DATE

04/03/26

PATIENT

Lola Dyer

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

04/26/11

WEIGHT

9.18 pounds

INTERPRETED BY

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

HOSPITAL NAME

Jacksonville Veterinary Hospital

REFERRING VET

Dr. Kablis

INVOICE

14839

PRESENTING CLINICAL SIGNS

Patient History: History of bloody diarrhea in January 2026 with weight loss, approx 3# in 3 years (2023). 3/18/26 further weight loss 10.93# (January) to 9.18# (current), occ vomiting, maybe not eating as well (multiple cats in house)

Current Medications: None.
Labwork Results: labwork not attached, reported as 1/23/26 BUN 41 Creat 2.5 SDMA 23.7 Neut 14842 T4 1.3 FT4 27.9 fecal NPS. 3/18/26 chem normal Neut 4482 T4 0.7 FT4 19.8 fecal NPS
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
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 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 is small (2.16 cm). Overall echogenicity is normal with decreased corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal. Mild pyelectasia is present measuring 0.13 cm.

The right kidney has a normal size and irregular shape (3.81 cm; this is likely due to a pervious infarct). Overall echogenicity is normal with decreased corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 0.33 cm width. 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 0.28 cm width. 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, 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. The spleen measured 0.73 cm width.

Liver

The liver is subjectively normal in size with slightly irregular shape. The parenchyma is homogenous echotexture. The visible portions of the vasculature appear normal. There is a poorly defined mixed echogenicity hypoechoic mass effect visualized in the mid-region of the liver measuring approximately 2.88 cm x 2.64 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 primarily anechoic. The bile duct appears slightly dilated and tortuous measuring approximately 0.30 cm and is lost to visualization distally.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7 cm 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. The duodenum measured 0.21 cm in diameter, and the jejunum measured 0.29 cm in diameter. Visualized peristalsis appears appropriate. There is segmental thickening of the muscularis layer of the small intestine with some areas of small intestine measuring up to 0.35 cm in thickness.

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 somewhat poorly defined but large, prominent, mottled and hypoechoic in both limbs with surrounding reactive mesentery.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are occasional prominent mesenteric lymph nodes with an example measuring 0.43 cm. The omentum is diffusely hyperechoic in the cranial abdomen, particularly in the region of both limbs of the pancreas.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Small irregular left kidney with a large irregular right kidney, both with decreased corticomedullary distinction and a right-sided infarct- 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 and chronic active pancreatitis.

- Poorly defined mixed echogenicity a hypoechoic ‘mass effect’ visualized in the liver- findings are concerning for a benign or neoplastic mass effect, although an irregular ‘bulge’ in the liver is possible.

- Mildly tortuous/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 (i.e. choledocholith, bile duct tumor, pancreatic disease, other).

- Diffusely ropey/thickened small intestine with some segmental areas of small intestine displaying more significant thickening and 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

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

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Both kidneys have changes consistent with chronic renal disease. Recommended a blood pressure, urinalysis and culture +/- urine protein creatinine ratio as a baseline. Consider continued monitoring of the right kidney as the irregular shape could be concerning for early infiltrative change.

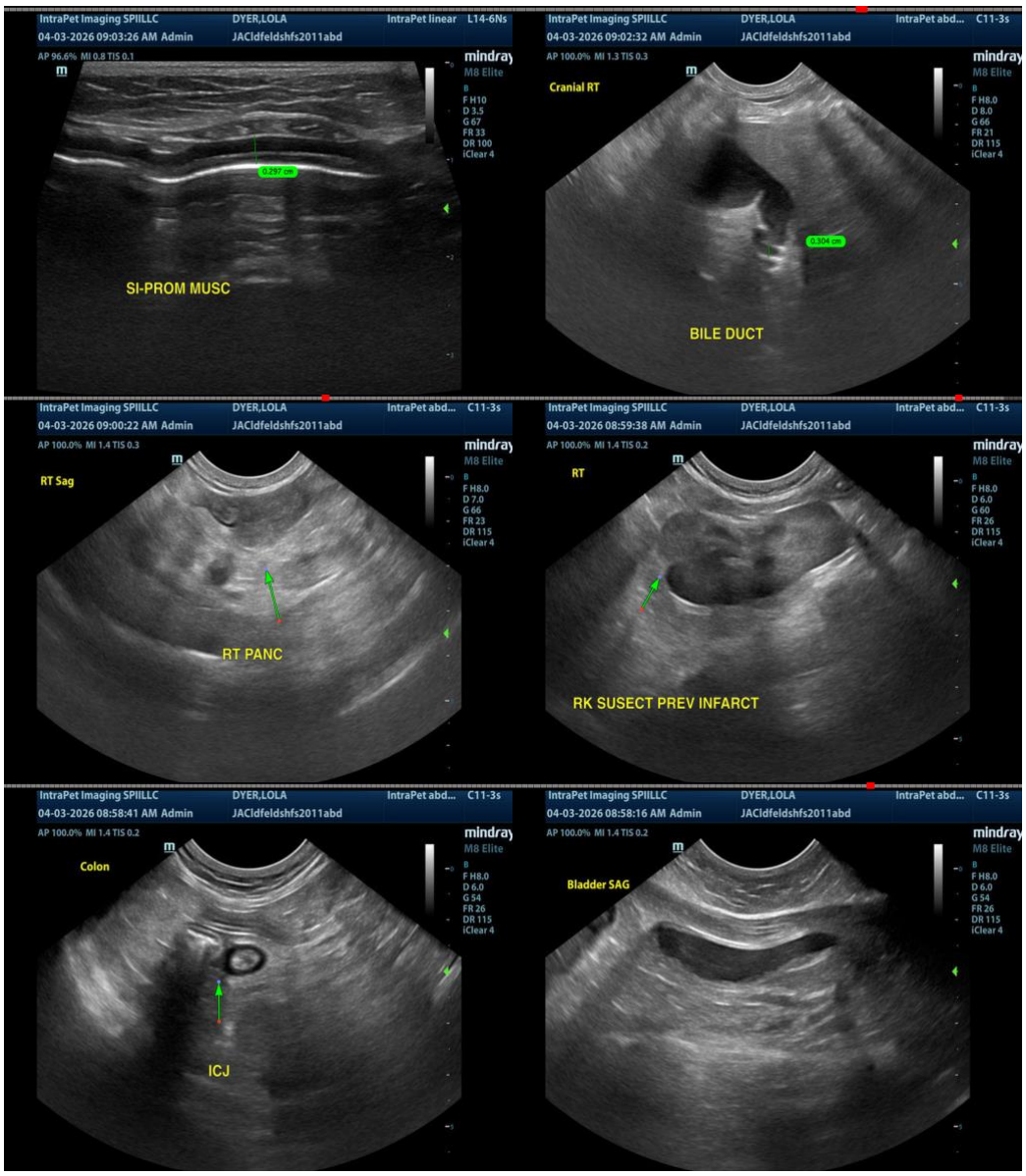
Both limbs of the pancreas are prominent and hypoechoic with surrounding reactive mesentery most consistent with chronic pancreatic remodeling and chronic active pancreatitis. Correlate with pLI level and consider empirical treatment for pancreatitis.

There is a poorly defined hypoechoic mixed echogenicity rounded area of the mid liver concerning for a poorly defined mass effect. This could represent a benign or neoplastic lesion. If a safe window for sampling is available, consider a fine needle aspirate. A contrast CT scan could be considered for further evaluation.

The bile duct appears somewhat torturous and dilated. No definitive obstruction or pathology is observed. If liver enzyme elevations are present, consider Ursodiol therapy and continued monitoring of the gallbladder.

The small intestine appears diffusely ‘ropey’ with some areas exhibiting more significant thickening and a prominent muscularis layer. These changes are most consistent with inflammatory type change although early neoplastic change can have a similar appearance. Consider dietary therapy with a hydrolyzed protein prescription diet. Additionally, consider a GI panel to Texas A&M for a qualitative FPLI, TLI, cobalamin and folate. If symptoms are persistent despite treatment for pancreatitis and dietary therapy, then ultimately surgical biopsies of the GI tract with samples obtained from the small intestine, pancreas and liver mass lesion for histopathologic evaluation.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.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SI-PROM MUSC
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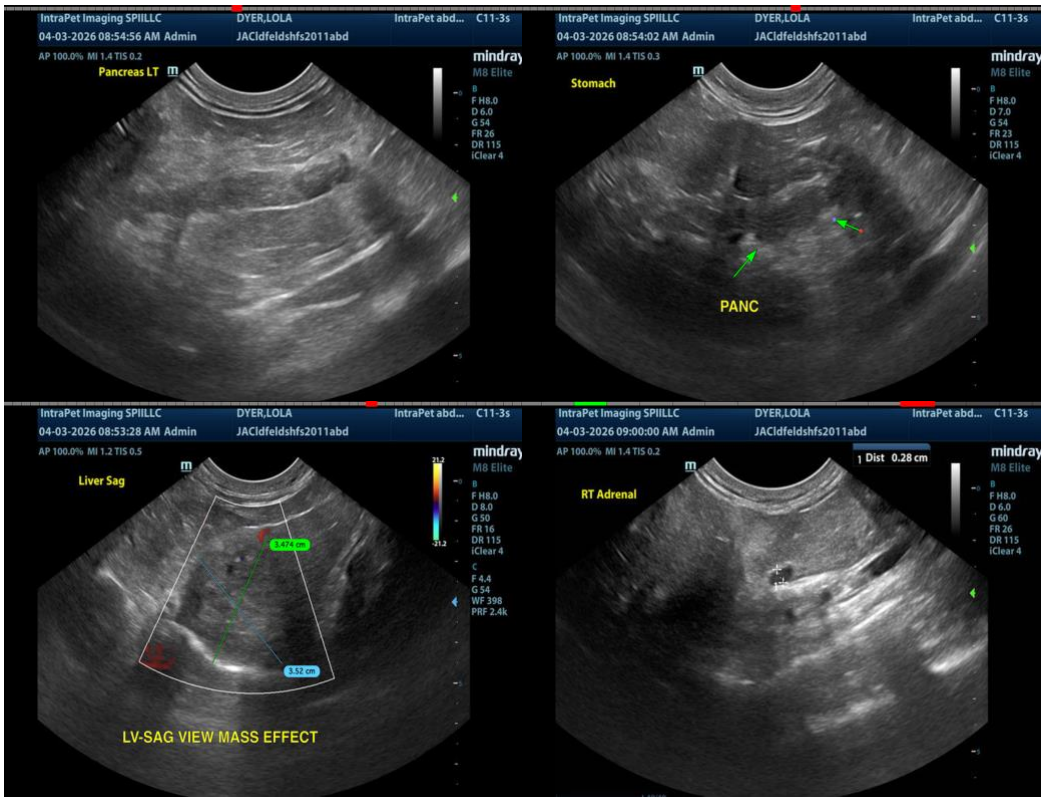
Bladder SAG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Pancreas LT
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Liver Sag
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3.52 cm
LV-SAG VIEW MASS EFFECT
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Dist 0.28 cm
RT Adrenal
mindray
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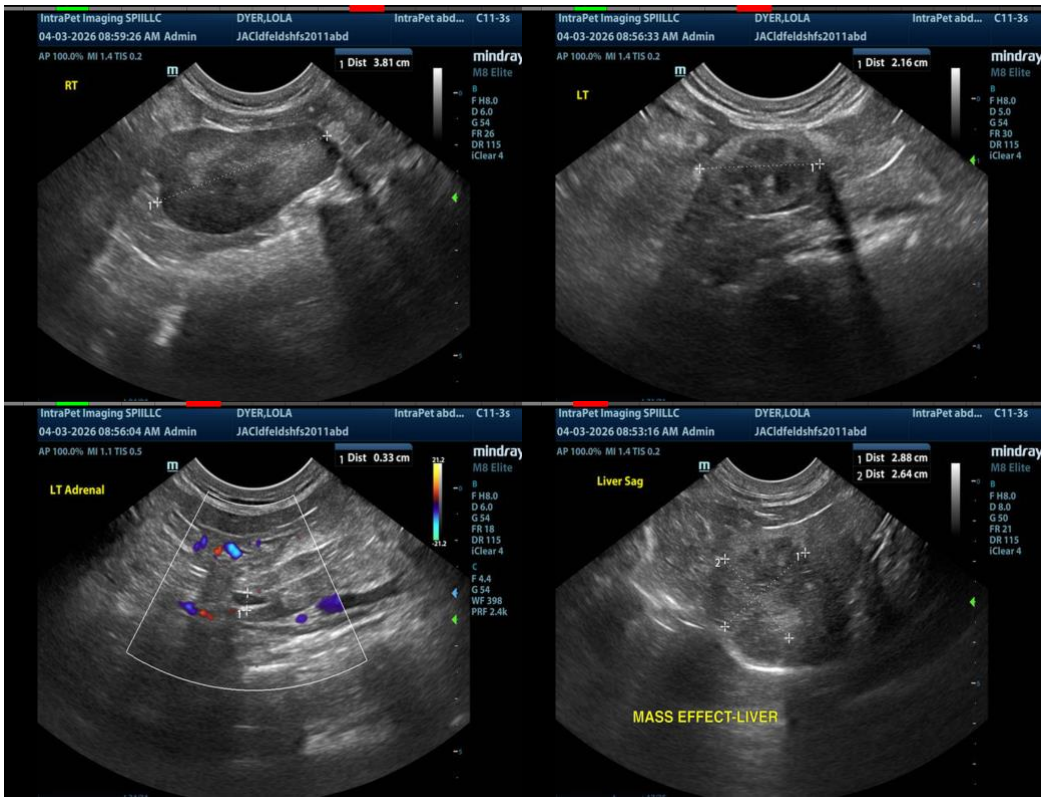

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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