



## PATIENT

Zoey Caswell

## SPECIES

Feline

## BREED

DSH

## SEX

Spayed Female

## AGE

10 Years

## WEIGHT

10.6 lbs

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Jillian Firsich, RDMS,  
LVT

## HOSPITAL NAME

SVS Imaging Michigan

## REFERRING VET

Shira Anchill, DVM

## INVOICE

75181

## DATE

5/14/26

## PRESENTING CLINICAL SIGNS

Vomiting, hyporexia (anorexia without mirtaz). Unintentional 1# weight loss in past 1 month. Recently on Elura, drontal and cerenia

Abnormal PE/Chem/CBC/UA Results: RT, V/D thoracic/abdominal-Structures of heart and lungs appear unremarkable. No apparent metastatic disease or LN enlargement. Stomach, intestines, colon and bladder appear empty aside from mild gas. No obvious displacement of abdominal contents or mass effect. History of eosinophilia Soft gassy abdominal palpation. No palpable lymphadenopathy. \*\*Please see attached labs

## 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 (3.33 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 (3.24 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 0.33 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 0.47 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 (0.72 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.



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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.

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### **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.

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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. Duodenum wall measures 0.30 cm. Jejunum wall measures 0.27 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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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.

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### **Pancreas**

The pancreas is large and hypoechoic to surrounding mesentery (particularly in the left limb). There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild to moderate pancreatitis.

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### **Free Abdomen**

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a mild mesenteric lymphadenopathy with lymph nodes at the ileocecal junction measuring 0.31-0.40 cm. Lymph nodes at the mesenteric root measure 0.63 cm x 1.95 cm and 0.75 cm x 2.29 cm. The omentum is mildly diffusely hyperechoic, particularly around the left limb of the pancreas.

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### **ULTRASONOGRAPHIC FINDINGS**

- Pancreatic changes consistent with active pancreatitis.
- Diffusely 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.
- Occasional prominent mesenteric lymph nodes – These have the appearance most consistent with reactive lymph nodes. An early neoplastic process cannot be ruled out.

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### **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Both limbs of the pancreas are prominent with prominent pancreatic duct. The left limb of the pancreas in particular has surrounding reactive mesentery concerning for active pancreatitis.

Additionally, the small intestine appears diffusely thickened with a prominent muscularis layer, concerning for possible concurrent chronic enteropathy. Consider the following:



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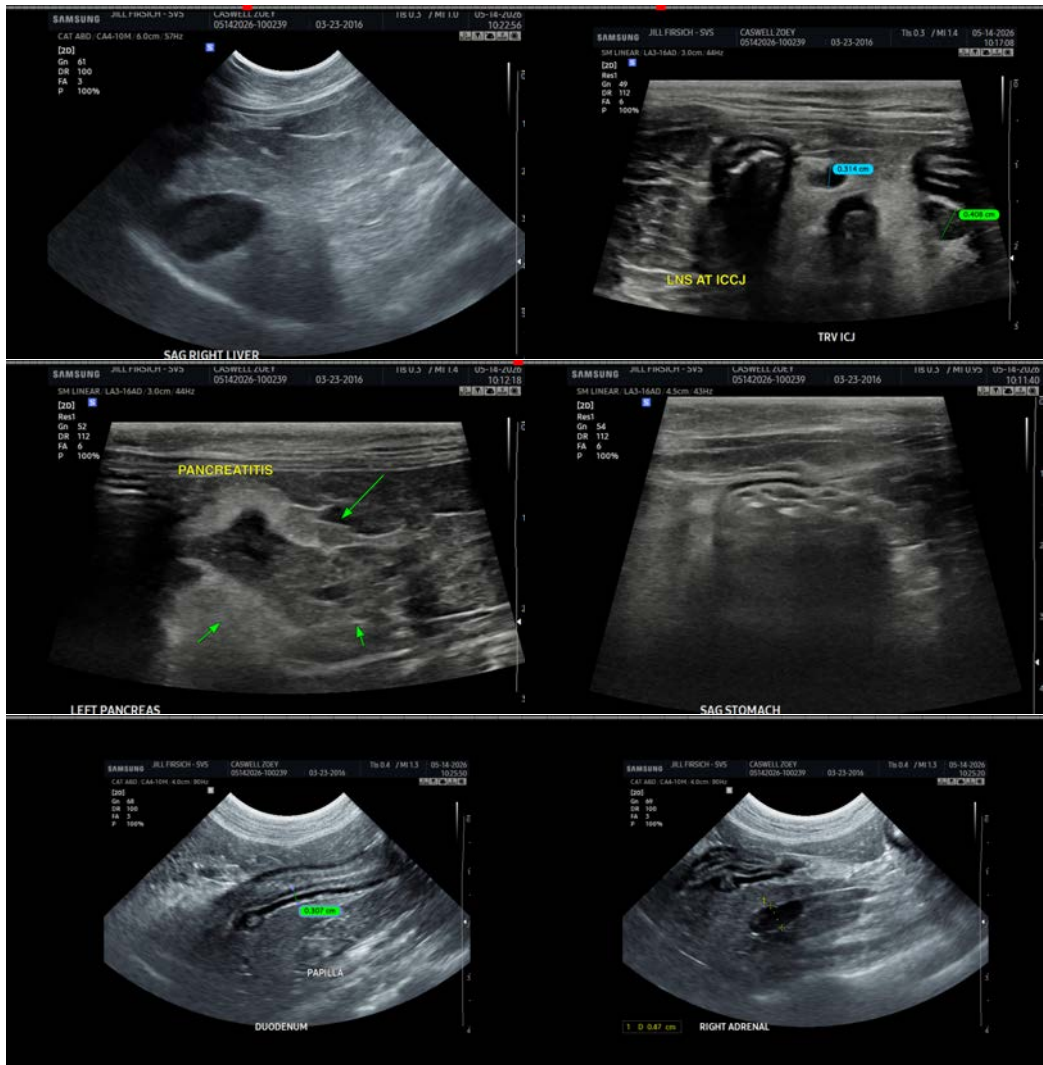
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- Recommend supportive care and treatment for acute pancreatitis (fluid management, pain medication, nausea medication, etc.).
- When the patient starts eating better, consider a prescription ultra low-fat/hydrolyzed protein prescription diet (Royal Canin has this combination).
- 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.

If symptoms are persistent despite appropriate treatment, ultimately biopsies of the GI tract and pancreas may be warranted. Prior to this you could consider repeat imaging, looking for progression of today's lesions or the development of any new lesions.





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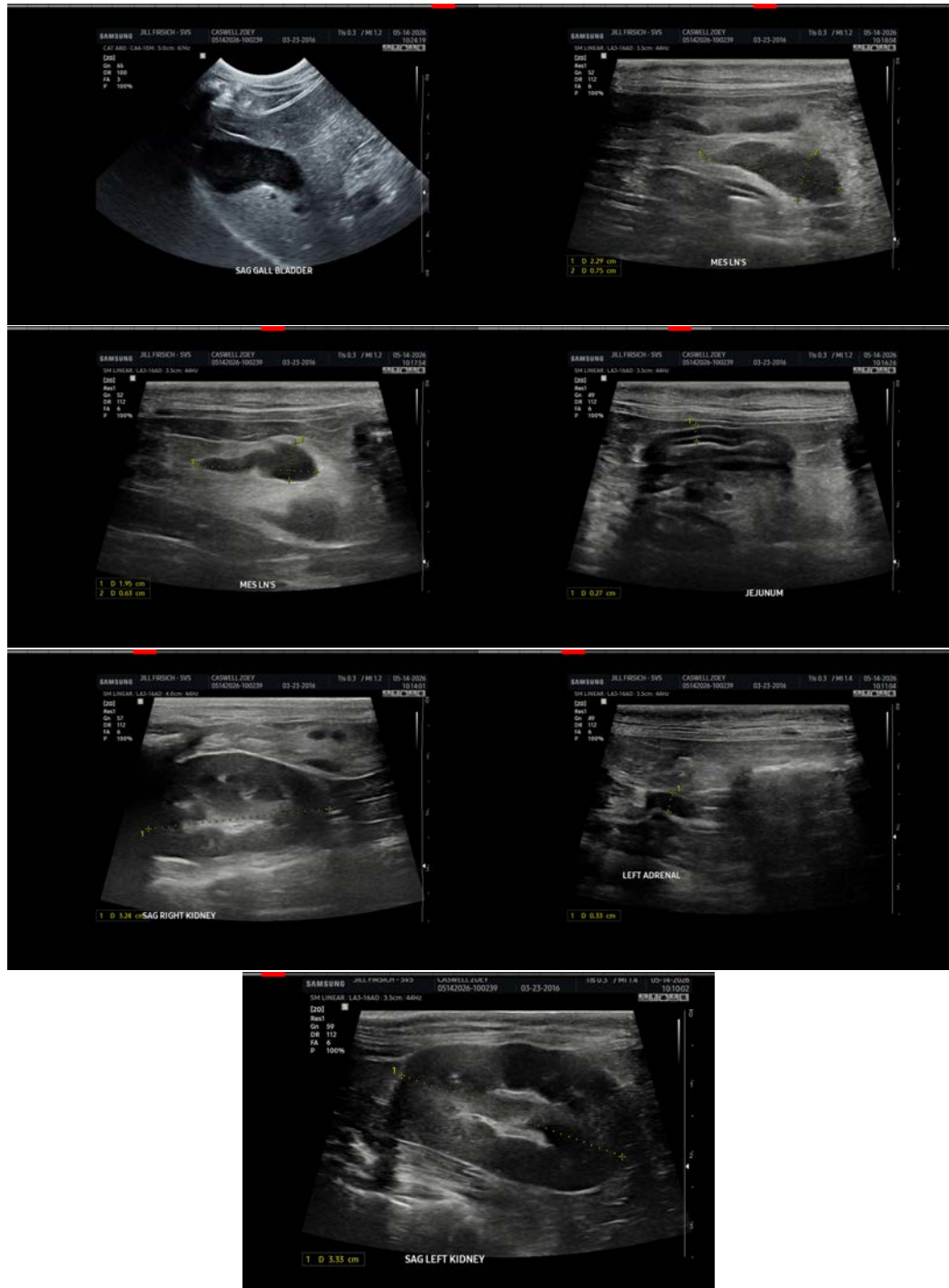
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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