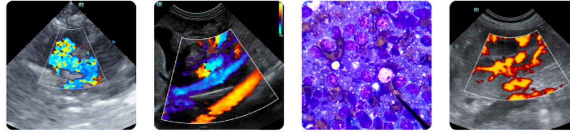


DATE

05/15/26

PATIENT

Hank Forth

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

07/20/14

WEIGHT

10 lbs

INTERPRETED BY

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

HOSPITAL NAME

Fallston Veterinary Clinic

REFERRING VET

Dr. Harvey

INVOICE

11962

PRESENTING CLINICAL SIGNS

Patient History: Presented 4/22 for 3 weeks of decreased appetite and vomiting within 1 hour of eating. Abdomen palpated doughy. Abdominal radiographs- digesta in stomach, stool in colon, large bladder

Current Medications: Doxycycline 50 mg PO q24 started 5/2, continued GI diet, mirtazapine, gabapentin
Cerenia 10 mg/ml- 0.45 ml SQ on 5/14
Labwork Results: Attached, reported as: CBC/Chem- mild normocytic normochromic nonregenerative anemia. FeLV/FIV- neg x2. AUS declined. 4/22.Recheck CBC 4/29 showed anemia stable. Recommend anemia panel to Idexx- declined in favor of empirically treating with doxycycline for 30 days. Vomiting returned 5/9 once daily, two episodes with blood. Still eating some but not taking any medications. Recheck CBC 5/14- mild worsening of anemia-moderate normocytic normochromic mildly regenerative anemia
Date of Previous IntraPet Ultrasound: No previous.
Sedation: DKT.
Stat Report: Declined at this time.
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 has a normal shape and size (3.43 cm). 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. Cortical mineralizations noted. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (XXcm). 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 0.33 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 0.41 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 (0.97 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. There's a hyperechoic nodule visualized in the left side of the liver measuring 1.0 cm.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. The gastric wall appears mildly thickened with intact wall layering in some regions but there is a significant portion of gastric wall with severe wall thickening and irregularity, and complete loss of layering measuring up to 1.32 cm in thickness. There's significant inflammation surrounding the abnormal gastric wall. There's a significant amount of shadowing ingesta visualized within the lumen. Suggestive of retained ingesta/gastric ileus. An outflow tract obstruction cannot be definitively ruled out as shadowing material interferes with clear visualization of this region.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis: mucosa layer ratio. The duodenum measured as normal (between 0.32 cm in wall thickness) and the jejunum measured as normal (between 0.2 cm) 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. Decending colon wall is prominent with intact wall layering measuring at 0.23 cm.

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 mild pancreatitis in the right limb.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a mild lymphadenopathy in the region of the stomach and the surrounding inflammation, example of lymph nodes measures 0.38 cm and 0.27 cm. The mesentery is highly reactive of around the cranial abdomen/right limb of the pancreas and stomach.

PRIMARY FINDINGS

- Right kidney has mildly reduced corticomedullar distinction with cortical mineralization.
- Prominent hypoechoic right limb of the pancreas with surrounding reactive mesentery. Findings are consistent with mild pancreatic inflammation/pancreatitis.

- Hyperechoic nodule in the left side of the liver. This generally has somewhat of a benign appearance. Recommend continued monitoring.
- Moderate gallbladder debris. The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting. Incidental gall bladder debris is less common in cats.
- Moderate shadowing ingesta within the stomach and a severely thickened wall with loss of wall layering. Findings are most consistent with infiltrative disease to the gastric wall (round cell neoplasia, carcinoma, eosinophilic infiltrates, etc.)
- Regional lymphadenopathy near the stomach. Findings are most consistent with highly reactive or early metastatic lymph nodes.

SECONDARY FINDINGS

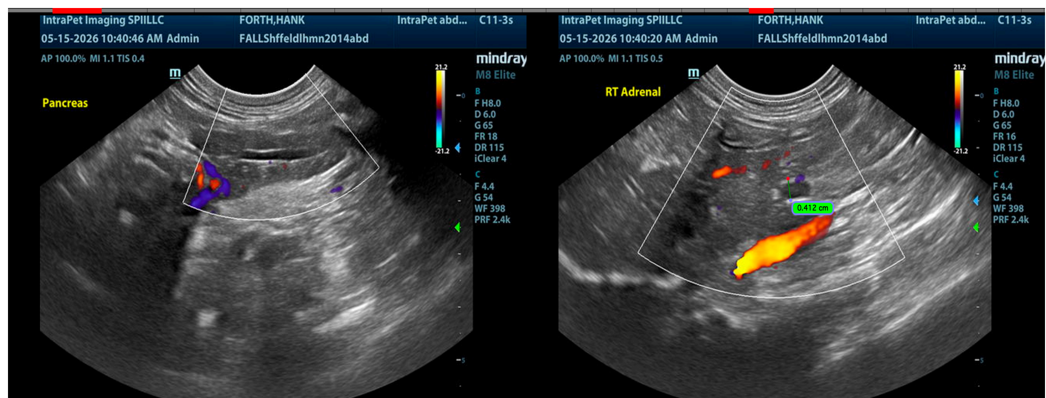
- Suspended echogenic debris in the urinary bladder. The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus. Recommend urinalysis and culture
- Age related changes visualized associated with both kidneys.

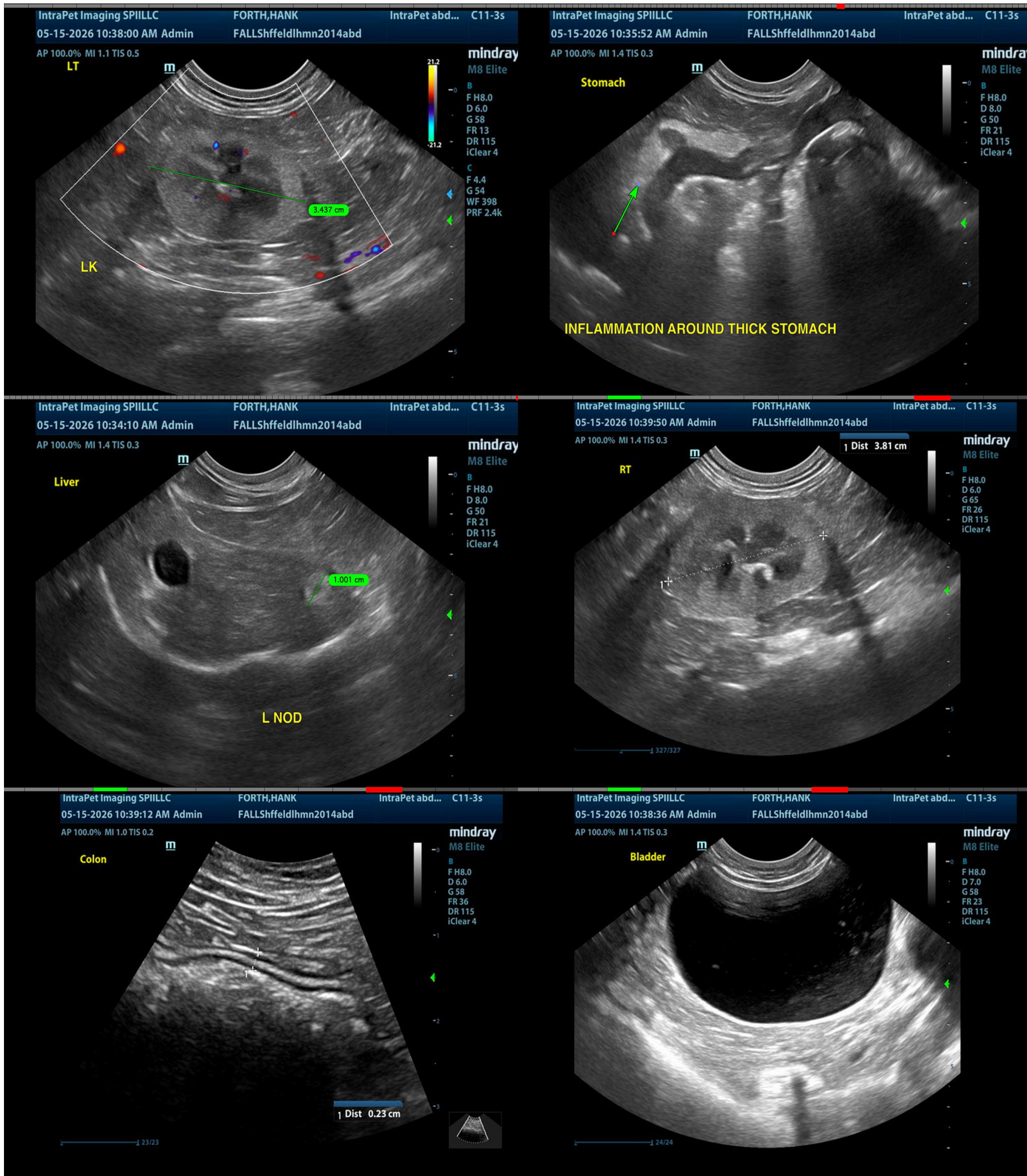
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach wall is severely thickened with severe loss of layering, highly suspicious for infiltrative round cell neoplasia. Recommend a fine needle aspirate of the gastric wall. There is significant inflammation and a mild lymphadenopathy in this region. The right limb of the pancreas is also prominent and hypoechoic with surrounding reactive mesentery. Possibly consistent with concurrent mild pancreatitis.

If a cytologic diagnosis can be obtained, recommend consultation with a veterinary oncologist. If cytology is non-diagnostic, gastric biopsies may need to be considered. There is some shadowing ingesta visualized within the gastric lumen. I suspect this is secondary to ileus and gastric pathology, but a partial outflow tract obstruction cannot be ruled out.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.





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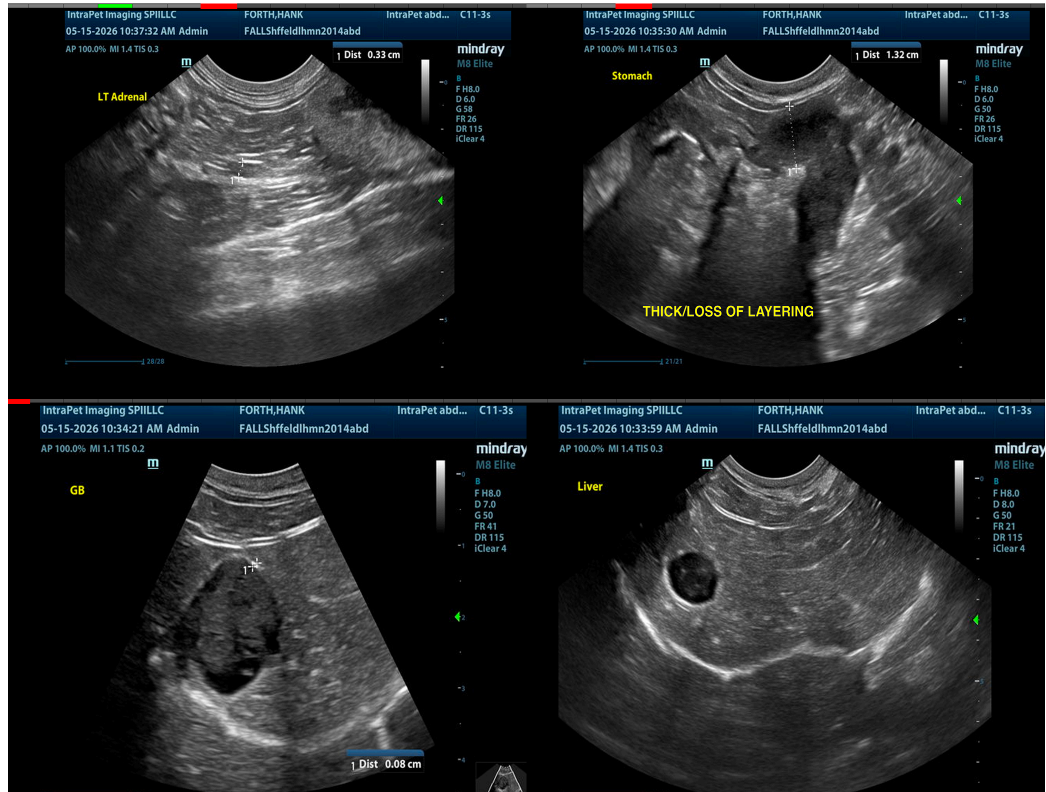

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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