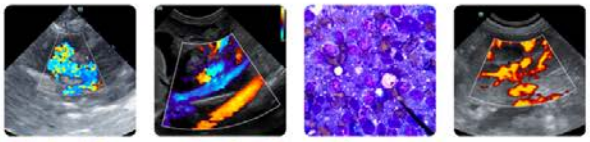


PATIENT

Pumpkin Lopez

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

12 Years

WEIGHT

10.38 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Megan Cassels-Conway, DVM

HOSPITAL NAME

Central Broward Animal Hospital

REFERRING VET

Dr. Lara Oms

INVOICE

75967

DATE

6/17/26

PRESENTING CLINICAL SIGNS

6/8 Presented for hematuria, chronic persistent. Vomiting and not eating, defecating small amounts. On PE hm 3/6, pulses wnl, small bladder. P vomited during bladders scan multiple timers. Bladder scan- very thickened bladder wall possible cystolith, bladder too small to sample. Rx. Cerenia, famotidine, gabapentin 50 mg tid and Mirtazapine, LRS 100ml sq daily. 6/9- SWO- urine much improved, not eating well. Appears hungry but not eating. O offering I/d. Rec offer regular diet or other more enticing. Start Lrs EOD, cont cerenia, famotidine and gabapentin. 6/12 recheck, not eating well. Plan:D/c Miratazapine, started Elura, D/c cerenia+ famotidine 48 hrs, cont gaba 50 mg tid. Cont LRS start EOD 100ml. 6/15- Restarted Cerenia and famotidine bcs still not eating well. Urine clear since 6/13. Cont Fluids eod and gabapentin tid. 6/16-Rec d/c gabapentin and schedule u/s, cont Elura, cerenia and famotidine. Fluids eod. Vomited new diet offered. 6/17- O noted p eating some but not full amount. Mild hematuria noted during ultrasound

Abnormal PE/Chem/CBC/UA Results: 6/8/26 Labs: Cbc- Nos- 10824 H Chem- Alt- 127 H,Na 161 H,Cpk- 687 H T4- 1.2 N U/a- From 6/9 Sp G 1.042Prot 2+ Blood- 3+ Wbc- 4-10 h Rbc>50 C/s- no growth

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended with anechoic urine. Much of the bladder wall appears normal I in thickness with a smooth mucosal surface. In the mid/cranial dorsal region of the urinary bladder the wall becomes irregular and focally thickened in a region measuring approximately 0.70 cm x 1.83 cm. The region of the trigone, ureteral papillae, and proximal urethra are free of any mass lesions or calculi.

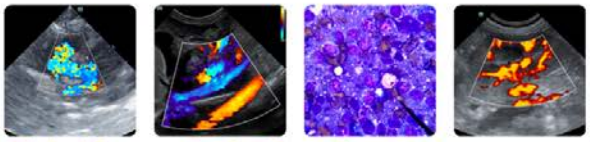
The left kidney has a normal shape and size (4.09 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.14 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. 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 0.32 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 0.28 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.



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Spleen

The spleen is subjectively normal in size (0.60 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.

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.

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. Duodenum wall measures 0.31 cm. Jejunum wall measures 0.27 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. There is no observed focal or generalized colon wall thickening or loss of layering.

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, 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

- Focal irregularity visualized associated with the bladder wall – Findings are concerning for possible early mass effect. Focal cystitis is also possible.
- Age related changes visualized associated with both kidneys.
- Pancreatic changes consistent with chronic pancreatic remodeling +/- chronic pancreatitis.

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- Diffusely mildly 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.

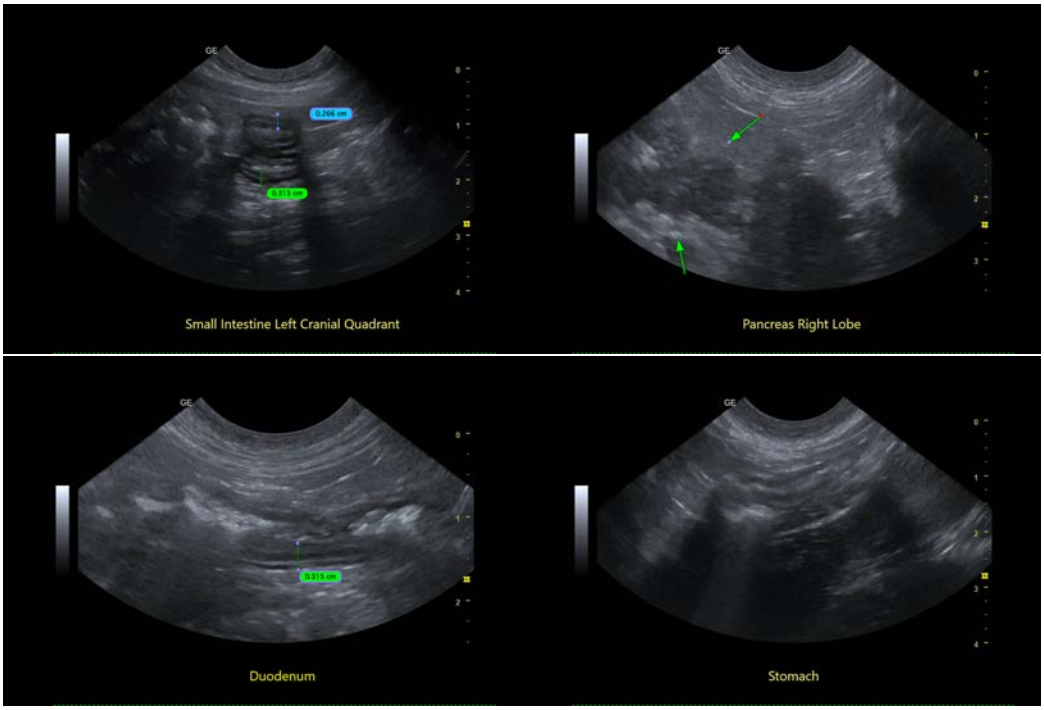
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a focal irregularity visualized associated with the urinary bladder wall. Based on the history, the urine culture is negative, increasing my concerns for possible early mass effect. A transitional cell carcinoma would be most likely. Consider cytology on a free catch urine sample if the sample is highly cellular. Otherwise, your options would be a traumatic catheterization, a fine needle aspirate (with the knowledge that you could track neoplastic cells along your needle path), or surgical biopsies. Additionally, you could consider reevaluation in 2-3 months to see if the lesion has progressed.

Both kidneys have changes consistent with age related renal disease. Correlate with urine concentrating ability +/- blood pressure evaluation.

Both limbs of the pancreas are prominent and mottled. Correlate with a PLI level, as chronic pancreatitis is a significant concern. Consider empirical therapy.

The small intestine is diffusely "ropey" with a prominent muscularis layer. The changes are most consistent with inflammatory type change, although early neoplastic change cannot be ruled out. If the patient is eating better, you could consider switching to a hydrolyzed protein prescription diet. Additionally, 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 and chronic probiotic therapy. It is possible that pain medication may be helpful for both potential pancreatitis and the bladder lesion.



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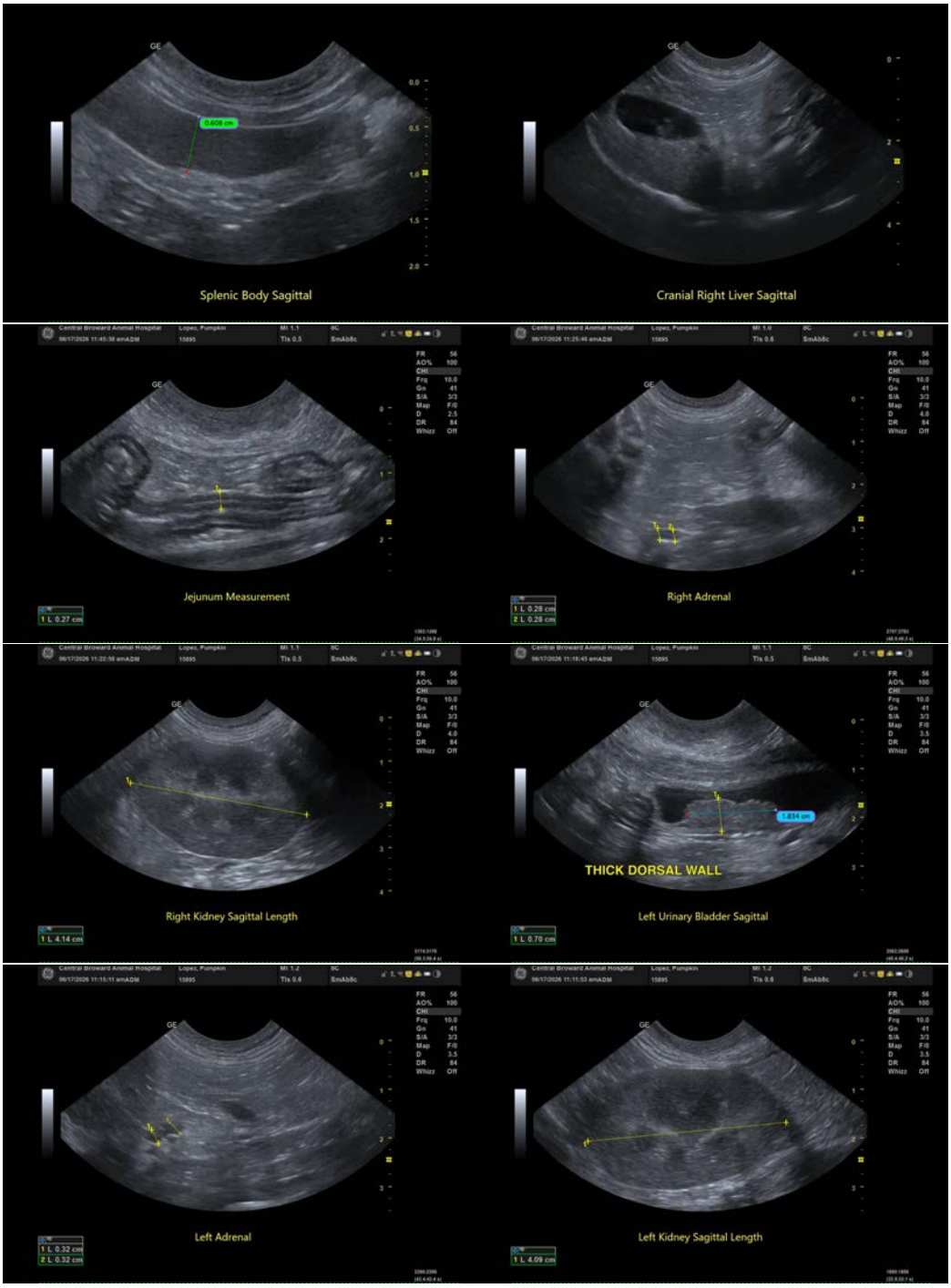

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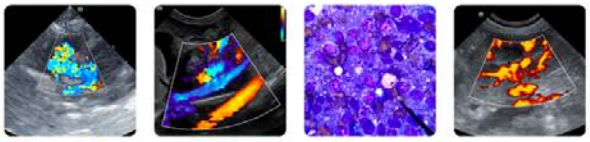

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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