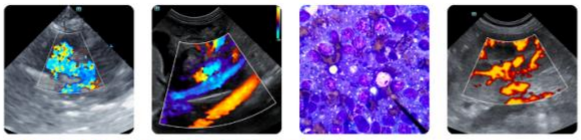


DATE

05/14/26

PATIENT

Smokey Ramsay

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

11/23/15

WEIGHT

11.2 lbs

INTERPRETED BY

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

HOSPITAL NAME

Perry Hall Animal Hospital

REFERRING VET

Dr. Baer

INVOICE

16248

PRESENTING CLINICAL SIGNS

Patient History: 5/11/26- presented for senior exam. P was seen by a veterinarian in Georgia for pancreatitis in April. P had been doing well since that visit. Returned from winter camping Thursday 05/07, and O reports he is acting off, Mrs. reports that he didn't want to eat any of the soft cat food, and he was hanging out in the basement but ate the whole bowl of dry food while in the basement. No v/d was noted. Mrs. did note that he's been drinking a lot of water. Mrs. notes that he's been drinking a lot of water while outside. PE: dull haircoat, dental grade 2/4 moderate tartar/calculus and gingivitis, no weight loss. HX I131 tx in Novemeber, hx stage 2 CKD. Blood work checked 5/11 showed nonregenerative anemia and ongoing azotemia, but more severe
anemia than expected

Current Medications: Gabapentin 100mg night before and 2 hr prior to appt
Labwork Results: Labwork not attached, reported as: 5/11/26 CBC: RBC (L) 4.96, HCT (L) 20.8, HGB (L) 7.5 CHEM 27: SDMA (H) 16, Crt (H) 2.9, BUN (H) 59, Phos (H) 6.4, K (H) 5.4. T4 WNL 1.1. UA- cysto, USG: 1.014, pH 5.5, Crystals, Ca OxMon (0-1)/HPF. TSH add on 0.45 ng/dL
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with suspended echogenic debris. The bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2.0 cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (4.04 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal. There is mild pyelectasia measuring 0.2 cm.

The right kidney has a normal shape and size (2.89 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 0.36 cm width. 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 0.39 cm width. 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 large in size (1.1 cm). The spleen echotexture is heterogenous and mildly mottled, 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. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of 0.24 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.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is 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 0.32 cm in diameter, and the jejunum measured 0.28 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. The descending colon wall measures 0.19 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 (left greater than right).

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are occasional prominent mesenteric lymph nodes with examples measuring 0.45 cm and 0.64 centimeters. Lymph nodes near the ileocecal junction measure 0.41 cm and 0.33 cm. The omentum is hyperechoic around the left limb of the pancreas.

ULTRASONOGRAPHIC FINDINGS

- Pancreatic changes most consistent with chronic pancreatic remodeling and chronic pancreatitis.
- Decreased corticomedullary distinction in both kidneys- Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.

- 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.

- Borderline large mildly mottled spleen- The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.

- 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 but seems unlikely to be causing a current issue. Recommend continued monitoring.

- Diffusely thickened small intestine with 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.

- Prominent lymph nodes most consistent with a reactive lymphadenopathy.

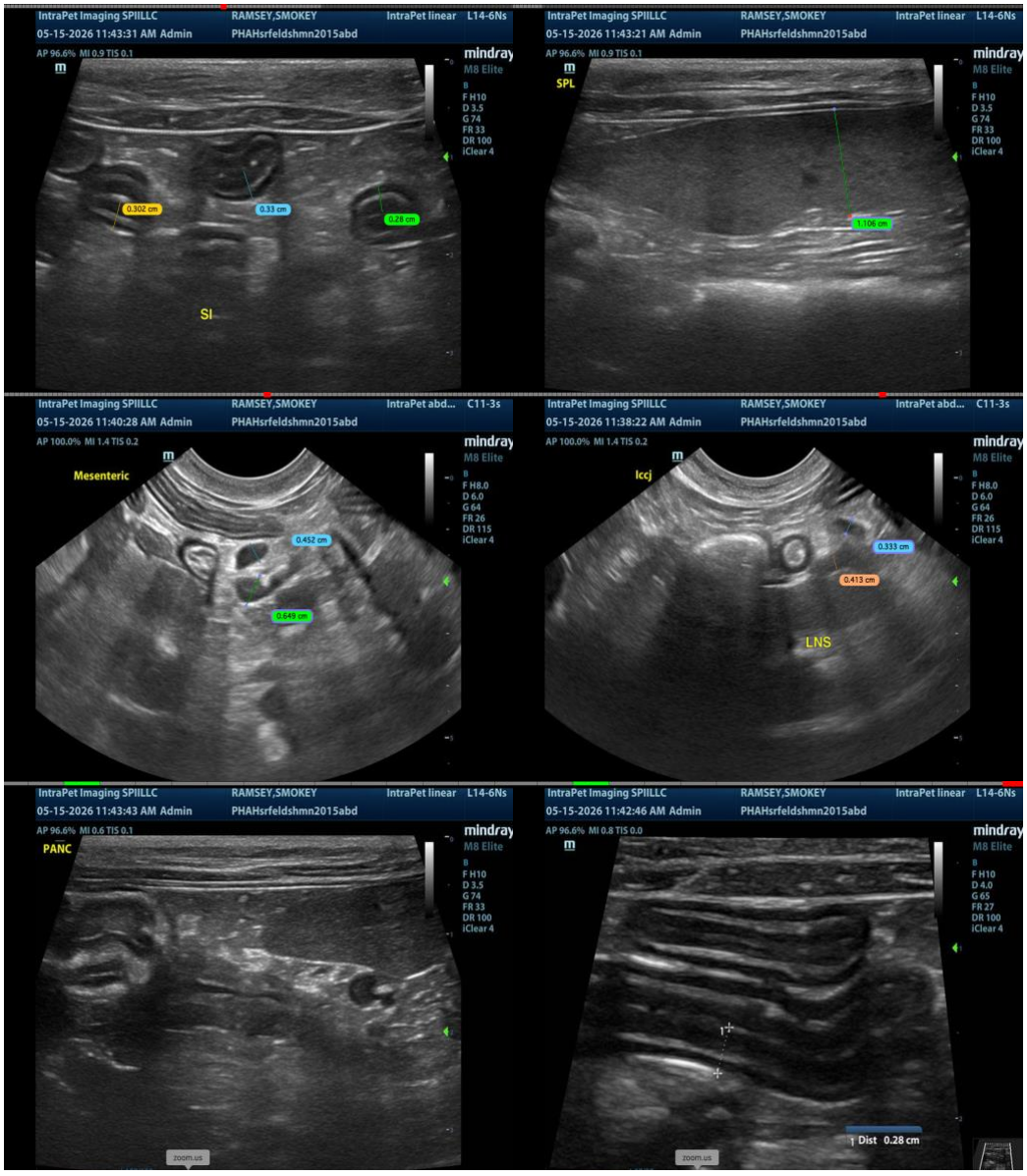
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Both limbs of the pancreas are somewhat prominent and mottled with some inflammation surrounding the left limb most consistent with chronic active pancreatitis. Correlate with a PLI level and consider empirical therapy.

Recommend current blood pressure, urinalysis and culture as well as possible short-term diuresis for the kidneys in the case of possible acute or chronic crisis.

The spleen is plump and mildly mottled. The significance of this is uncertain. Options include continued monitoring or a fine needle aspirate.

The small intestine appears diffusely thickened with a prominent muscularis layer. These changes are most consistent with inflammatory type change, although early neoplastic change cannot be ruled out. Consider empirical treatment for an enteropathy with a novel protein diet/hydrolyzed protein diet, consider a GI panel to Texas A&M for qualitative FPLI, TLI, cobalamin and folate and possible nausea medications, etc. Ultimately, biopsies of GI tract may be warranted if significant underlying gastrointestinal disease is strongly suspected.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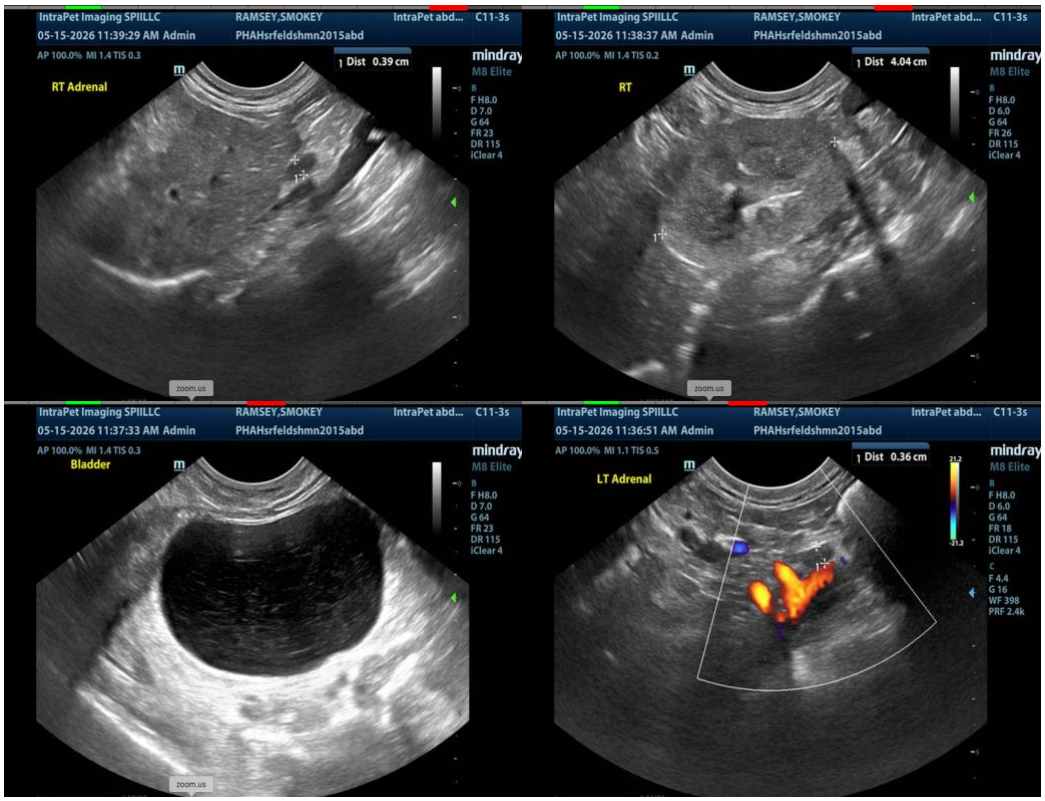
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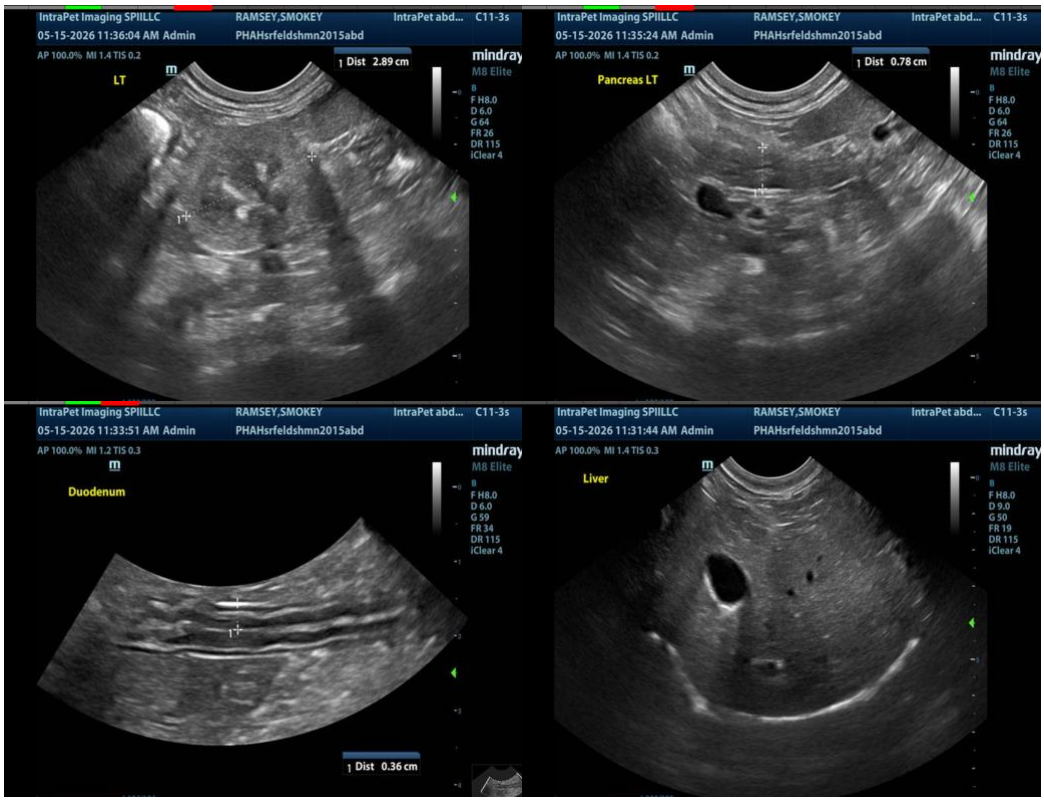

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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