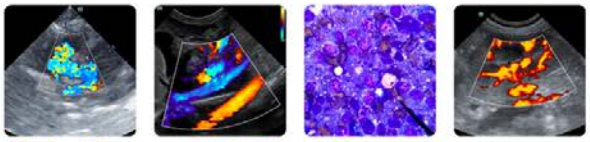


PATIENT

Hyacinth Shank

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

13 Years

WEIGHT

8.7 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Mary Pearce

HOSPITAL NAME

Chambersburg Animal Hospital

REFERRING VET

Dr. Mary Pearce

INVOICE

75177

DATE

5/14/26

PRESENTING CLINICAL SIGNS

Presented for re-evaluation of swelling under the left eye and concerns for periodontal disease requiring COHAT. Hx diabetes mellitus, receives Prozinc 2U BID. P has a good appetite and mainly now eats tuna, has been more picky about her food preferences but is still eating. Drinking normally, no evidence of PU/PD. Currently on clindamycin for dental disease. Discussed proceeding with COHAT, send out pre-op BW. O approved plan. Pre-op BW showed some concerns, recommended additional workup including ultrasound, GI panel, etc. O elected to proceed, came in today for these diagnostics. r/o IBD, GI neoplasia, PLE, open

Abnormal PE/Chem/CBC/UA Results: PE: Severe periodontal disease, missing many teeth, r/o tooth root abscess left side with mild firm swelling under the left eye. Weight loss: 8.7lb now, was 9.7lb as of 2/7/26. 5/14/26: Pancreatic lipase normal 2.2. TT4 normal 1.8. Radiographs: Thoracic and abdominal images unremarkable other than mild spondylosis. 5/12/26: HCT 34.5%, retic 100 (0-70). WBC normal, mono 1.019 (H), PLT 475 (H). Glu 371. Total protein 7.8, albumin 2.4 (L 2.6-3.9), glob 5.4.

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. (4.22 cm) with a cortical cyst measuring 0.94 cm. Overall echogenicity is normal with adequate 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 (4.47 cm). Overall echogenicity is normal with adequate 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.

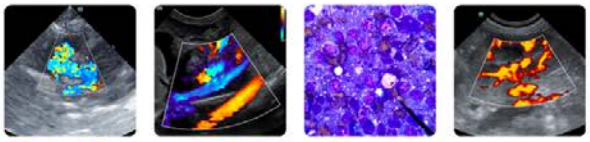
Adrenal Glands

The left adrenal gland is normal in size measuring 0.39 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 0.51 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 (0.67 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.



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Liver

The liver is subjectively normal in size with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in 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 significantly distended. Some areas of the wall appear mildly thickened with adherent debris. There is a large amount of primarily non-organized echogenic debris. There is no evidence of bile duct dilation.

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. Duodenum wall measures 0.26 cm. Jejunum wall measures 0.24 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 left limb of the pancreas is prominent and mottled 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

There is scant free fluid visualized in the mid abdomen between bowel loops and near the gallbladder. There are occasional prominent mesenteric lymph nodes, examples measure 0.52 cm x 0.81 cm and 0.56 cm x 0.76 cm. The omentum is generally mildly hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- Pancreatic changes most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.
- Hyperechoic liver – Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- Large gallbladder debris – A large amount of debris is evident in the gall bladder with no evidence of a mucocele or associated inflammation at this time. This could represent an early mucocele or cholestasis, with minimal evidence of associated inflammation at this time. Continued monitoring of labwork and ultrasound are warranted for progression of this lesion. Ursodiol therapy could be considered.

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- Mildly "ropey" small intestine with some areas exhibiting a slightly 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.

- Scant free abdominal fluid and some prominent mesenteric lymph nodes – Findings are most consistent with reactive lymph nodes. Early neoplastic lymph nodes cannot be ruled out.

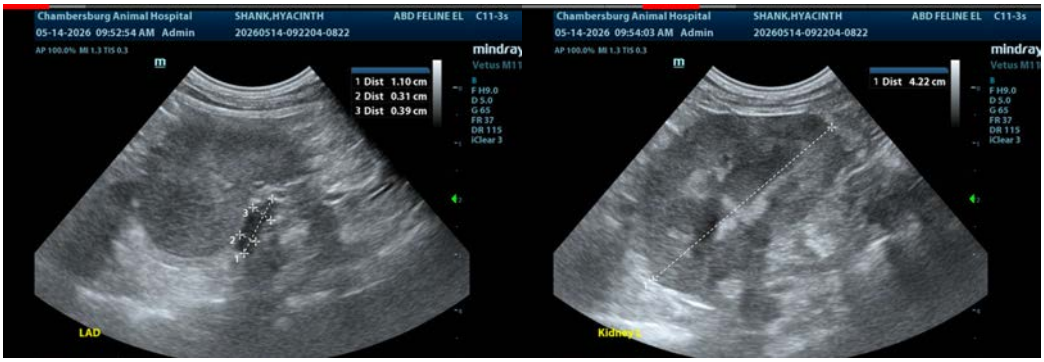
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The left limb of the pancreas is prominent and somewhat hypoechoic. These changes could be consistent with chronic pancreatic remodeling +/- chronic active pancreatitis. Correlate with a PLI level and consider empirical treatment for pancreatitis if warranted.

The liver is mildly hyperechoic, possibly consistent with a diabetic hepatopathy. This is a common finding and possibly incidental at this time.

The gallbladder appears somewhat large with echogenic intraluminal debris. There is no evidence of adhered debris, stones, or significant inflammation, but there is a scant amount of free fluid near the gallbladder. The significance of this is uncertain, particularly in the absence of liver enzyme elevations. Ursodiol therapy could be considered in addition to continued monitoring of the gallbladder.

Some sections of small intestine appear mildly "ropey", and there is a mild mesenteric lymphadenopathy with low albumin levels. Consider the possibility of a protein losing enteropathy despite relatively mild changes to the GI tract. Recommend urinalysis and with urine protein to creatinine raito to rule out loss from the kidneys. Additionally, you could consider a liver function test to look for any occult liver dysfunction, and a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate, looking for evidence of underlying gastrointestinal disease. If this is abnormal, consider hydrolyzed protein prescription diet, probiotic therapy, etc. Ultimately biopsies of the GI Tract may be warranted +/- reevaluation of the GI tract in the future with ultrasound to look for progressive thickening/irregularity.



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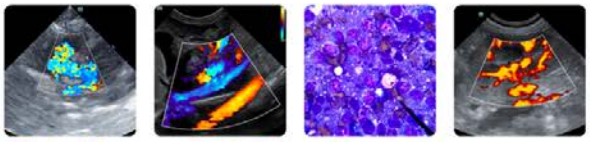

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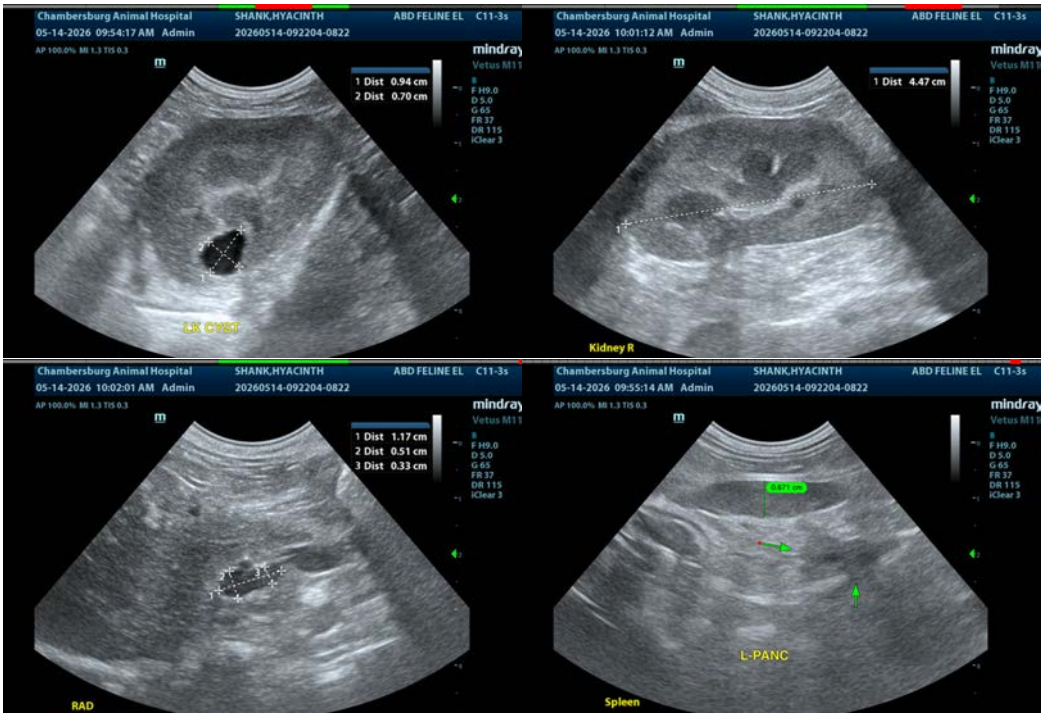

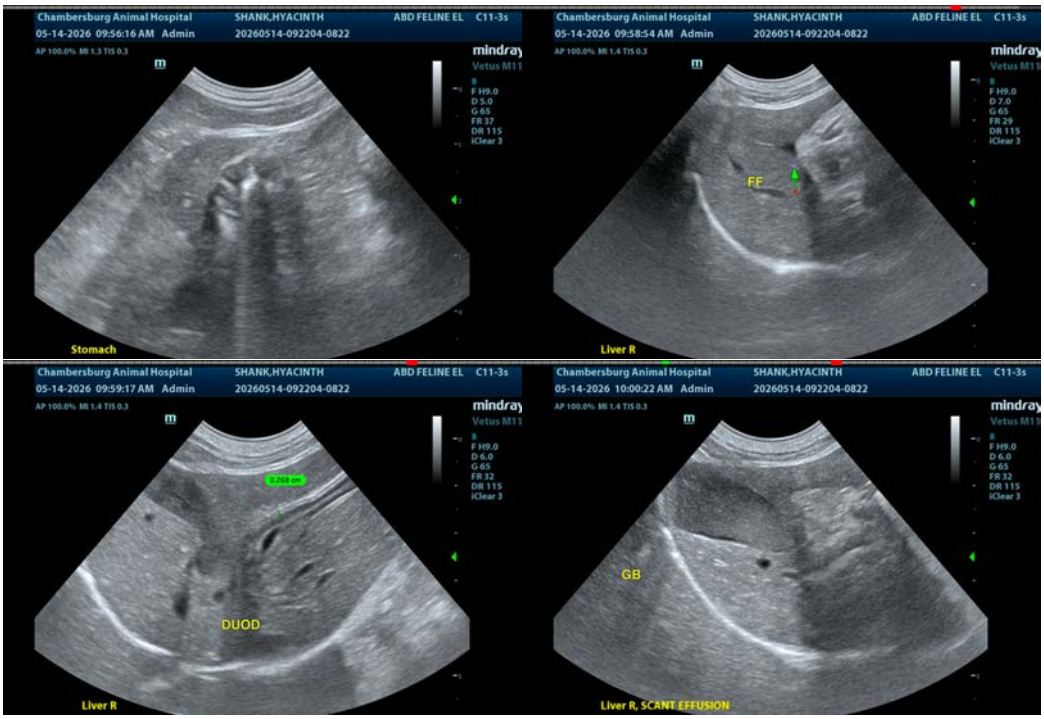

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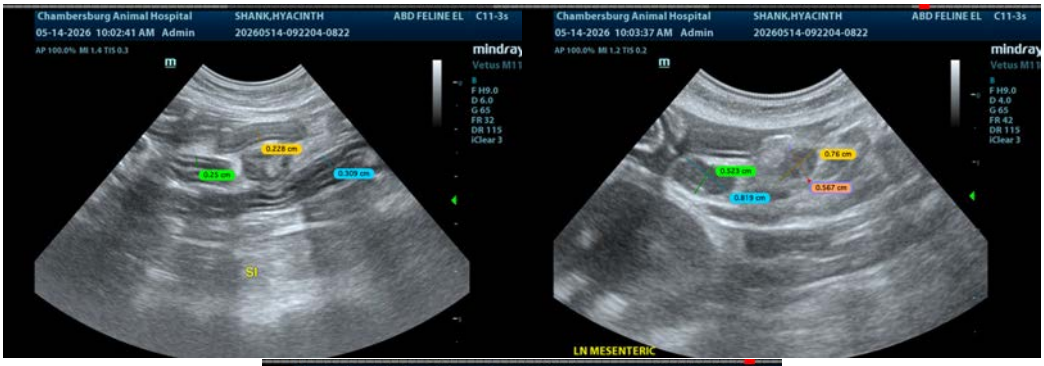

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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