

**PATIENT**

Tigress Righellis

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

3 Years 1 Month

WEIGHT

3.7 kg

INTERPRETED BYKathleen Sennello DVM,
MS, Diplomate ACVIM
(Small Animal Internal
Medicine)**IMAGING
PERFORMED BY**Loetitia Saint-Jacques,
LVT**HOSPITAL NAME**Incline Veterinary
Hospital**REFERRING VET**Ivan Grechanichenko,
DVM**INVOICE**

72910

DATE

1/1/26

PRESENTING CLINICAL SIGNS

History of recurrent vomiting episodes since July. This is the fourth episode. Previous episode responded well to a GI Biome diet. Client was attempting to transition patient back to Wellness brand food. Client was out of town for four nights. A neighbor was feeding the patient. The neighbor fed an unauthorized food, Tiki Cat, and treats on Friday. Vomiting began yesterday, 2025-12-29. Vomiting occurs 2-3 times per day, typically within 10 minutes of eating. Vomitus consists of bile or undigested food. Patient acts hungry but then refuses food. She has eaten a few small bites of wet and dry food over the past two days. She kept down some wet food last night. Client reports lethargy yesterday. Stool is currently formed; client has not observed diarrhea with this episode yet. Working diagnosis Recurrent vomiting and mild inappetence - r/o dietary indiscretion, pancreatitis, foreign body, inflammatory bowel disease, stress-induced gastroenteritis, others

Abnormal PE/Chem/CBC/UA Results: ALKP < 10 14 - 111 U/L LOW QPL 9.7 0.0 - 4.4 U/L HIGH

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 normal in size (3.02 cm) but slightly irregular in shape (likely due to previous infarct in the caudal pole). Overall echogenicity is slightly hyperechoic with mildly reduced 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 or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.2 cm). Overall echogenicity is slightly hyperechoic with mildly reduced 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.

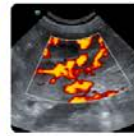
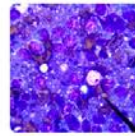
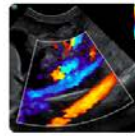
Adrenal Glands

The left adrenal gland is normal in size measuring 0.37 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 0.34 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 (0.90 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.



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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 common bile duct is visualized distally at the level of the duodenal papilla, measuring at 0.24 cm.

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 increased. Bowel loops follow a typical curvilinear path. wall measures 0.25 cm. Jejunum wall measures 0.27 cm. Visualized peristalsis appears appropriate. The muscularis layer appears diffusely prominent.

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 hyperechoic and mottled with prominent pancreatic duct at 0.29 cm. 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 a mild diffuse mesenteric lymphadenopathy with elongated isoechoic mesenteric lymph nodes measuring 0.71 cm x 1.43 cm and 0.38 cm x 1.65 cm.

ULTRASONOGRAPHIC FINDINGS

- Mild age related changes visualized associated with both kidneys and a suspected previous infarct in the left kidney.
- Pancreatic changes consistent with chronic pancreatic remodeling.
- Diffusely prominent muscularis layer of the small intestine with mild small intestinal thickening- The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.
- Suspect diffuse reactive lymphadenopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes observed are most consistent with a diffuse inflammatory enteritis (IBD or similar). Early neoplastic change cannot be ruled out but seems less likely at this time. The renal changes are



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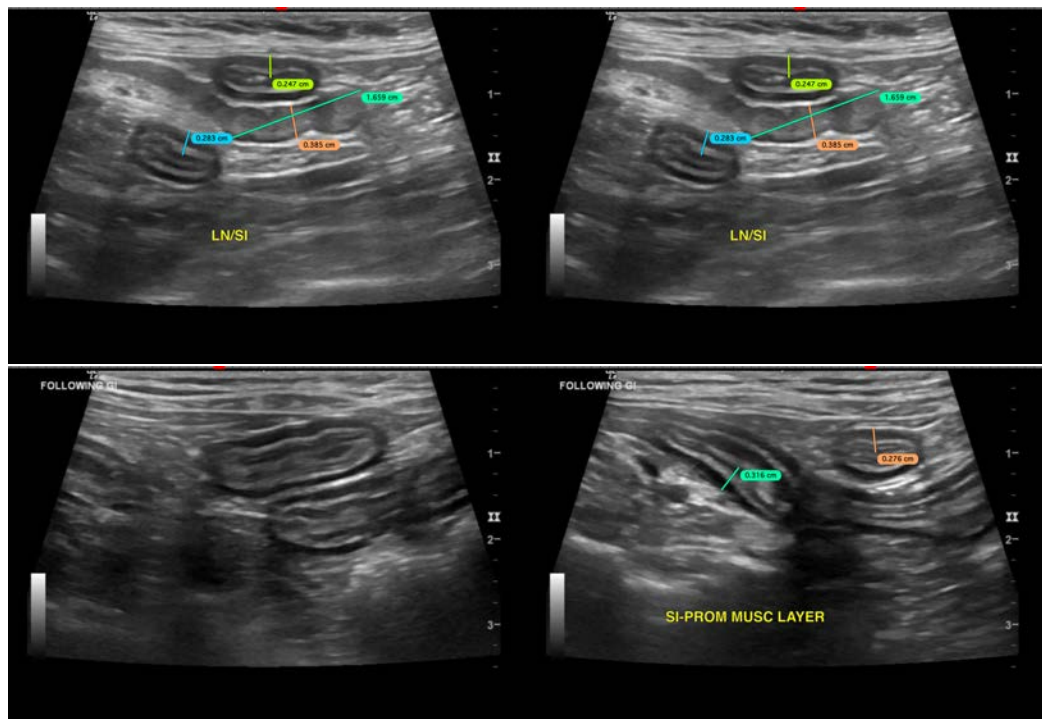
somewhat subtle and of uncertain significance. Correlate with urine specific gravity, blood pressure, etc.

Recommend the following:

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- 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.

The appearance of the pancreas is most consistent with chronic pancreatic remodeling, but given the elevation in PLI, mild chronic pancreatitis may also be present. Consider concurrent treatment for pancreatitis.

If symptoms are progressing or not responding to empirical therapy, biopsies of the GI tract may be warranted for further evaluation.



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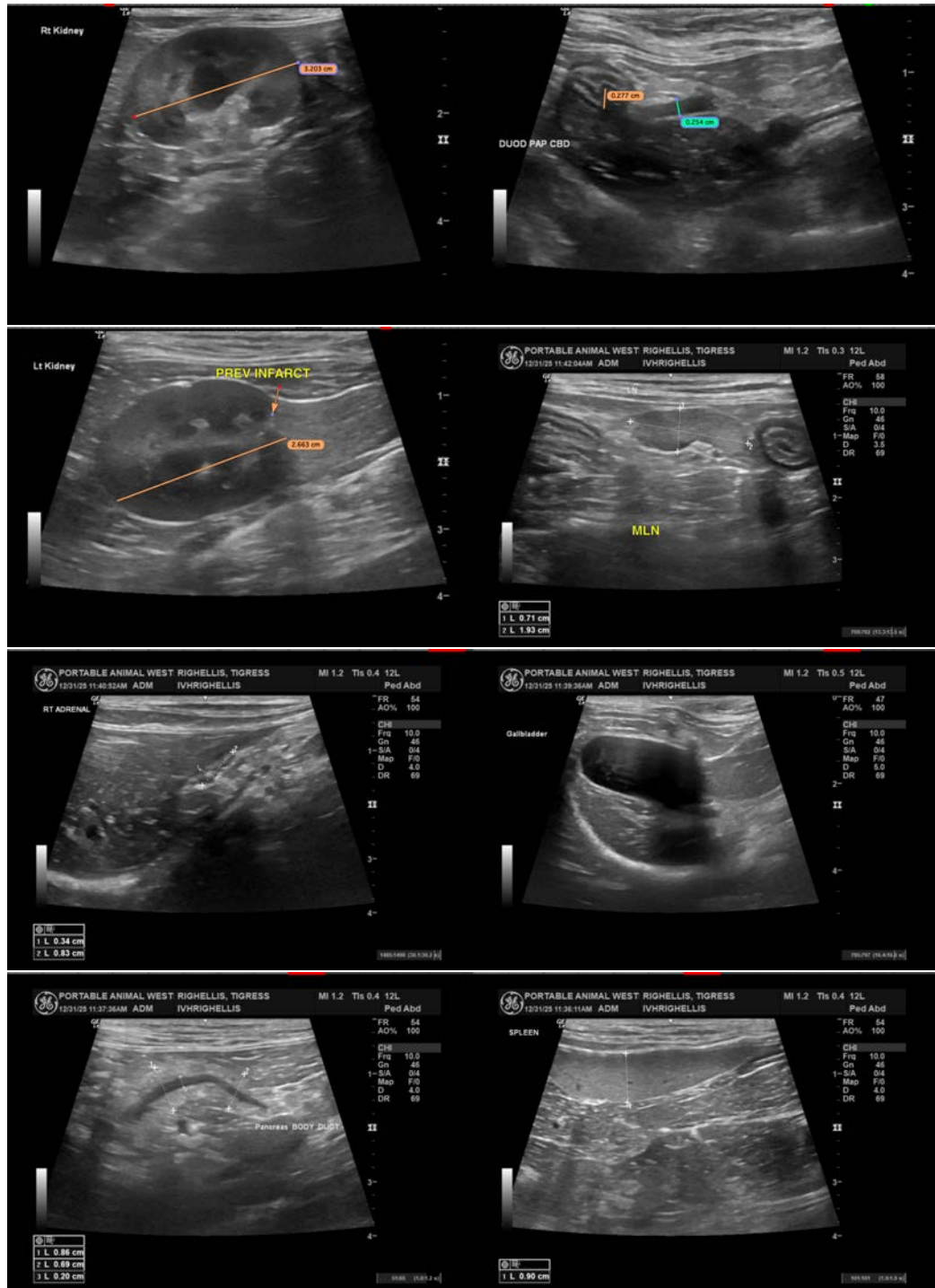
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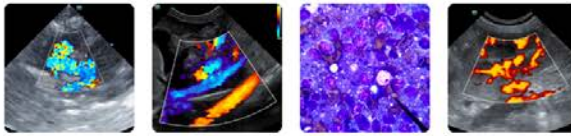
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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