proBNP in 2024, not heard in past several visits, briefly heard possible extremely faint murmur on exam but not confirmed/consistent. Radiographs of thorax & abdomen appear unremarkable aside from moderate gas distension in large intestine & degenerative joint changes. BG 202 (71-159), BUN 75, SDMA 14 (0-14) , creat 1.2 (0.8-2.4), Ca 7.3 (7.8-11.3), Glob 6.7 (2.8-5.1), alb 3.3 (2.3-3.9), TP 10 (5.7-8.9); ALT 143 (12-130), ALP <10 (14-111); Na 143 (150-165), Cl 102 (112-129); pancreatic lipase 3.1 (0-4.4), T4 16.5 (0.8-4.7), WBC 17.2 (2.87-17.02), PMNs 11.9 (2.3-10.29), Mono 1.12 (0.05-0.67).

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.

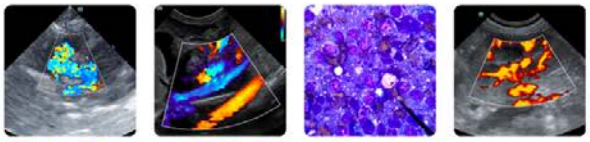
The left kidney has a normal shape and size (4.06 cm). Overall echogenicity is slightly hyperechoic with mildly reduced corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.24 cm). Overall echogenicity is slightly hyperechoic with mildly reduced 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 0.47 cm at the cranial pole and 0.47 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 0.42 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.



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Spleen

The spleen is subjectively normal in size (0.50 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. Luminal contents are mild and likely incidental at this time. The bile duct is visible/mildly tortuous, measuring at 0.25 cm at the level of the duodenal papilla.

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 to moderate fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Duodenum wall measures 0.31 cm. Jejunum wall measures 0.25 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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

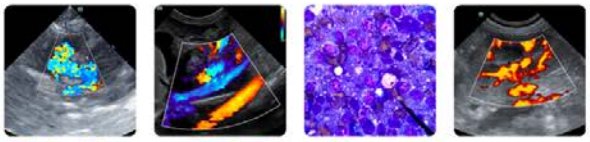
The pancreas is prominent and mottled (particularly in the right limb) compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a significant mesenteric lymphadenopathy with large, irregular, hypoechoic, mottled mesenteric lymph nodes. Examples measure 1.04 cm x 2.19 cm and 1.38 cm x 2.43 cm. In the caudal abdomen cranial to the urinary bladder there is a mass effect suspected to be a cluster of large mesenteric lymph nodes measuring 2.33 cm x 2.29 cm. The omentum is mildly diffusely hyperechoic.

PRIMARY FINDINGS

- Age related changes visualized associated with both kidneys.
- Pancreatic changes most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.



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- Mildly thickened 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).

- Large, hypoechoic, irregular, mottled mesenteric lymph nodes – Findings are concerning for a neoplastic process, although infectious or inflammatory differentials are possible.

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.

- Mildly dilated 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).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a significant mesenteric lymphadenopathy with clusters of large, irregular, hypoechoic, mottled mesenteric lymph nodes. The appearance favors a neoplastic process, although an inflammatory process, granulomatous disease, etc. cannot be ruled out. Recommend repeat aspiration with sample for cytologic evaluation.

No focal lesions were visualized associated with the small intestine. Subjectively, some areas appear moderately fluid distended and mildly thickened. Based on the history, low B12 levels, chronic diarrhea, etc., a primary enteropathy is strongly suspected.

The pancreas is prominent and hypoechoic, particularly in the right limb, with some mild reactive mesentery in the region, possibly consistent with mild chronic pancreatitis or infiltrative disease to the pancreas.

If a diagnosis cannot be obtained based on cytologic evaluation of the lymph nodes, further evaluation such as testing for causes of granulomatous/pyogranulomatous disease (FIP, bartonella, etc.) could be considered. Ultimately, biopsies of the GI tract and mesenteric lymph nodes may be warranted.

Consider topical Methimazole treatment to help control the hyperthyroidism, and injectable B12 to help regulate these levels.

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

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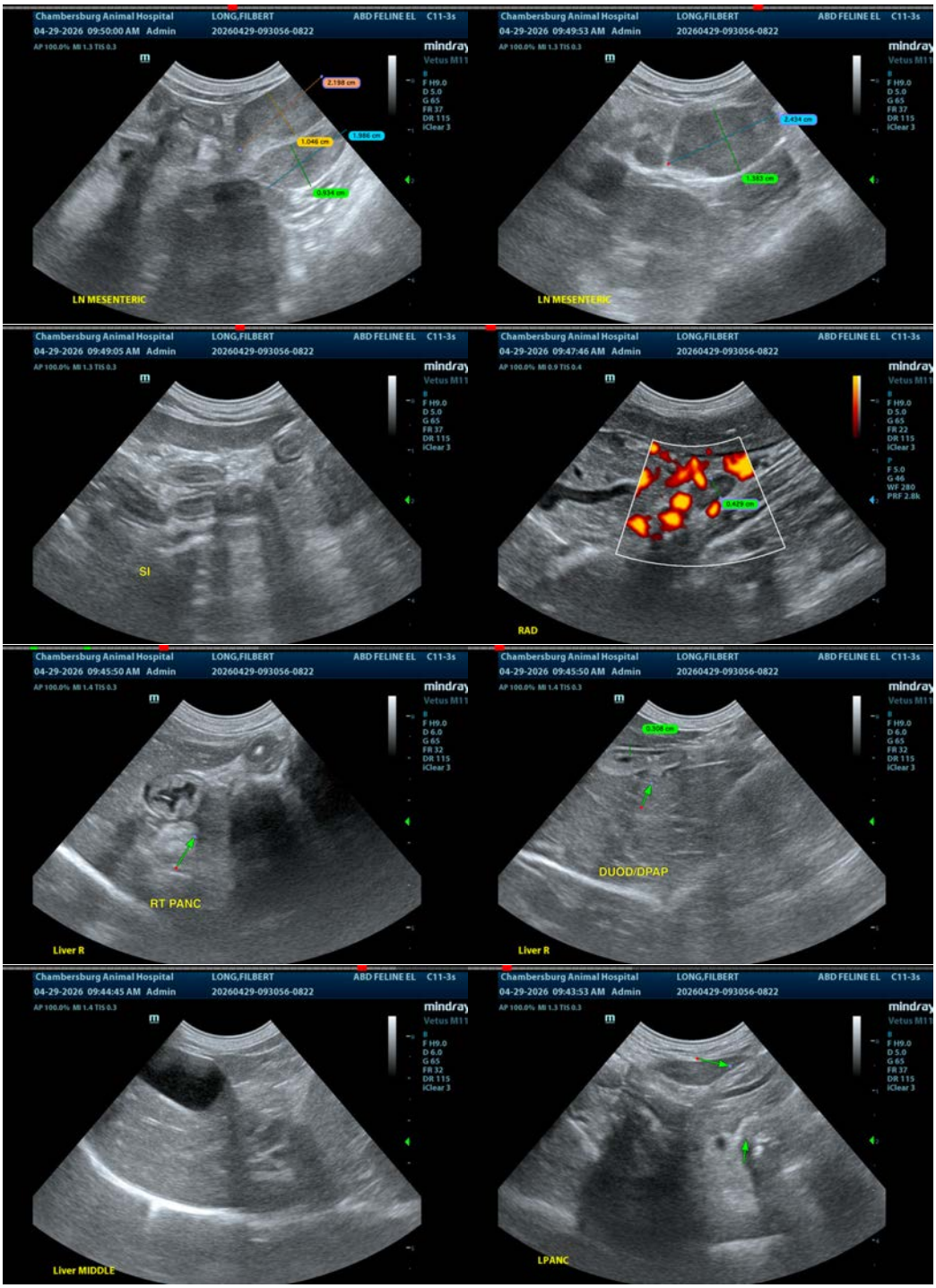

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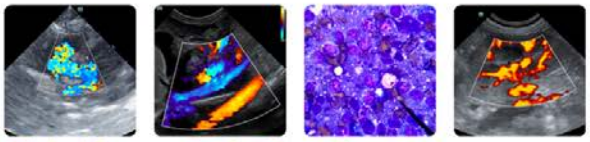

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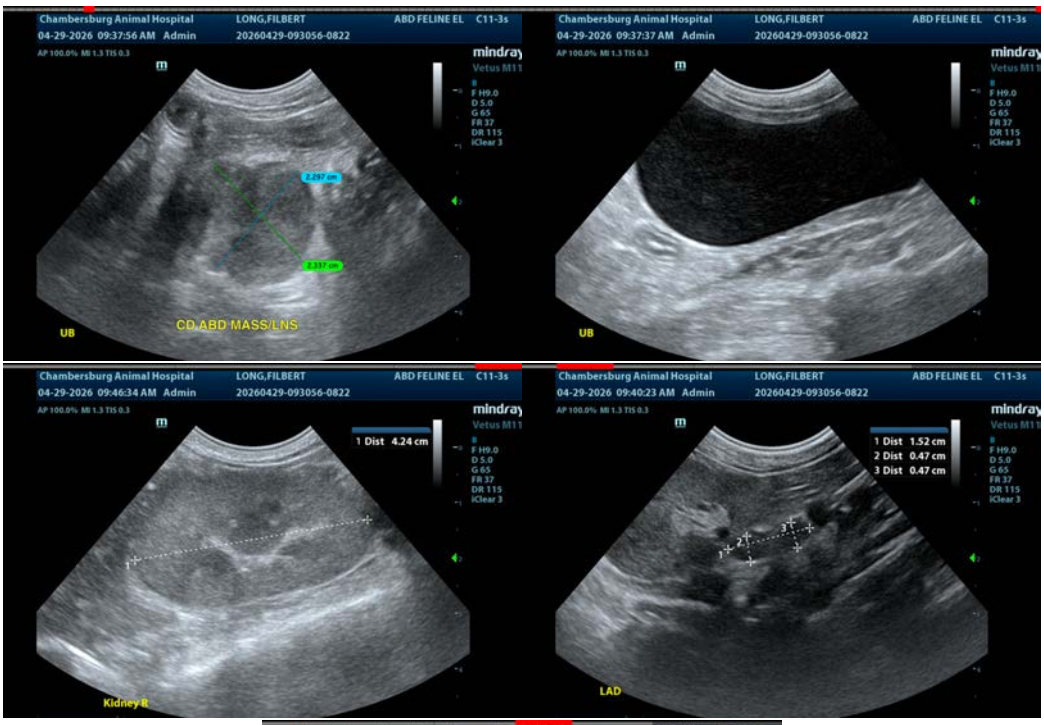

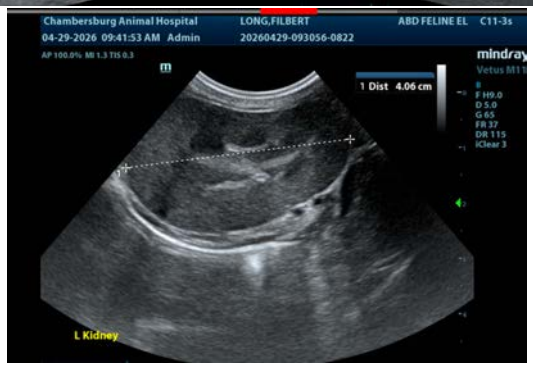

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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