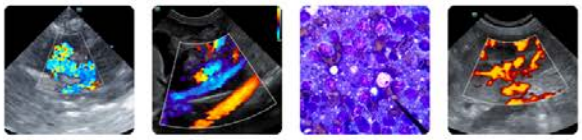


PATIENT

Jax Harb

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

11.5 Years

WEIGHT

7.7 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Animal Clinic of Penn Valley

REFERRING VET

Dr. Nancy Reese

INVOICE

75011

DATE

5/7/26

PRESENTING CLINICAL SIGNS

"Jax" Harb is an 11.5 year old male neutered DSH with s 1.5 year hx of intermittent vomiting, bloody diarrhea, and weight loss. Bloodwork (including T4) in 5/2025 was all WNL and in 2/2026 blood/UA/fecal Ova and parasites and Giardia (neg/neg) showed only mild neutrophilia and eosinophilia. 2/2026 symptoms improved with metronidazole but relapsed in 3/2026 and symptoms again improved with prednisone. When I saw him 5/4/26 I felt some irregular thickening/lumpy area in the mid abdomen along with a low hanging kidney or large LN? so we wanted to get a better look at the abdomen w/U/S. Overall weight loss has been from a high of 11.2# in 2023 to 7.7# in May 2026.

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 (3.53 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 evidence of previous infarcts in both the cranial and caudal poles. There is no evidence of pyelectasia, nephroliths, or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.63 cm) with previous infarcts noted in the cranial pole. 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, or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.29 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.

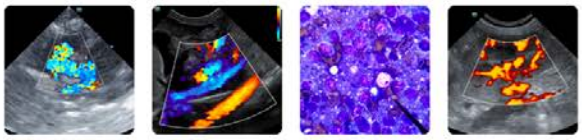
The right adrenal gland is normal in size measuring 0.36 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (0.71 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 gallbladder wall is hyperechoic and slightly prominent, measuring at 0.14 cm. There is focal non-vascular material visualized in the dependent portion of the gallbladder, most consistent with adhered 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 <0.36cm 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. Jejunum wall measures 0.31 cm. Duodenum wall measures 0.25 cm. Visualized peristalsis appears appropriate. Some areas of small intestine have more severe thickening, measuring up to 0.44 cm in thickness with a very prominent muscularis.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with nonformed fecal material and gas shadowing distally. The descending colon wall appears significantly thickened with reduced detail of wall layering, measuring at 0.28 cm (up to 0.37 cm).

Pancreas

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

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a significant lymphadenopathy present, particularly in the caudal abdomen in the region of the colon. Sublumbar lymph nodes are visualized measuring 0.67 cm and 0.57 cm in diameter. A large mesenteric in the mesenteric root near the ileocecal junction measures 2.57 cm x 1.6 cm. Other lymph nodes near the ileocecal junction measure 0.53 cm and 0.43 cm. The omentum is mildly diffusely hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- Bilateral renal infarcts – The solitary renal lesion identified is ill defined and hyperechoic, this could be consistent with a previous renal infarct and can be an indicator of current or previous renal disease.
- Pancreatic changes consistent with chronic pancreatic remodeling.
- Prominent wall and adhered debris visualized in the gallbladder – 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.
- Diffusely thickened small intestine with a prominent muscularis layer in some areas segmentally demonstrating more severe thickening – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.

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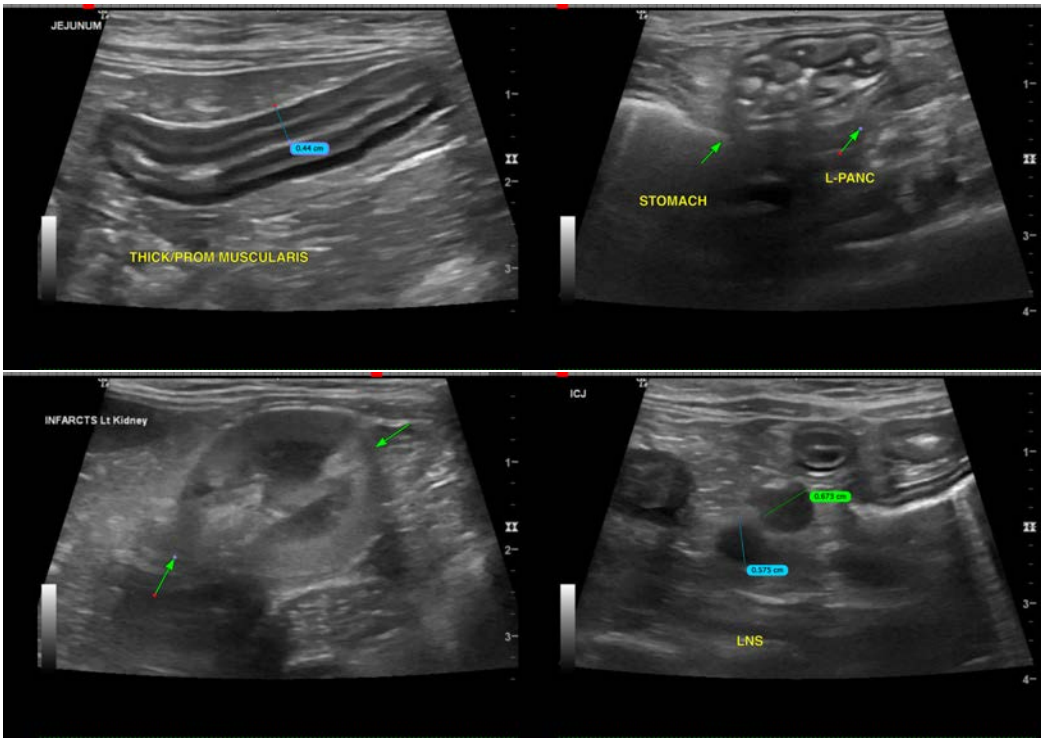
- Thickened distal descending colon with decreased detail of wall layering – Findings are most consistent with severe inflammation/colitis or infiltrative disease.
- Moderate to severe caudal abdominal lymphadenopathy – Findings are most consistent with severely reactive or neoplastic lymph nodes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The distal colon appears significantly thickened with reduced detail of wall layering, most consistent with severe inflammation or a neoplastic process. Additionally, there are numerous large, hypoechoic sublumbar lymph nodes and a very large lymph node at the mesenteric root. Recommend a fine needle aspirate for cytologic evaluation.

Additionally, the ileocecal junction and the small intestine appear significantly thickened with a very prominent muscularis layer. Findings are concerning for severe inflammatory or early neoplastic change. If cytology from a lymph node is not diagnostic, then consider biopsies of the large and small intestine. Additionally, you could consider a hydrolyzed protein prescription diet and a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate, looking for evidence of exocrine pancreatic insufficiency, B12 insufficiency, etc. Chronic probiotic therapy is recommended.



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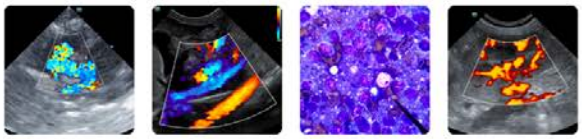

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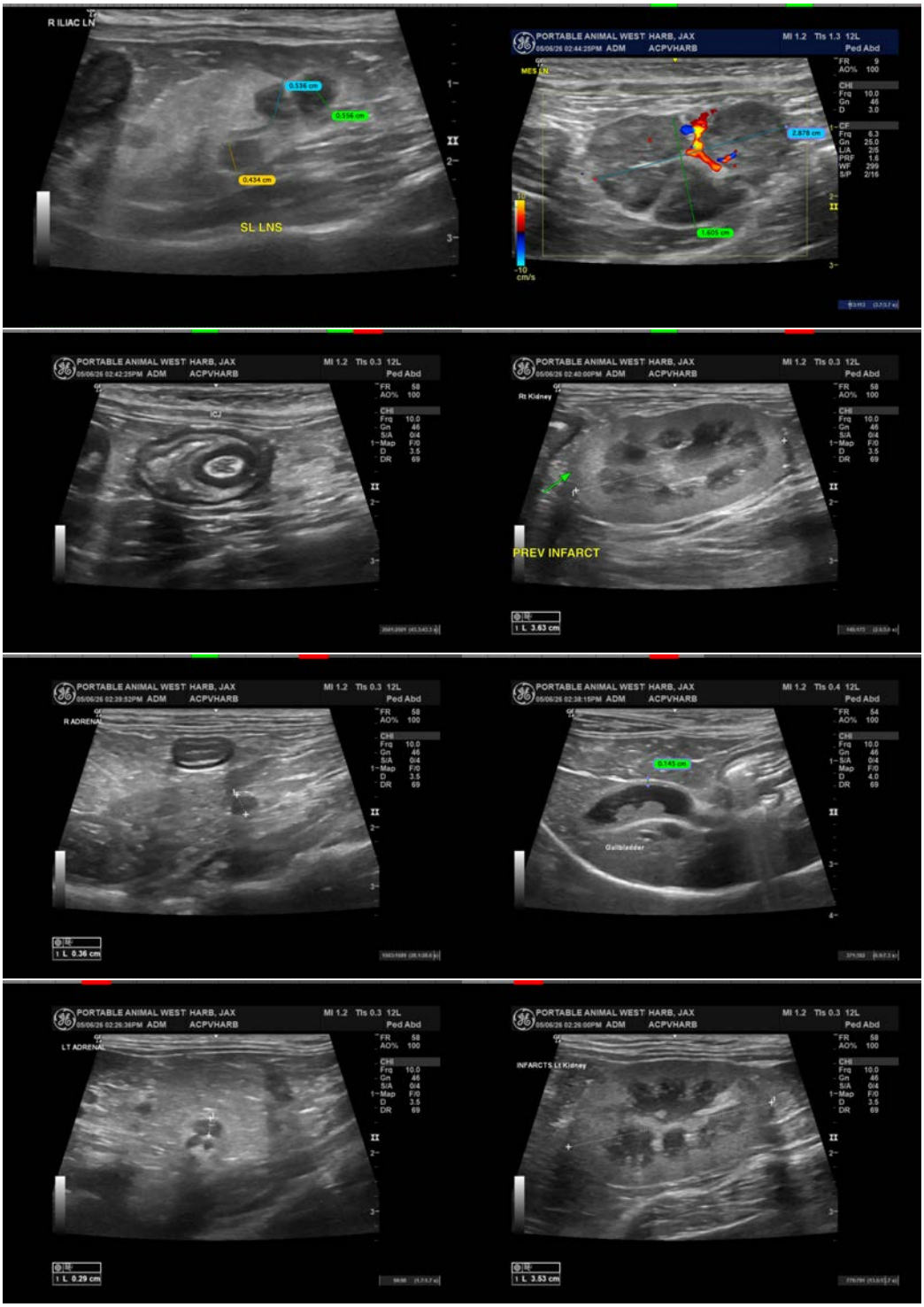

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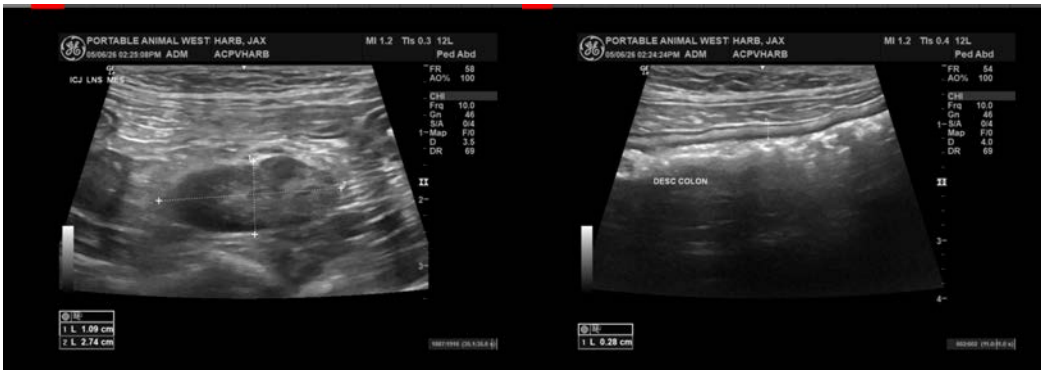

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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