



PATIENT

Andie Schlup

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

10 Years

WEIGHT

10.5 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Animal Hospital of
Lake Brandt

REFERRING VET

Dr. Wallace

INVOICE

72247

DATE

1/15/26

PRESENTING CLINICAL SIGNS

P presented for US due to chronic vomiting, weight loss, and pot bellied appearance over the past few months. P is fed a raw diet.

Abnormal PE/Chem/CBC/UA Results: Chol 79, Mono 0.71, Eos 1.7

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 has a normal shape and size (4.36 cm) with pinpoint non-obstructive mineralizations. Overall echogenicity is normal with adequate 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, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.72 cm) with pinpoint non-obstructive mineralizations. Overall echogenicity is normal with adequate 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, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.44 cm at the cranial pole and 0.40 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 0.38 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 (0.95 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. There is a moderate amount of non-organized echogenic debris. The bile duct appears mildly dilated and tortuous, measuring at 0.31 cm.



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Gastrointestinal

The stomach contains a large amount of fluid and shadowing ingesta. It measures at a normal thickness of <0.7cm 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. Gas, fluid and shadowing ingesta interfere with full evaluation of the stomach and some areas of the cranial abdomen.

Most of the visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with moderate fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Jejunum wall measures 0.20 cm. Duodenum wall measures 0.34 cm. 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 distended with non-formed fecal material. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The left limb of the pancreas is prominent and hypoechoic as compared to the surrounding isoechoic 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 are occasional prominent mesenteric lymph nodes. An example of a small cluster measures 1.12 cm x 1.15 cm and 0.74 cm x 0.73 cm. The omentum is normal in echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Pancreatic changes most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.
- Moderate gallbladder debris with mild bile duct dilation – Dilation of the common bile duct could be consistent with a functional obstruction (i.e. primary hepatic disease resulting in hepatocellular swelling) or with an extrahepatic bile duct obstruction (ie. choledocholith, bile duct tumor, pancreatic disease, other).
- Large fluid/ingesta distended stomach and small intestine – Correlate with feeding history. The appearance is suggestive of generalized ileus, although a post-prandial patient cannot be ruled out.
- Lymph node changes consistent with reactive lymphadenopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the GI tract to explain the chronic vomiting reported. The stomach and small intestine appear diffusely significantly fluid and ingesta distended. If the patient was adequately fasted this likely represents diffuse ileus and reduced progressive motility. This is often secondary to a primary enteropathy. Consider the following:



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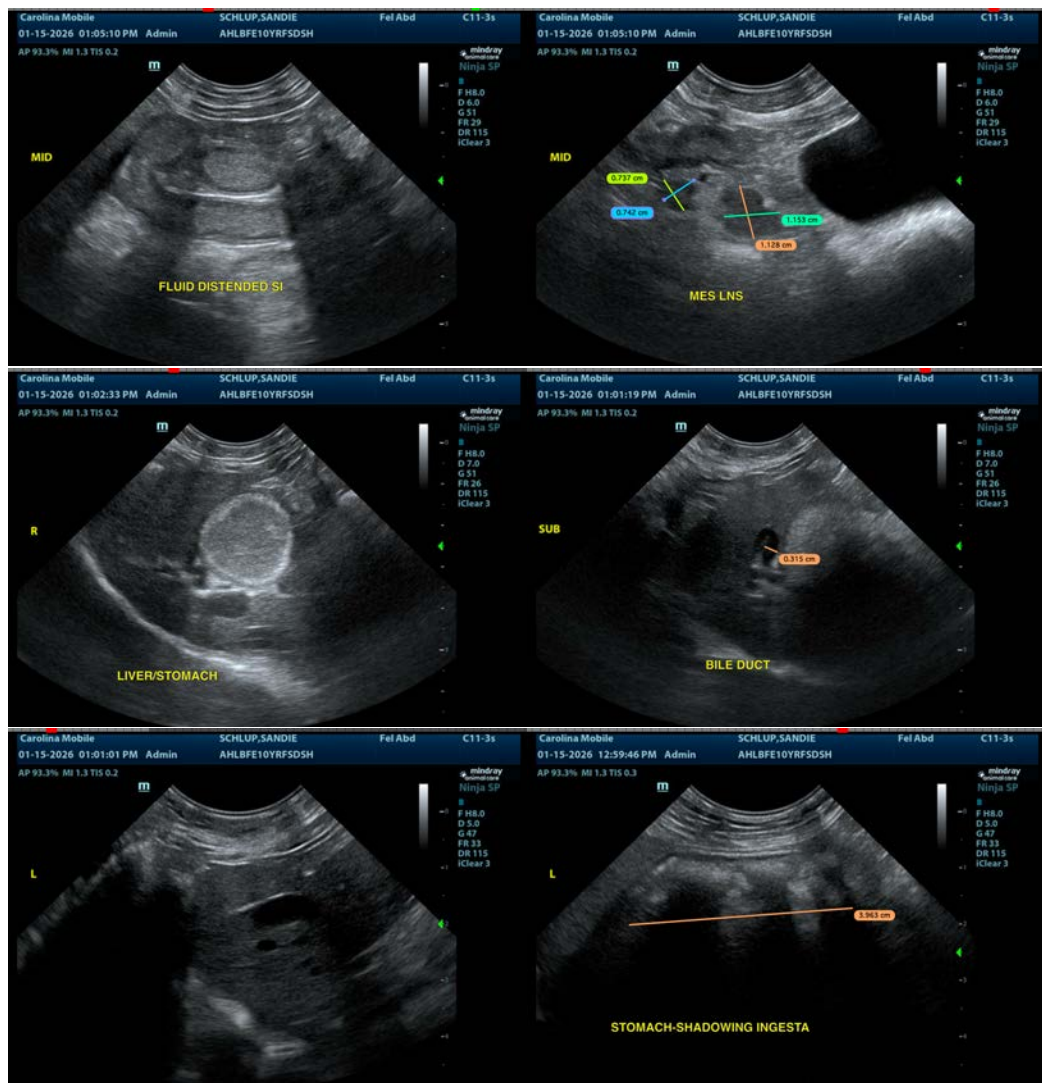
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- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.

The pancreas is prominent and hypoechoic. Correlate with a PLI level. Consider empirical treatment for pancreatitis (consider a combination ultra low-fat/hydrolyzed protein prescription diet – Royal Canin has one).

If there is question about appropriate fasting, consider a minimum 12 hour fast and reassessment (radiographs +/- ultrasound).

If symptoms are persistent, biopsies of the GI tract may eventually be warranted.





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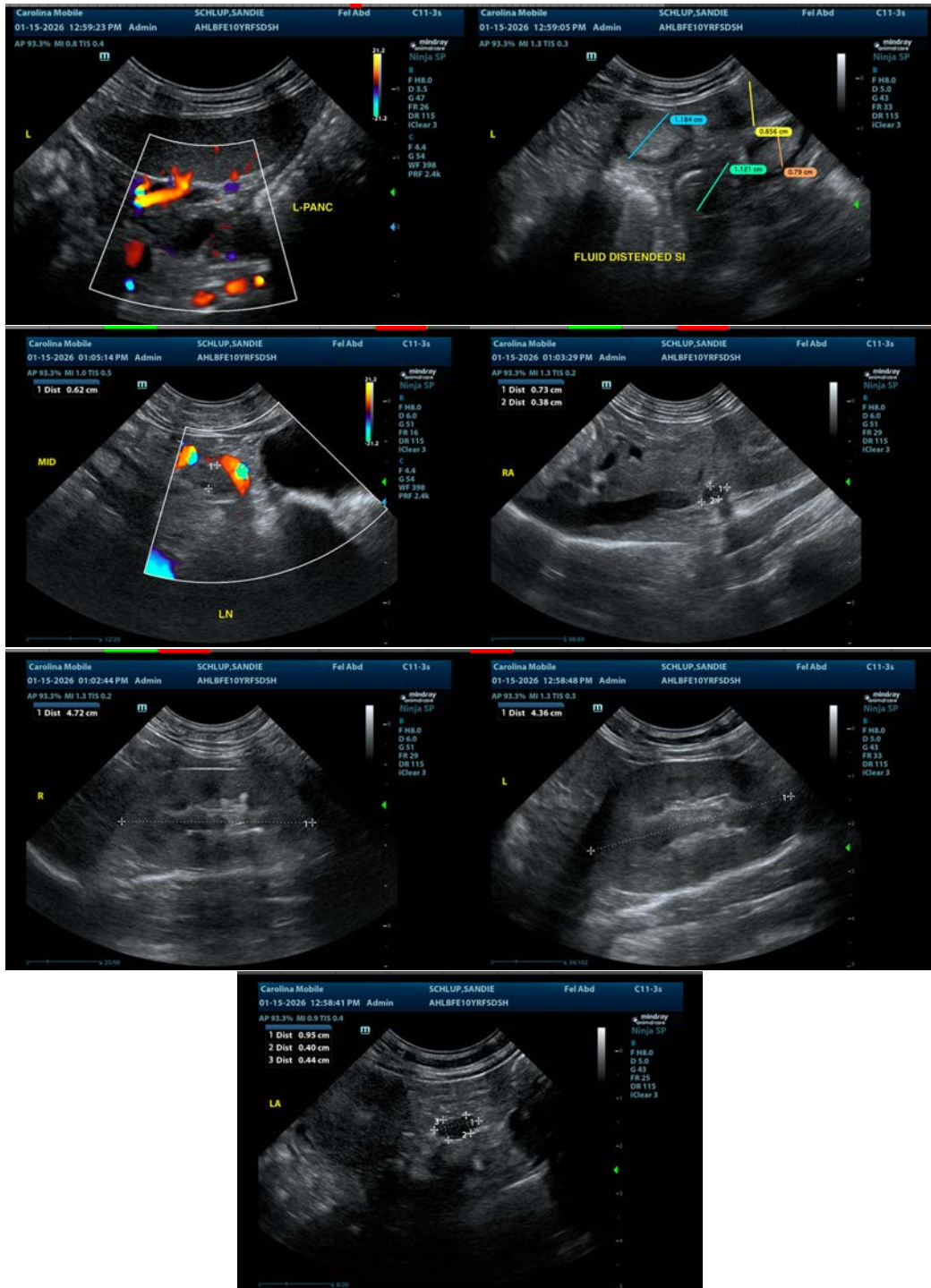
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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