

**PATIENT**

Bella Reed

**SPECIES**

Feline

**BREED**

DLH

**SEX**

Spayed Female

**AGE**

14 Years

**WEIGHT**

4.4 kg

**INTERPRETED BY**

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

**IMAGING  
PERFORMED BY**

Loetitia Saint-Jacques,  
LVT

**HOSPITAL NAME**

VCA Feline

**REFERRING VET**

Dr. Smith

**INVOICE**

13342

**DATE**

01/22/26

**PRESENTING CLINICAL SIGNS**

- Attached prev US report, Weight loss (08-Jan-2026)
- Anorexia (04-Feb-2025)
- Vomiting (08-Jan-2026)
- Prev AUS: Primary Abnormal Findings:
- The cystic structures with thin walls and irregular margins in the liver, that contain anechoic fluid are very concerning
- for neoplasia (including cystadenocarcinoma, cystadenoma) although without a biopsy cannot be sure.
- The large cystic structure that has an irregular margin that contains echogenic fluid is very concerning for an abscess.
- Pancreatitis

Abnormal PE/Chem/CBC/UA Results: Weight loss SDMA 17.6 Renal tech prediction inconclusive. USG 1.050 Protein 2+ Bilirubin 1+ Occult blood 3+ RBC 11-20/hpf CBC/Chem/T4 otherwise wnl. LMOM. No signs on labs for weight loss, anorexia and vomiting. Rec AUS as next steps.

**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 2.0 cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (3.59 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.

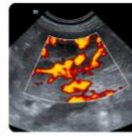
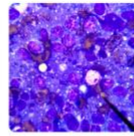
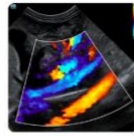
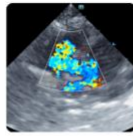
The right kidney is slightly irregular in shape due to a previous infarct at the cranial pole (2.76 cm). Overall echogenicity is slightly hyperechoic with mildly reduced corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal. The proximal ureter appears slightly prominent and dilated measuring at 0.23 cm with mildly reactive mesentery/focal inflammation most consistent with ureteritis. Mild pyelectasia was present measuring at 0.20 cm.

**Adrenal Glands**

The left adrenal gland is normal in size measuring 0.47 cm width. 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 0.37 cm width. 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**



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The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. The spleen measured 0.88 cm width. There was a small hyperechoic nodule in the parenchyma measuring 0.27 cm and is consistent with a benign myelolipoma.

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**Liver**

The liver is large and irregular in shape with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There are too numerous to count irregular anechoic complex cystic lesions visualized throughout the parenchyma with examples measuring 1.11 cm, 0.68 cm and 1.53 cm in diameter. No definitive mass-like lesions are visualized.

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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 primarily anechoic. The bile duct appears somewhat prominent, particularly at the level of the duodenal papilla where it measured 0.41 cm. No evidence of obstruction is visualized.

**AGE**

14 Years

**Gastrointestinal**

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The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7 cm 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.

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Most of the visualized areas of duodenum, jejunum and ileum generally have a relatively uniform diameter with minimal 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. The duodenum measured as normal (0.24 cm in wall thickness) and the jejunum measured as normal (0.25 cm). Visualized peristalsis appears appropriate. Some sections of small intestine appear mildly 'ropey' with a prominent muscularis layer. Additionally, the proximal duodenum appears mildly thickened and contains echogenic non-shadowing luminal material possibly consistent with non-shadowing ingesta/tissue (polyp/mass) etc. no evidence of an obstruction is observed.

**IMAGING  
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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.

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**Pancreas**

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The pancreas is prominent and hypoechoic in the left limb. There is no evidence of nodules or cystic lesions. There is mild inflammation/reactive mesentery around the pancreas.

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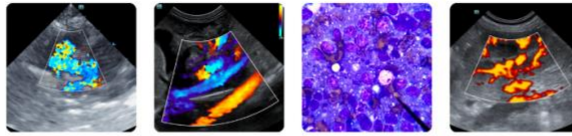
**Free Abdomen**

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Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is occasional prominent mesenteric lymph nodes. A larger mesenteric lymph node visualized measures 0.64 cm x 1.79 cm. A portal lymph node is visualized measuring 0.35 cm. The omentum is slightly hyperechoic around some areas of the left limb of the pancreas and at the right proximal ureter.

**ULTRASONOGRAPHIC FINDINGS**



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- Age-related changes visualized associated with the kidneys as well as suspected proximal right ureteritis.
- Pancreatic changes consistent with chronic pancreatitis +/- chronic pancreatic remodeling.
- Large irregular liver with too numerous to count irregular cystic lesions-these generally appear most consistent with cystadenomas. Other differentials such as cystadenocarcinomas, abscesses, etc. are possible but potentially less likely.
- Occasional prominent mesenteric lymph nodes- findings are most consistent with reactive lymph nodes although an early neoplastic change cannot be ruled out.
- Segmental thickening of the small intestine with some areas exhibiting a mildly prominent muscularis layer- findings are most consistent with inflammatory type change.
- Intraluminal material in proximal duodenum-the significance of this is unclear no obstruction is visualized-possibilities include non-shadowing ingesta, soft tissue (mass/polyp etc..)

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The liver appears similar to the previous exam in 2025. There are large expansile irregular cystic lesions. No significantly echogenic lesions are observed on today's exam making the likelihood of an abscess or similar less likely.

Both kidneys have changes consistent with chronic renal disease and the proximal right ureter appears somewhat inflamed. Recommend urine culture and possibly empirical treatment for pyelonephritis even if the culture is negative. Consider continued monitoring of the right ureter (recheck in four to six weeks after a course of antibiotics).

The pancreas is prominent and hypoechoic in the left limb. Correlate with a PLI level. If there are symptoms consistent with pancreatitis, consider empirical treatment.

The small intestinal descriptions are similar to the previous exam. If symptoms concerning for underlying gastrointestinal disease are present, further workup may be warranted. This could include a diet trial with a hydrolyzed protein prescription diet, a GI panel, or possibly even upper GI endoscopy to further evaluate the proximal GI tract (slightly thickened area proximal duodenum) and obtain biopsies. There is questionable hyperechoic non-shadowing intraluminal material in the proximal duodenum. No obstruction is noted-the significance of this is uncertain. If vomiting symptoms persist upper GI endoscopy (as described above) could be considered to further evaluate.

Imaging performed by



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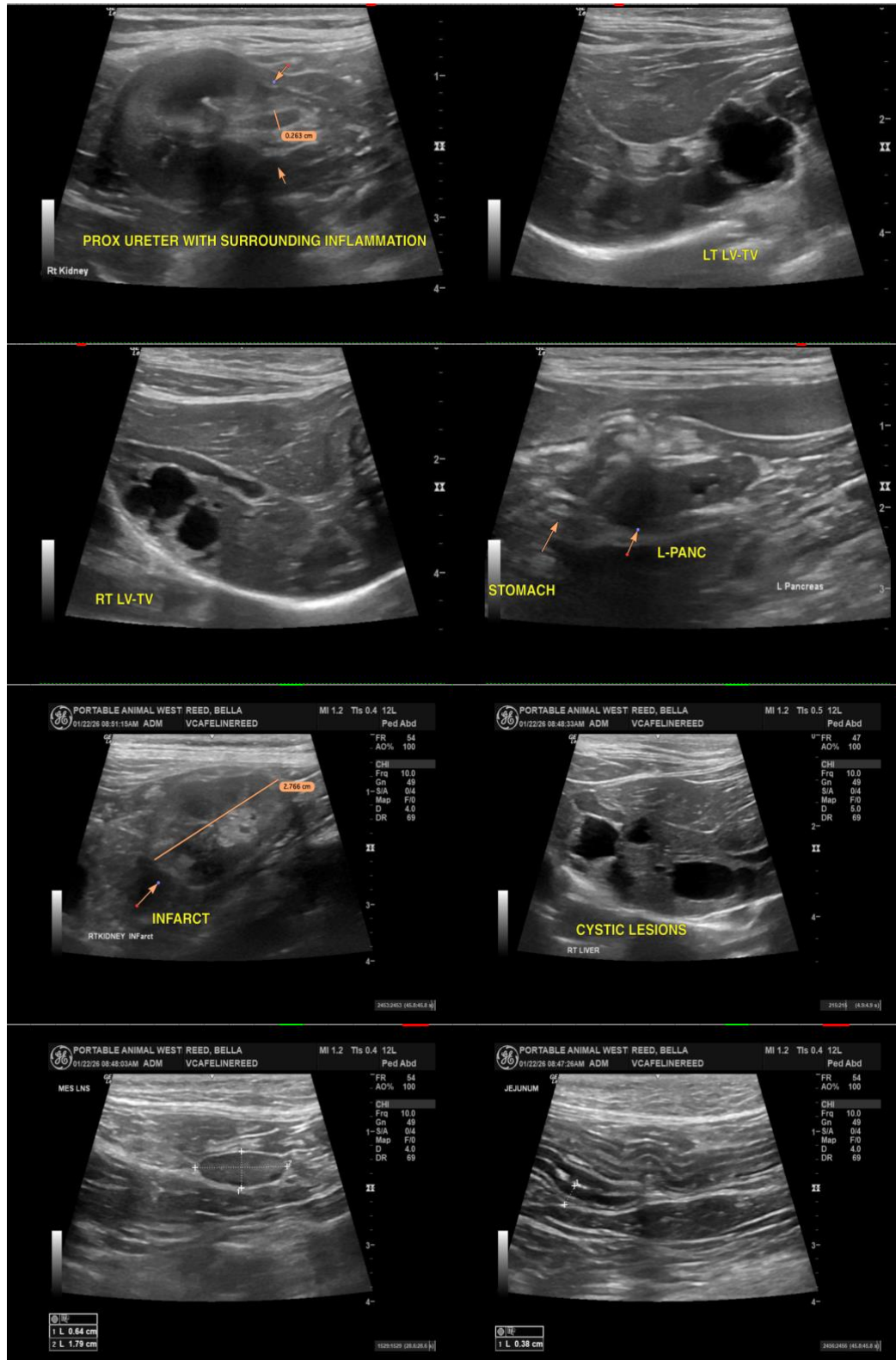
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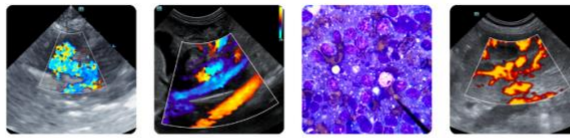
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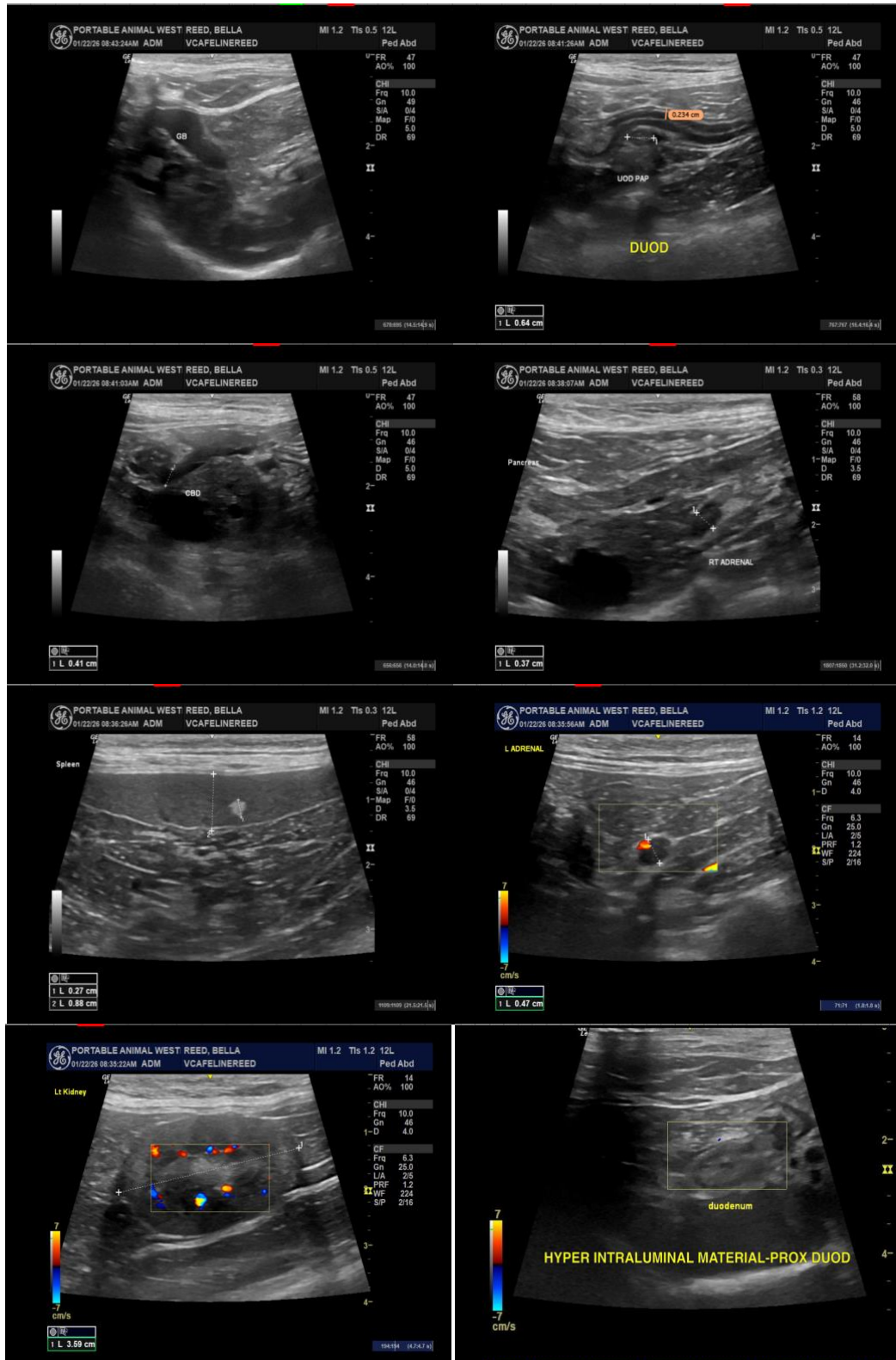
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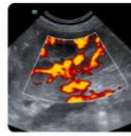
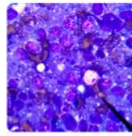
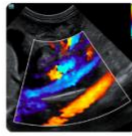
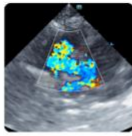
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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