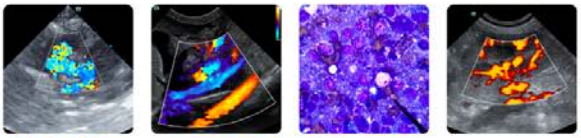


PATIENT

Roxanne Ray

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

10 Years 2 Months

WEIGHT

8 lbs 10 oz

INTERPRETED BY

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

IMAGING PERFORMED BY

Chloe Lowe, CVT

HOSPITAL NAME

VCA Northside Animal Hospital

REFERRING VET

Dr. Fusselman

INVOICE

75612

DATE

6/2/26

PRESENTING CLINICAL SIGNS

Weight loss. Per Owner history of asthma. Mild dental disease. Rest of exam WNL.
Abnormal PE/Chem/CBC/UA Results: 4/11/26 Glucose 187 (stress) , rest of labs NSF, Fel/Fiv negative.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with suspended and dependent 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 (3.83 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 (3.94 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 0.31 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 0.39 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.

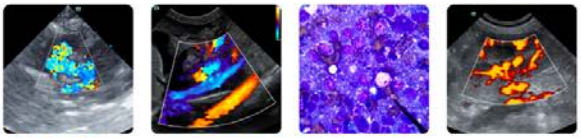
Spleen

The spleen is subjectively normal in size (0.85 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.



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Gastrointestinal

The stomach contains a mild/moderate amount of fluid and gas. 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 to mild fluid and gas 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. 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 area of the pancreas is normal and isoechoic to surrounding 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 no evidence of a significant diffuse lymphadenopathy. The lymph nodes at the mesenteric root are prominent, measuring 0.51 cm and 0.55 cm in diameter. The omentum is generally normal in echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Suspended dependent echogenic debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.
- Age related changes visualized associated with both kidneys.
- Mild/moderate fluid and gas distended stomach – Correlate with the feeding history. If the patient was adequately fasted, this could represent delayed gastric emptying.
- Mildly thickened small intestine with a prominent muscularis layer and some areas of mild fluid distention – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.
- Occasional prominent mesenteric lymph nodes – Findings are most consistent with reactive lymphadenopathy. An early neoplastic lymphadenopathy cannot be definitively ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach has a moderate amount of fluid and gas, and some sections of small intestine are mildly fluid distended. Additionally, some areas of the small intestine appear “ropey” with a prominent muscularis layer. These changes could be seen with gastric ileus and a primary enteropathy/enteritis, although other differentials are possible.

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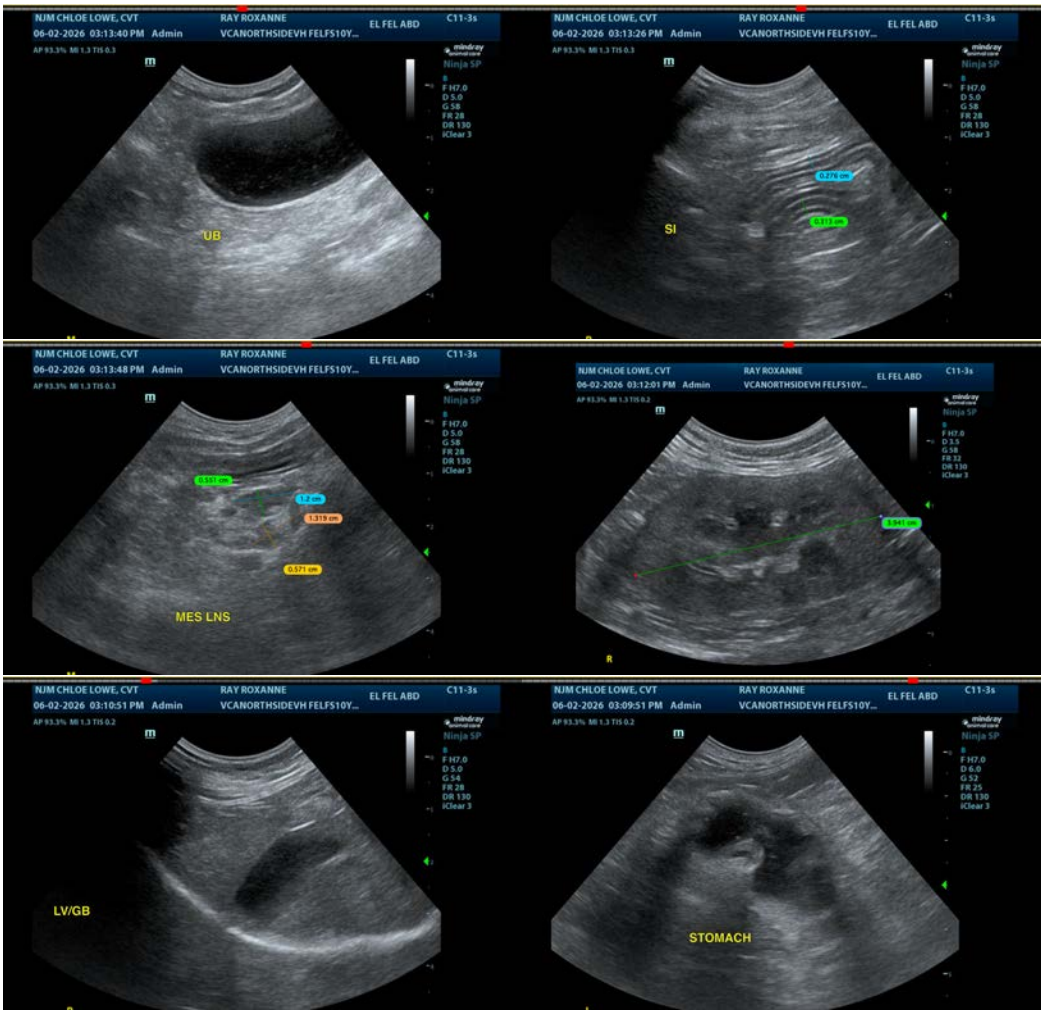
Both kidneys have changes consistent with age related renal changes. Correlate with renal values and urinalysis +/- culture.

If primary gastrointestinal disease is suspected, you could consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to further evaluate. If evidence of concurrent gastrointestinal disease is present, further evaluation may be warranted.

If symptoms are persistent, repeat imaging over time could be considered, looking for progression/persistence of today's lesions.

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



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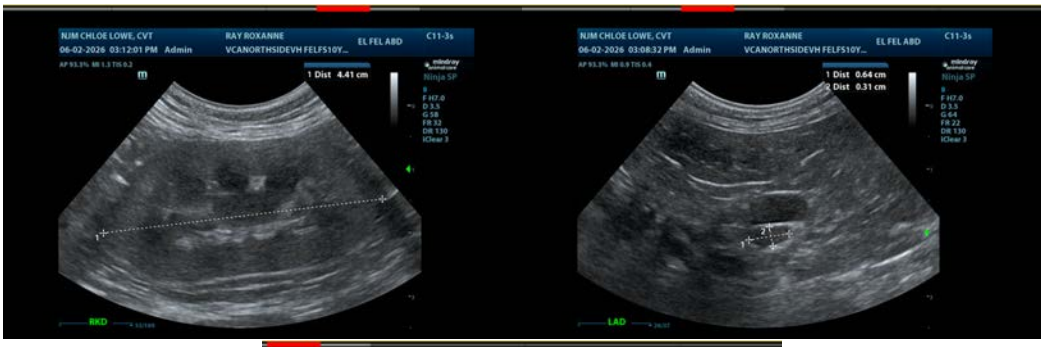

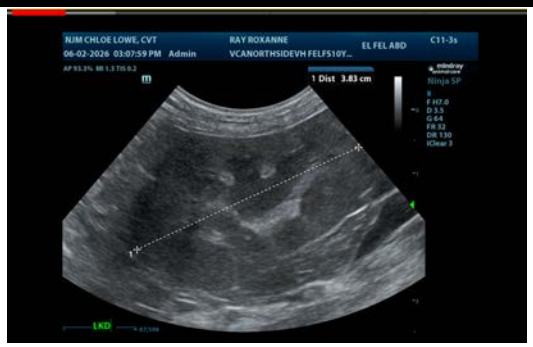

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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