PATIENT

Bentley Hosler

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

15 Years 8 Months

WEIGHT

9 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Chloe Lowe CVT

HOSPITAL NAME

All Creatures Great & Small Denville

REFERRING VET

Dr. Silas Ashmore

INVOICE

14801

DATE

04/02/26

PRESENTING CLINICAL SIGNS

- severe weight loss. Was 16 pounds three months ago.
- E / D OK per Owner
- DX with stage one renal disease, six months ago
- vomiting occasionally, but not much
- no diarrhea
- no PU/PD

Abnormal PE/Chem/CBC/UA Results: T4 <0.5 SDMA 18.5 Amylase 1384 PSL 39

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.

The area of the aortic trifurcation was free of pathology.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 3.0 cm in length. The right kidney measured 3.9 cm in length.

Adrenal Glands

The adrenal glands were overtly normal in size, position and shape. The left adrenal gland measured 0.33 cm width. The right adrenal gland measured 0.37 cm width.

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

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The stomach presented overall intact wall layering with mildly thickened nonobstructive pylorus wall with mild retained pyloric fluid. The pylorus wall measured 0.35 cm wall width.

The intestinal walls demonstrated intact wall layers with diffusely thickened walls and altered 1:3 muscularis / mucosa ratio primarily consisting of muscularis hypertrophy. Possible emerging segmental loss of mid abdomen jejunal wall layering. The jejunum wall measured 0.35 cm to 0.37 cm wall width.

Normal visible colon wall layers were present with apparent formed feces in lumen.

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 visualized significant or swollen mesenteric lymphadenopathy or peritoneal effusion was present.

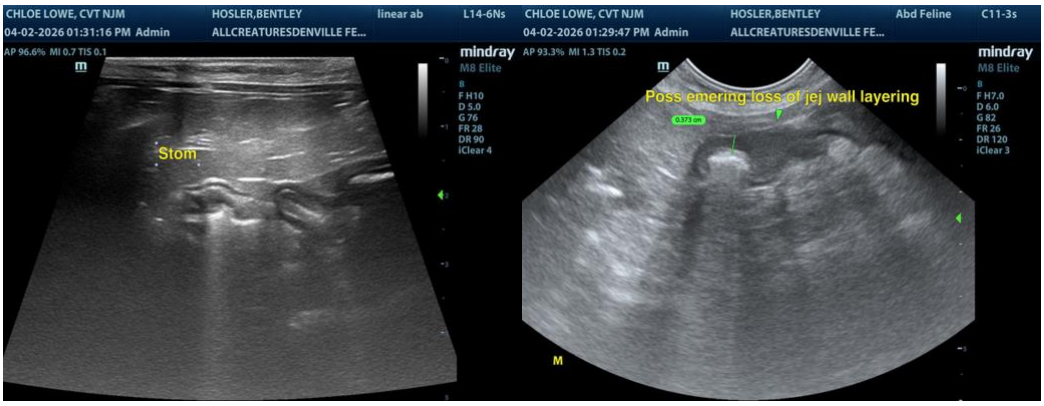
ULTRASONOGRAPHIC FINDINGS

- Mildly thickened nonobstructive pylorus with minor retained pyloric fluid.
- Infiltrative enteropathy pattern with possible emerging segmental loss of jejunal wall layering.
- Normal area of the pancreas.
- Mild chronic renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Considerations for the small intestine may include IBD or other inflammatory enteropathy with potential for emerging segmental jejunal mural mass which is concerning for neoplastic criteria i.e. lymphoma or other. No evidence of active or chronic pancreatitis as a contributing factor although mild pancreatitis may present sonographically normal in conjunction with PSL. Full GI panel to include PLI, TLI, cobalamin and folate and screening three view chest radiographs if not done are suggested.

Defensive diagnosis would require intestinal biopsies for histopathology. Gastrointestinal support with empirical IBD protocol and serial sonographic monitoring of the small intestine for evidence of progressive mural changes if continued gastrointestinal signs or weight loss would be more conservative.



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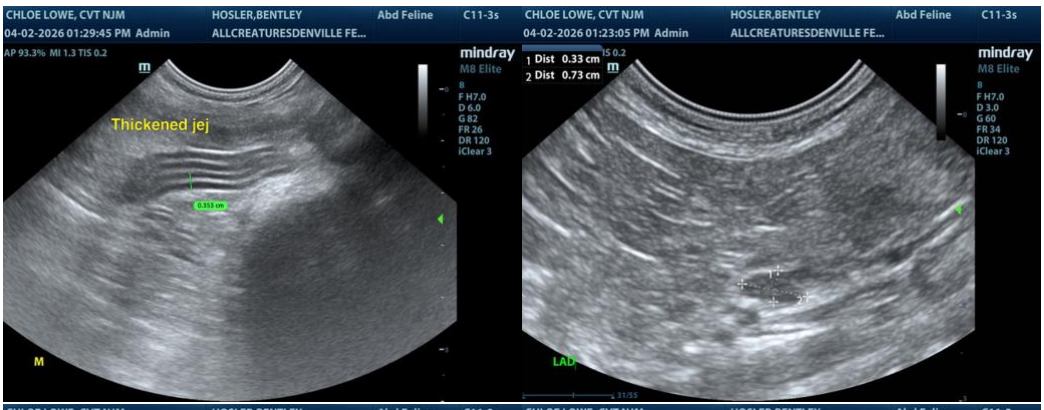

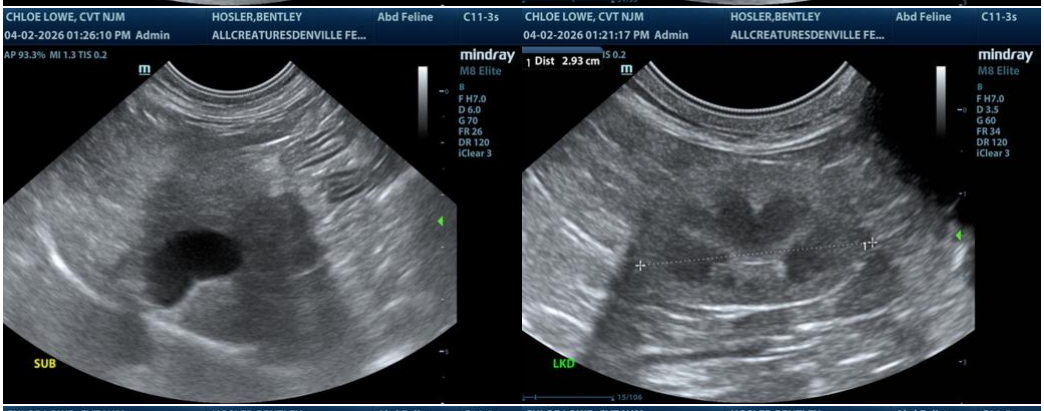

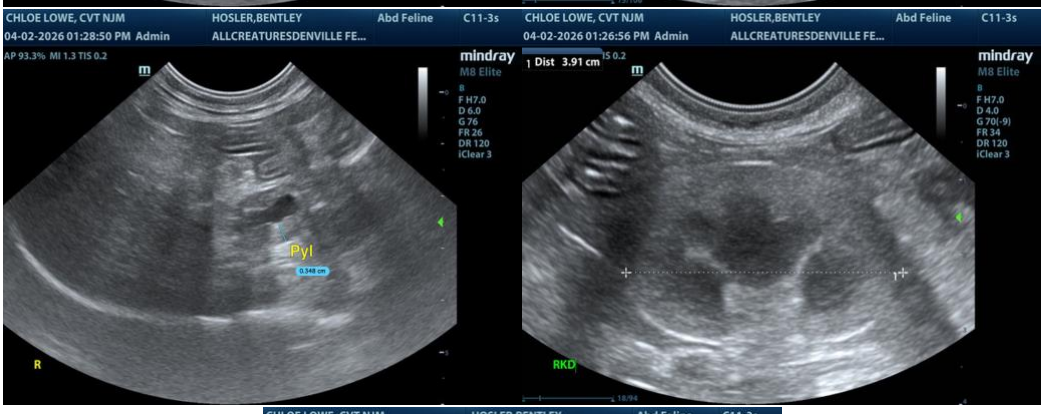

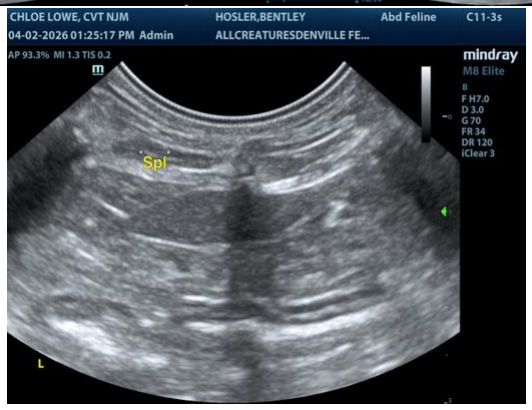

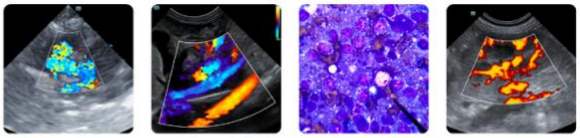

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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