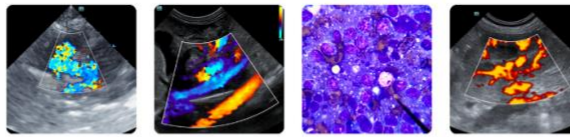


PATIENT

Nellie Masino

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

2019

WEIGHT

7.8

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

IMAGING PERFORMED BY

Rebekah Jakum, CVT, ARDMS/RVT

HOSPITAL NAME

Alburtis Animal Hospital

REFERRING VET

Dr. Klemp

INVOICE

14676

DATE

03/26/26

PRESENTING CLINICAL SIGNS

- 3-4 month history of weight loss, intermittent vomiting and decreased appetite - though ravenous for non-cat food items like table scraps In Jan: ALT 312, ALP 82, fPL 1.3 TT4 2.1 Mildly elevated LEs detected in January, improved after Clavamox and Zeniquin. Appetite and vomiting improved then, but weight loss has continued. On exam last week: mildly thickened intestinal loops, palpated 2-2.5cm irregular, firm, mass-like structure mid abdomen

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic change were noted.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 3.3 cm in length. The right kidney measured 3.5 cm in length.

Adrenal Glands

No obvious pathology in the areas of the left or right adrenal glands.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver & Gallbladder

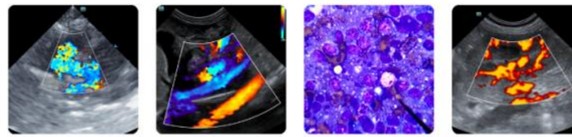
The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The small intestine presented intact overall nonthickened wall exhibiting segmental to generalized propensity for mildly prominent muscularis layer. The duodenum wall measured 0.24 cm wall width. The jejunum wall measured 0.23 cm wall width. The ileocolic wall measured 0.33 cm wall width.



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Normal visible colon wall layers were present with semi formed fecal matter.

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

No obvious significant or swollen mesenteric lymphadenopathy or peritoneal effusion was present.

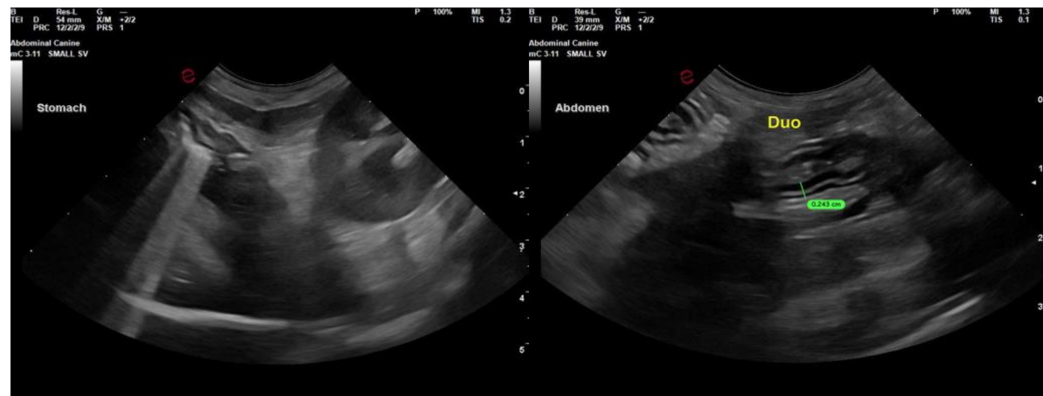
ULTRASONOGRAPHIC FINDINGS

- Nonthickened intestine exhibiting subjective mild prominent muscularis layer.
- Sonographically normal liver/gallbladder.
- Normal area of the pancreas.
- Semi formed fecal matter in colon.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although no evidence of significant gastrointestinal, pancreatic or hepatobiliary pathology, mild IBD and triaditis are primary considerations. No evidence of intrabdominal masses or overt neoplastic criteria which is thought less likely.

A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Screening three view chest radiographs are suggested if not done. Gastrointestinal support, empirical therapy for triaditis with monitoring of clinical response may prove beneficial. Sonographic reassessment is indicated if progressive weight loss or clinical signs. Biopsies may be required for a definitive diagnosis.



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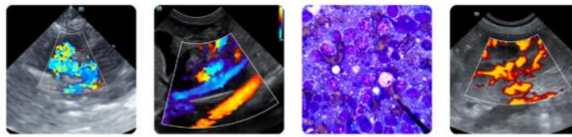

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

info@SonoPath.com