



## PATIENT

Zha Mao Lin

## SPECIES

Feline

## BREED

DLH

## SEX

Neutered Male

## AGE

9 years

## WEIGHT

5.6 kg

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Natalia Franco

## HOSPITAL NAME

Eagleson Veterinary  
Clinic

## REFERRING VET

Dr. Mohamed Zaid

## INVOICE

11039

## DATE

1/7/2026

## PRESENTING CLINICAL SIGNS

Presented of Anorexia, Vomiting and dysuria. History of IBD; patient on Budesonide. Has been on I/D diet but might have eaten other cat's food. Recommended AUS for further investigation.

Abnormal PE/Chem/CBC/UA Results: Urinalysis: Proteinuria and Hematuria. No other significant finding.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder is moderately distended with mild primarily suspended echogenic debris present. 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 calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (4.54 cm). 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, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.5 cm). 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, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

### Adrenal Glands

The region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.5 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 (0.88 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. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

### Gastrointestinal



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The stomach contains minimal luminal contents. The gastric wall appears prominent and thickened (up to .94cm) in some areas, with reduced detail of wall layering and surrounding inflammation. there is the impression of reduced peristaltic activity.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. Bowel loops follow a typical curvilinear path with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis:mucosa layer ratio. The duodenum measured 0.24 cm in diameter and the jejunum measured 0.3 cm in diameter. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

Sections of colon (including the ICCJ) are visualized with non 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 visible/mildly mottled in both limbs. 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, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

## ULTRASONOGRAPHIC FINDINGS

- Suspended echogenic debris in the urinary bladder. The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus. Recommend urinalysis and culture.
- Pancreatic changes most consistent with chronic pancreatic remodeling. Mild chronic pancreatitis cannot be ruled out.
- Thickened gastric wall with reduced wall layering-findings are concerning for infiltrative disease (neoplasia, eosinophilic infiltrates etc..) severe gastritis is possible.
- Diffusely thickened/prominent small intestinal with a prominent muscularis layer. The small intestinal wall changes are most consistent with an inflammatory process or early neoplastic change.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A "ropey" small intestine with a prominent muscularis layer is visualized. These changes are most consistent with inflammatory type change, although early neoplasia change cannot be ruled out. Additionally, the stomach appears prominent and thickened with reduced wall layering. These changes are concerning for a neoplastic process. Recommend a fine needle aspirate of the gastric wall.

Additionally, consider the following:

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



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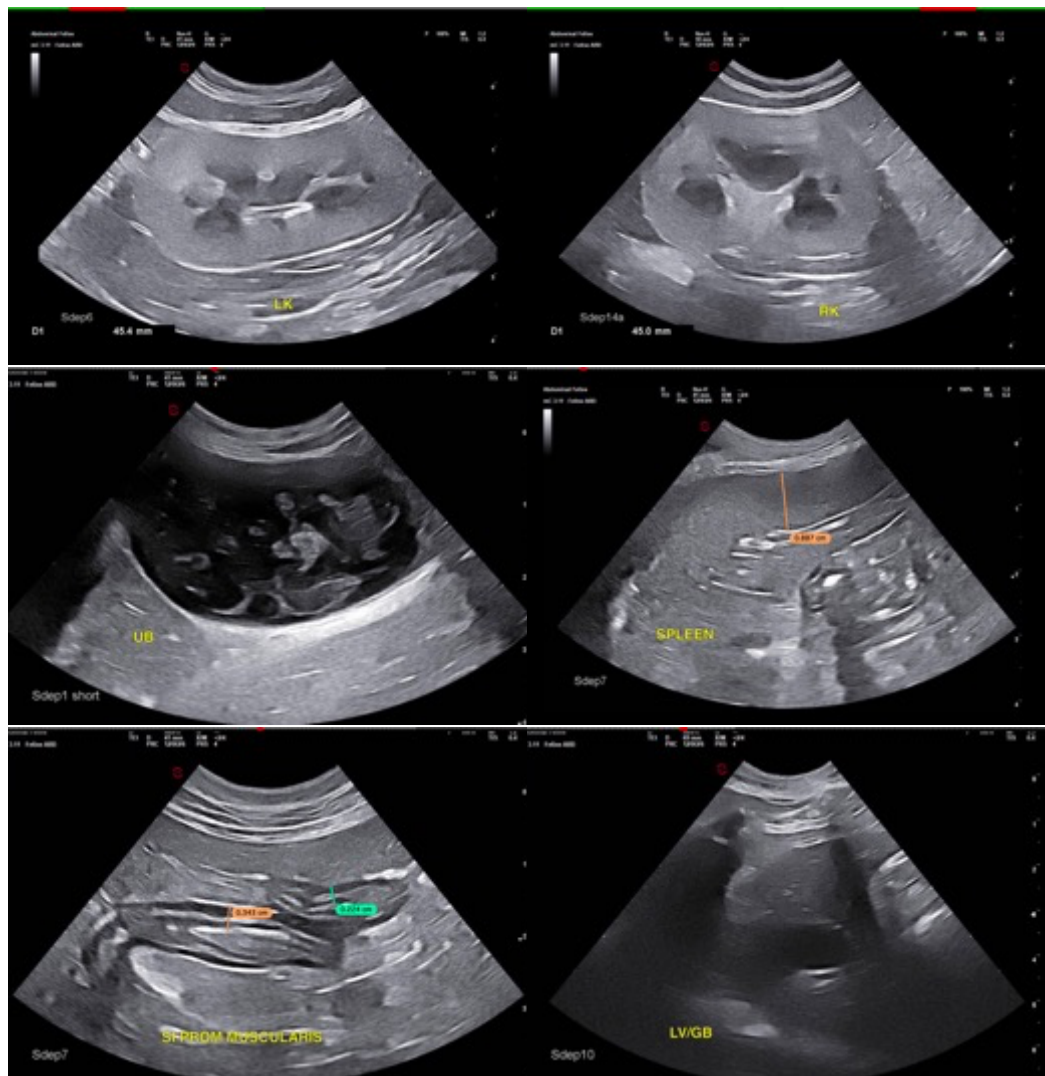
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- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.

If symptoms are persistent, and cytology is not helpful, surgical biopsies of the GI tract (stomach and SI) may eventually be warranted.

Correlate with PLI level. If this is significantly elevated, consider a concurrent treatment for pancreatitis.





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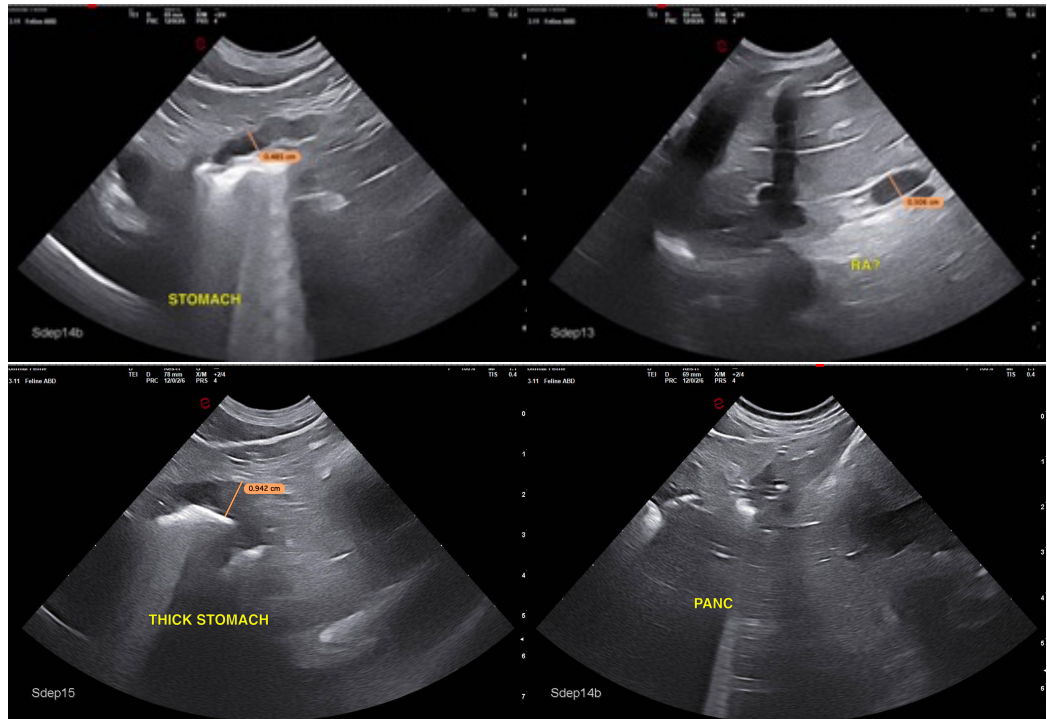
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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