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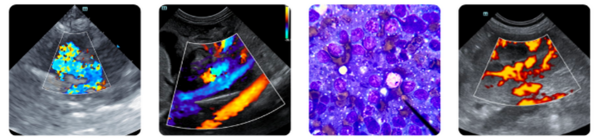


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Patches Writer

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

13 years

WEIGHT

6.32 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Mary Pearce

HOSPITAL NAME

Chambersburg Animal Hospital

REFERRING VET

Dr. Mary Pearce

INVOICE

12075

DATE

6/3/2026

PRESENTING CLINICAL SIGNS

Presented 5/12/26 for weight loss, difficulty walking/unsteadiness, decreased appetite. BW submitted, mirtazapine and gabapentin started. BW found possible azotemia, slight liver value elevation, recommended next steps for further investigation of weight loss/decreased appetite included radiographs and ultrasound. O elected for abdominal ultrasound.

Abnormal PE/Chem/CBC/UA Results: 5/13/26: CBC unremarkable. Creat 1.9, BUN 59, AST 105, otherwise normal chem. TT4 2.6. PE: decreased BCS, periodontal disease.

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 is borderline small in size (2.8 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. Mild pyelectasia measuring 0.18 cm. 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 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 0.29 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.

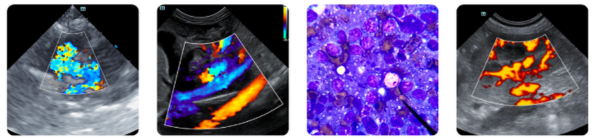
The right adrenal gland is normal in size measuring 0.48 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (0.91 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 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 to moderate fluid distension (particularly the duodenum). 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. The duodenum measured 0.29 cm in diameter and the jejunum measured 0.3 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.

Pancreas

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

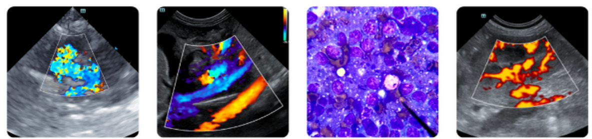
Evaluation of the peritoneal cavity revealed scant free fluid. There is a mild lymphadenopathy present with a cluster of prominent mesenteric lymph nodes measuring 0.96 cm and 0.41 cm in diameter, and a hypoechoic lymph node near the left kidney measures 0.75 cm. The omentum is mildly diffusely hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- Decreased corticomedullary distinction in both kidneys with a smaller left kidney with mild pyelectasia. Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.
- Diffusely 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.
- Mild diffuse lymphadenopathy. Findings are suggestive of reactive lymph nodes, although early neoplastic change cannot be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a general impression of generalized inflammation and thickened bowel loops with a prominent muscularis layer and occasional prominent mesenteric lymph node, suggestive of an inflammatory



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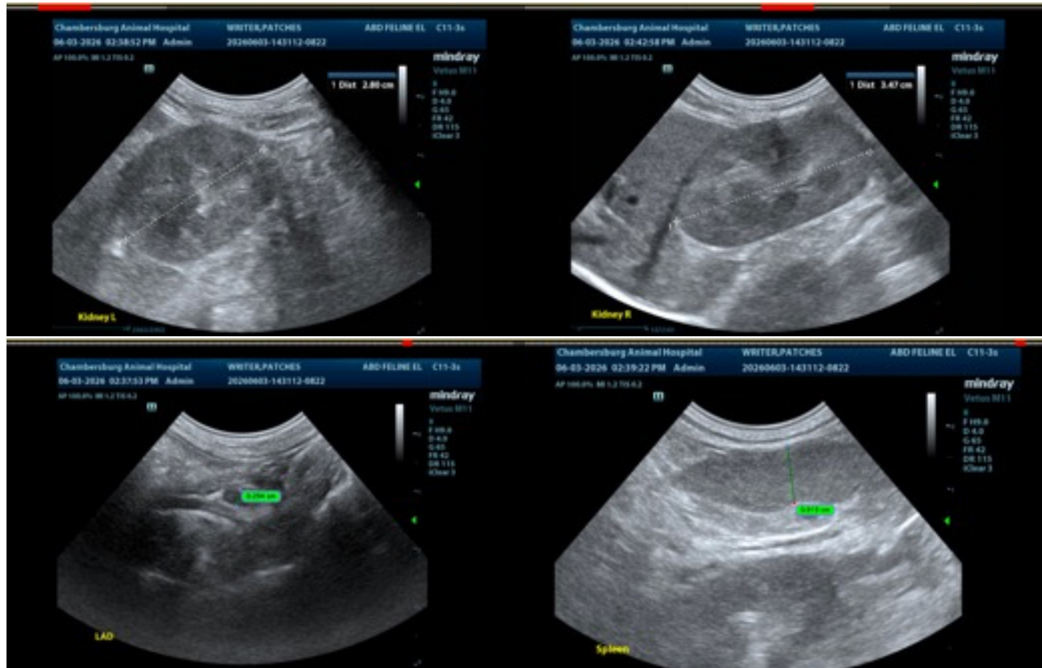
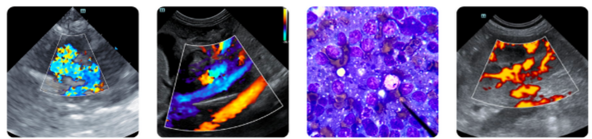
enteropathy/enteritis. Early neoplastic change can have a similar appearance and cannot be ruled out. Additionally, both kidneys have changes consistent with chronic kidney disease which may be contributing to the symptoms reported. Consider the following:

- Consider a combination hydrolyzed protein/renal diet (I believe Royal Canin has this combo.)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.
- If not already done recommend a urinalysis +/- culture, and blood pressure evaluation as a baseline for chronic renal disease and treatment for uremia if indicated.

It is difficult to determine if the symptoms reported are secondary to the renal changes or the GI changes, although I suspect the GI changes are playing a role. Recommend symptomatic therapy as well as the above recommendations. If there is no improvement, ultimately biopsies of the GI tract may be warranted. Additionally, fluid therapy could be considered for underlying renal disease in case of an acute on chronic exacerbation.

Additionally, consider repeat imaging in the future looking for the progression of today's lesions in the case of a possible underlying neoplastic process.





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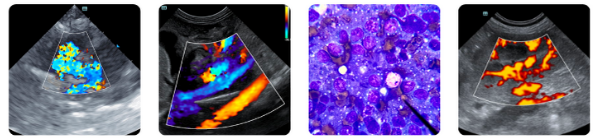
The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.



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