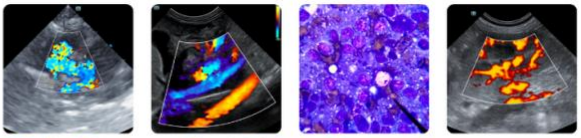


PATIENT

Bianca Dejesso

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

13 Years

WEIGHT

6 Pounds

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM

IMAGING PERFORMED BY

Shari Reffi, CVT

HOSPITAL NAME

Harmony AH

REFERRING VET

Dr. Epple

INVOICE

36879

DATE

4/30/26

PRESENTING CLINICAL SIGNS

History: BCS 3/9. Weight loss, hematochezia, no palpable abdominal mass, underweight BCS. No current meds.

Abnormal PE/Chem/CBC/UA Results: SpecFPL 6.0

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is minimally distended with urine, making full evaluation and visualization difficult. No abnormalities are noted in the region.

The left kidney has a normal shape and size (2.71 cm). Overall echogenicity is slightly hyperechoic with decreased 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 (3.04 cm). Overall echogenicity is slightly hyperechoic with decreased 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 0.53 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 0.32 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

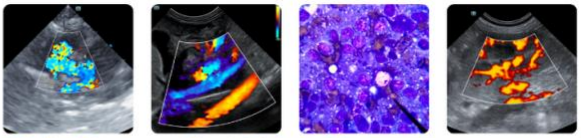
The spleen is subjectively borderline plump in size (0.96 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

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 primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains mild fluid/ingesta. 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.



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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 0.31 cm in diameter, and the jejunum measured 0.25 cm in diameter. 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. The descending colon wall was slightly prominent with intact wall layering, measuring at 0.26 cm.

Pancreas

The pancreas is prominent and hypoechoic in the left limb, as 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. A prominent pancreatic duct was noted, measuring at 0.54 cm.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Age-related changes visualized associated with both kidneys
- Pancreatic changes most consistent with pancreatic remodeling and chronic pancreatitis. Neoplastic infiltration cannot be ruled out but seems less likely.
- Thickened 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.
- A prominent colon, descending colon wall with intact wall larynx findings could be consistent with mild colitis.
- Borderline plump spleen- Findings could be consistent with the anatomic variation, congestion, splenitis, lymphoid hyperplasia, or neoplastic infiltration.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine appears diffusely thickened and “ropey” with a prominent muscularis layer. These changes are most consistent with inflammatory type change, although early neoplastic change cannot be ruled out. Correlate with current symptoms. If small intestinal disease is suspected, 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.

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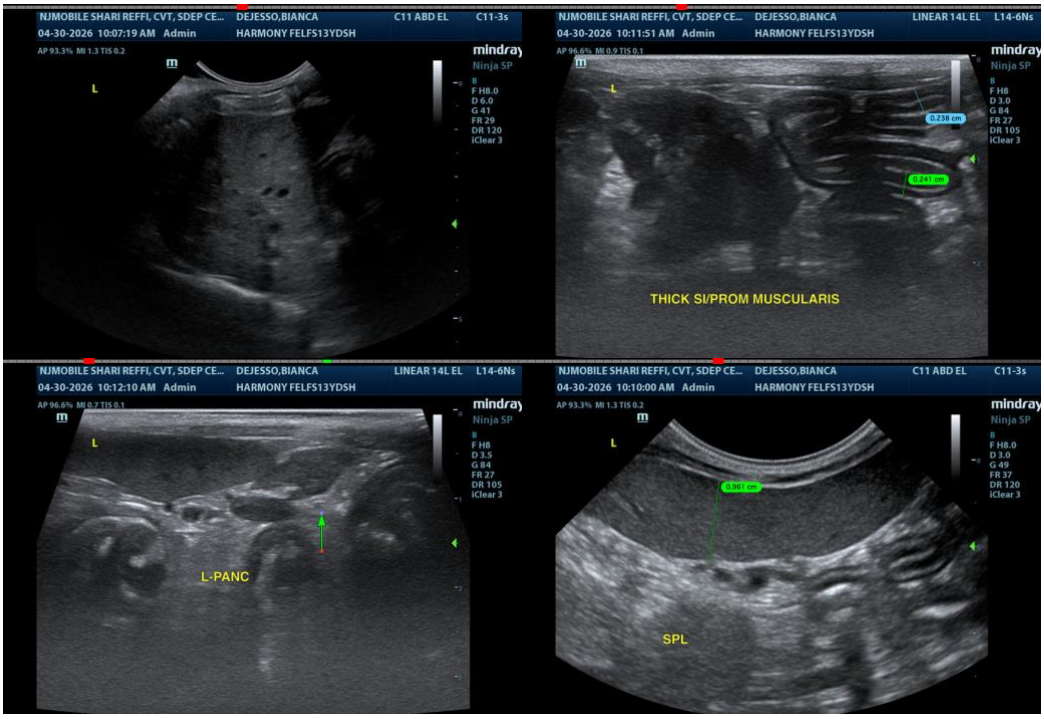
- Recommend chronic probiotic therapy.

Additionally, the colon wall appears slightly prominent. You could consider screening for infectious causes of large bowel diarrhea.

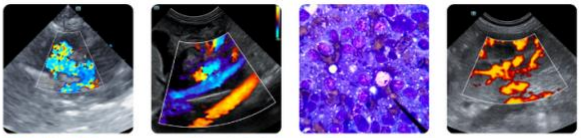
Both kidneys have decreased corticomedullary distinction. Correlate with current renal values and urine concentrating ability.

The left limb of the pancreas is prominent and hypoechoic with prominent pancreatic duct. This could be consistent with chronic pancreatitis. Correlate with the PLI level and consider empirical therapy.

If symptoms are persistent, despite taking these steps, consider biopsies of the GI tract for histopathology. If symptoms are primarily large bowel signs, endoscopic biopsies of the colon and small bowel could be considered. Additionally, consider repeat imaging looking for the progression of today's lesions or the presence of a focal lesion not seen on today scan. A fine needle aspirate of the pancreas could be considered. Additionally, a fine needle aspirate of the spleen could be considered.



New Jersey Mobile
FUELED BY SONOPATH VETERINARY ULTRASOUND



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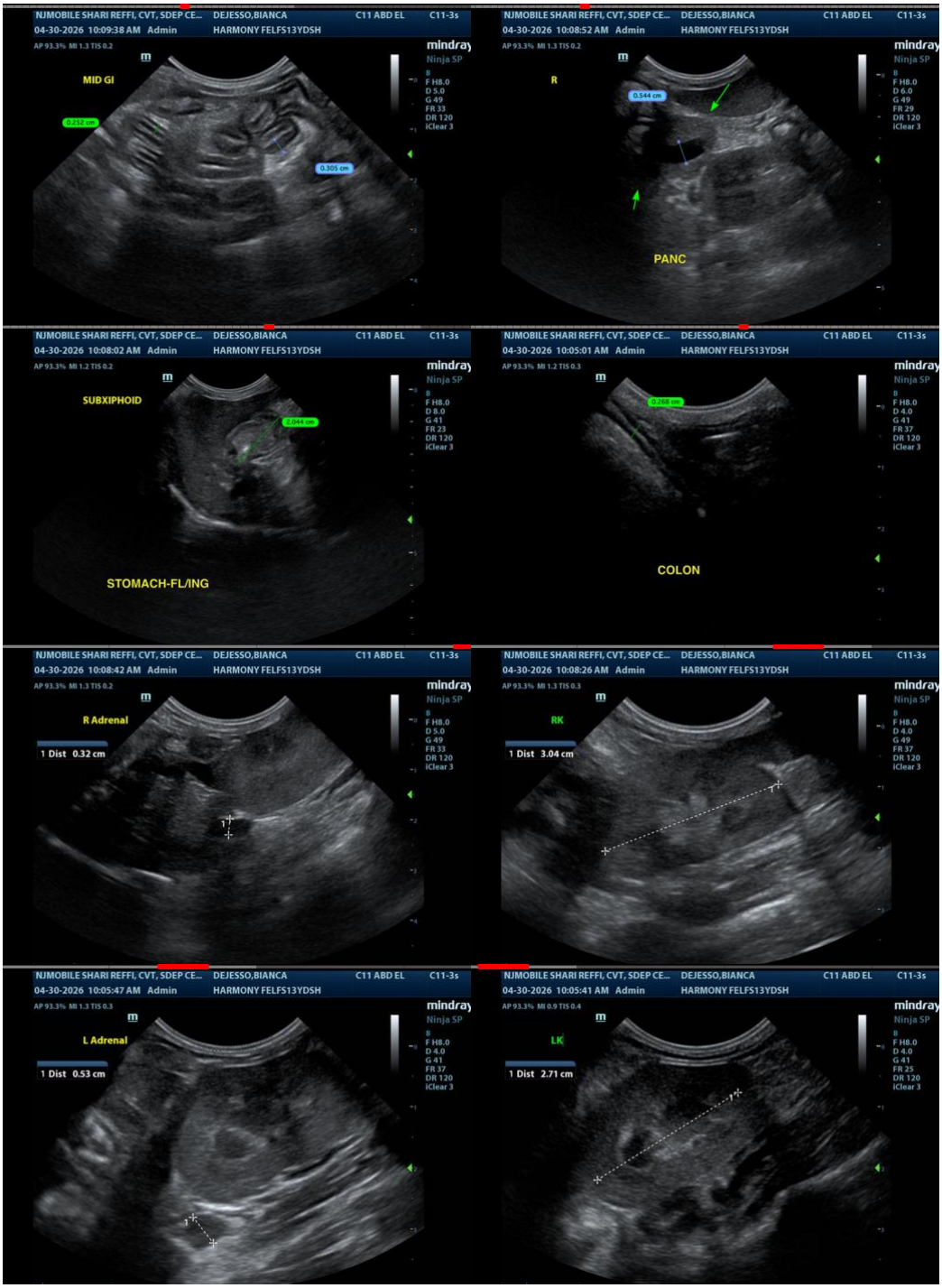

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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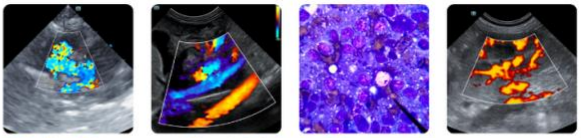

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

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

info@sonopath.com