PATIENT

Wuzzy Susan

SPECIES

Feline

BREED

DLH

SEX

FS

AGE

13 years

WEIGHT

6.0 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

North Fork Veterinary Clinic

REFERRING VET

Dr. Kristi Whitten

INVOICE

11657

DATE

4/9/2026

PRESENTING CLINICAL SIGNS

Wuzzy is a 13-year-old spayed female Domestic Medium Hair with a significant history of severe dental disease requiring multiple extractions, a diagnosed heart condition (DRVOTO), obesity, and a recent presentation for vomiting with findings suggestive of gastric retention and potential chronic renal disease. On 11-02-2021, an annual exam revealed numerous Feline Odontoclastic Resorptive Lesions (FORLs), severe gingivitis, and many missing teeth, prompting a recommendation for a dental procedure. A new Grade 4 left parasternal murmur was detected on 10-28-2022. An echocardiogram performed on 11-28-2022 diagnosed the cause as Double Right Ventricular Outflow Tract Obstruction (DRVOTO). Following this diagnosis, the patient was cleared for a dental procedure on 12-14-2022. During this procedure, ten teeth were extracted due to severe disease, leaving only the upper incisors and teeth 204 and 308. Pre-anesthetic bloodwork on that day showed elevated glucose (212 mg/dL), which was attributed to stress after a urinalysis was inconsistent with diabetes. Subsequent exams on 11-07-2024 and 10-24-2025 noted no murmur or arrhythmia.
Working diagnosis: GI mass, pyloric outflow obstruction, GIFB, ileus

Abnormal PE/Chem/CBC/UA Results: The patient presented on 04-06-2026 for vomiting undigested food immediately after eating for the past couple of days. Physical exam revealed slight dehydration and lumpy kidneys. Initial radiographs showed a very full stomach. After five hours without food, repeat radiographs showed a persistent, large amount of material in the stomach. A formal radiology report noted the persistent gastric content with mild stomach enlargement, somewhat small kidneys suspicious for chronic renal disease, and a small intestinal pattern concerning for inflammatory changes, while not ruling out a partial obstruction. An abdominal ultrasound was recommended for further evaluation.

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 is normal in size (3.65 cm), and irregular in shape (likely due to previous infarct in the caudal pole.) Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of free fluid, but the mesentery appears hyperechoic surrounding the left kidney. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.19 m), and irregular in shape (with a likely infarct in the caudal pole). Overall echogenicity is slightly hyperechoic 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 0.4 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 0.36 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 (0.59 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 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, 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 0.2 cm in diameter and the jejunum measured 0.26 cm in diameter. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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 large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with moderate pancreatitis in the left caudal limb.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is no significant lymphadenopathy. The omentum is hyperechoic, particularly in the left abdomen around the caudal aspect of the left limb.

ULTRASONOGRAPHIC FINDINGS

- Age related changes and infarcts visualized associated with both kidneys.

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- Pancreatic changes in the caudal aspect of the left limb of the pancreas most consistent with moderate pancreatitis.
- Subjectively, mildly “ropey” small intestine with some areas exhibiting 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

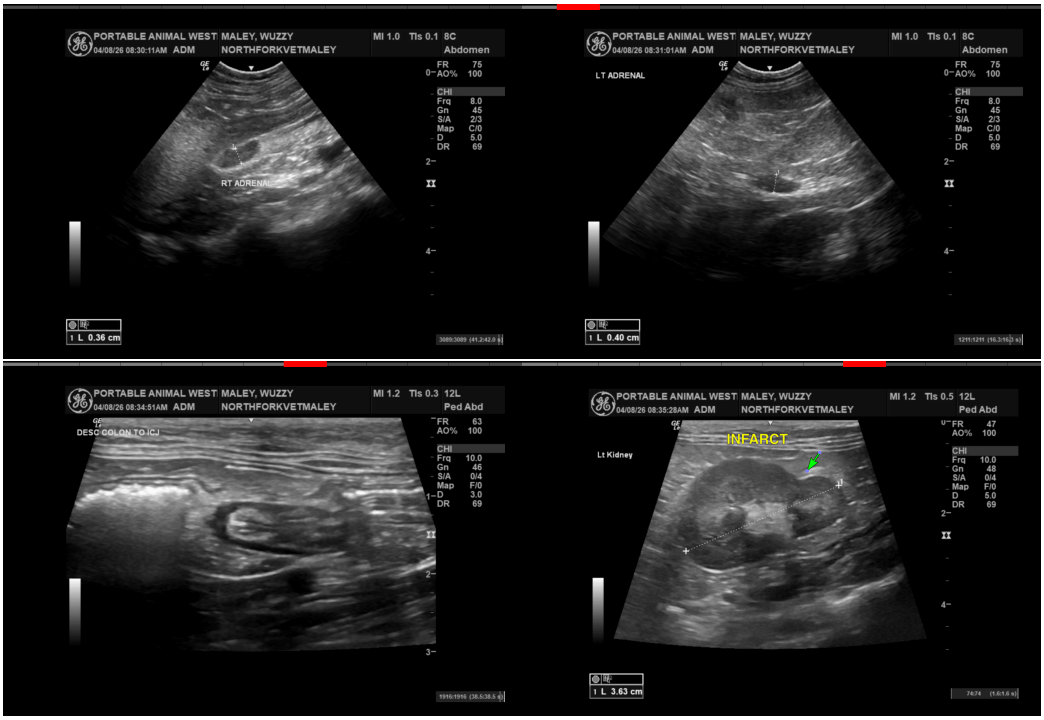
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach appears relatively empty on today’s exam with no focal lesions observed. The small intestine has some areas which appear mildly “ropey” with a prominent muscularis layer, but no focal lesions are observed. Findings could be consistent with underlying inflammatory type change, and ileus, or an unseen partial out flow tract obstruction, etc.

There are significant changes visualized associated with both kidneys. Most notably irregularly shaped kidneys, likely due to previous infarcts. Recommend a blood pressure, urinalysis and culture as a base line if not already done.

The left and right limb of the pancreas are visible, most notably the caudal left limb of the pancreas is hypoechoic and mottled with highly reactive mesentery surrounding. Most consistent with active acute pancreatitis. Correlate with PLI level and recommend treatment for acute pancreatitis.

If pancreatitis is improving and the GI symptoms are persistent, ultimately biopsies of the GI tract and further evaluation of the stomach/outflow tract may be warranted.



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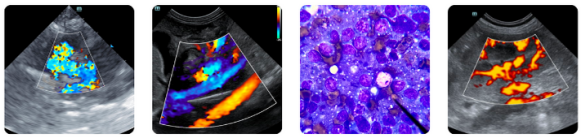

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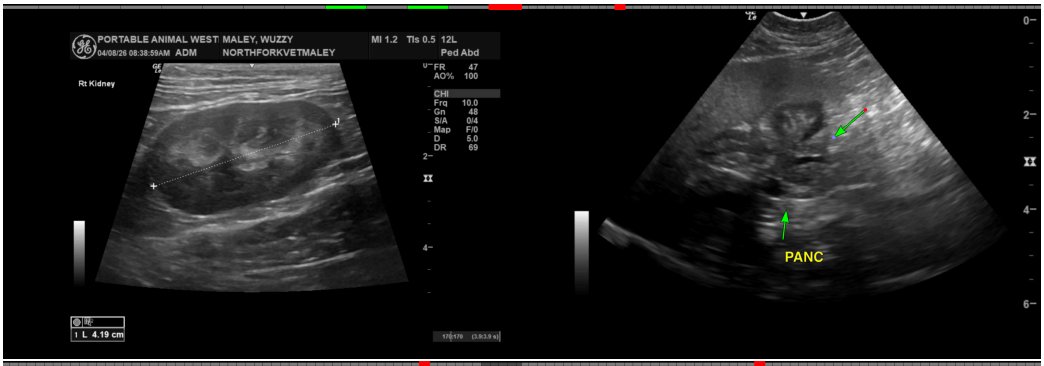

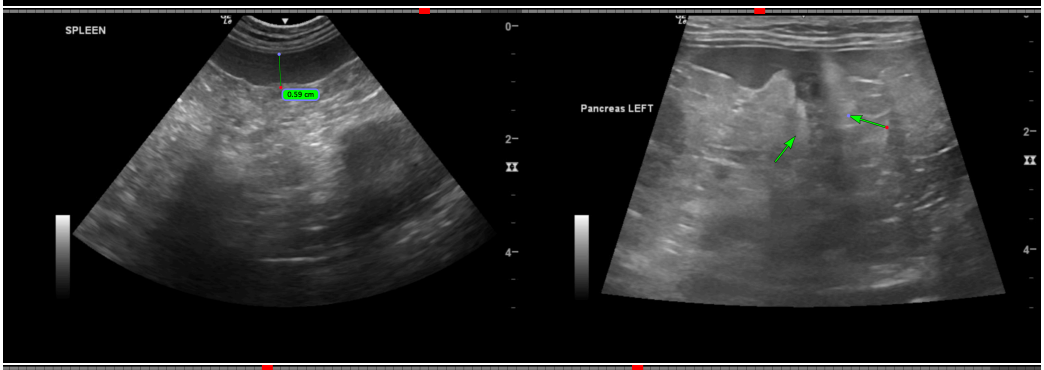

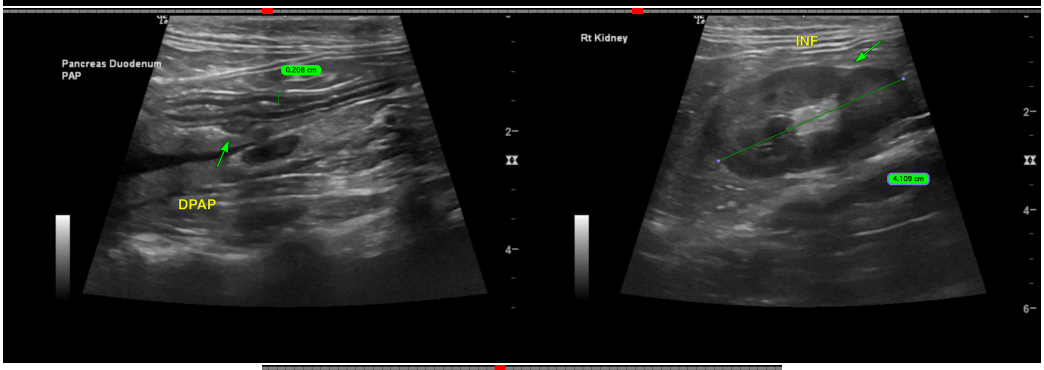

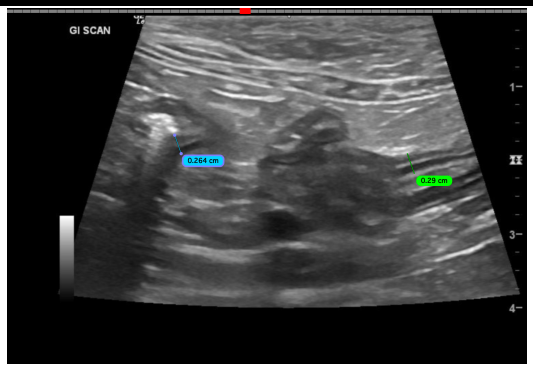

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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)

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