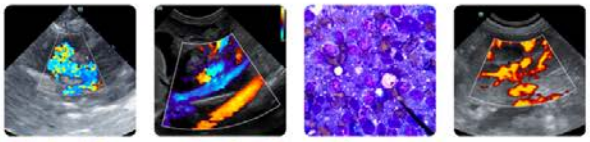


PATIENT

Noodle Rohlfing

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

14 Years

WEIGHT

8.0 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Nikki Kollman, RVT

HOSPITAL NAME

Airpark Animal Hospital

REFERRING VET

Dr. Hawkesworth-Heft

INVOICE

74968

DATE

5/6/26

PRESENTING CLINICAL SIGNS

Presented for polyuria on 4/24/26. Urinalysis showed a UTI. Given Convenia. Lost 1.1 lbs in a little over a year. Ran bloodwork due to weight loss.

Abnormal PE/Chem/CBC/UA Results: CBC: WBC: 26.4 Neuts: 22.7 Chemistry: ALT: 108 (previously 32 in Aug 2024) AST: 96 (previously 16 8/2024) Urinalysis: pH- 9.0, 500 protein, 50 glucose, 250 blood (>50 phpf), >50 wbc phpf, rods, <1 unclassified crystals

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 (3.32 cm). Overall echogenicity is slightly hyperechoic with mildly reduced 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 (3.47 cm). Overall echogenicity is slightly hyperechoic with mildly reduced 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 0.49 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 0.33 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.

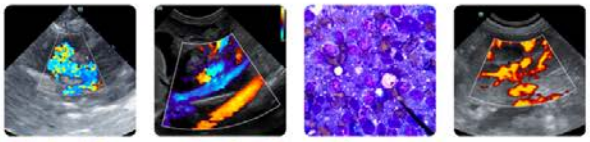
Spleen

The spleen is normal in size but irregular in shape, measuring 0.66 cm in width at the level of the hilus. The blood flow through the hilus and splenic parenchyma appears normal. There is a hyperechoic nodule towards the tail of the spleen measuring 0.67 cm x 0.66 cm.

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.



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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.

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. Duodenum wall measures 0.30 cm. Jejunum wall measures 0.20 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 pancreas is visible/mildly mottled in the right limb.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Mild age related changes visualized associated with both kidneys.
- Hyperechoic nodule in the spleen – This generally has an appearance most consistent with a benign nodule such as a myelolipoma, although other differentials are possible.
- Pancreatic changes in the right limb, most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the urinary bladder to explain the urinary tract infection reported. If PU/PD is persistent, consider a culture once off antibiotics for at least 5 days to determine if the infection has resolved, as E.coli can cause PU/PD.

There is a hyperechoic nodule in the spleen. This generally has an appearance most consistent with a benign lesion, although an early neoplastic lesion cannot be ruled out. Options moving forward would include a fine needle aspirate or continued monitoring with ultrasound.

The right limb of the pancreas is prominent and somewhat mottled, consistent with chronic pancreatic remodeling +/- chronic pancreatitis. Correlate with a PLI level. If this is significantly elevated, mild chronic pancreatitis may be present.

No significant lesions are visualized associated with the GI tract, although the stomach has some mild fluid distention. In the absence of other causes for weight loss, mild gastrointestinal disease could be a consideration. If this is thought likely, you could consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate, looking for additional evidence of underlying small intestinal disease that may

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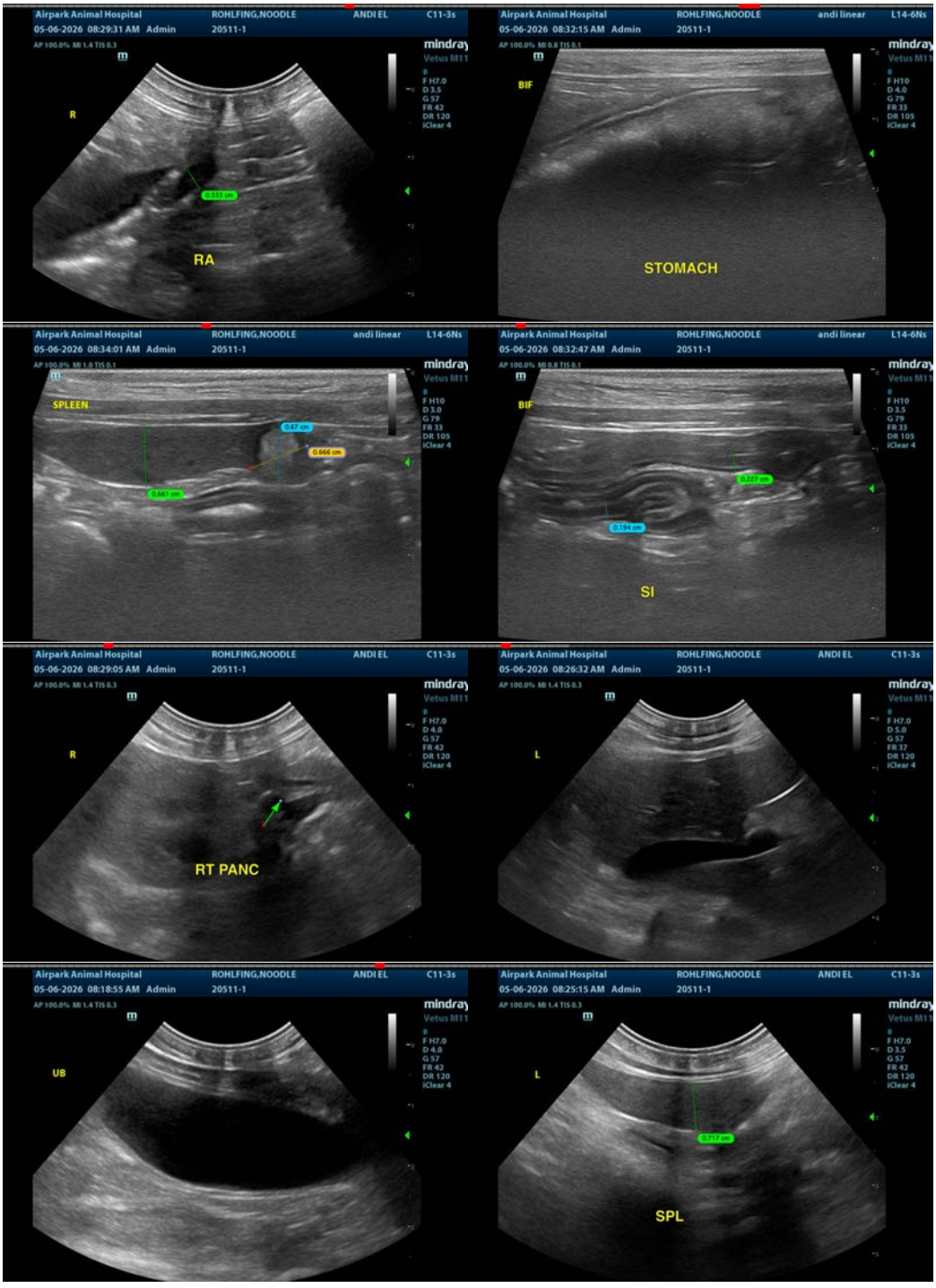
require further evaluation.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement (disregard if this has already been done).



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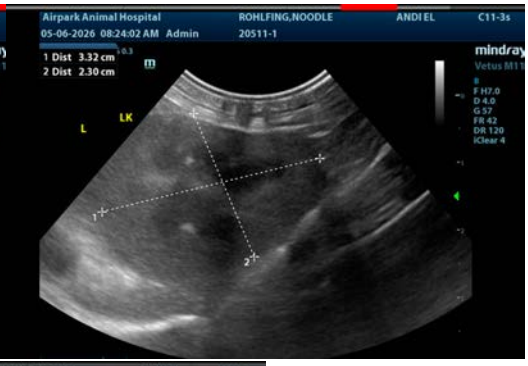

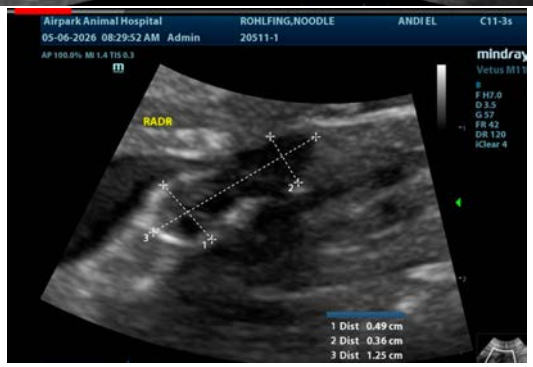

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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