



PATIENT

Nugget O'Neil

SPECIES

Feline

BREED

Domestic Medium
Longhair

SEX

Spayed Female

AGE

6 Years

WEIGHT

4.9 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Shane Stafford

HOSPITAL NAME

West Newton Animal
Clinic

REFERRING VET

Dr. Shane Stafford

INVOICE

71739

DATE

11/12/25

PRESENTING CLINICAL SIGNS

The patient presented for an annual examination with the owner's primary concern being a change in behavior and condition over the last 2.5-3 weeks. Nugget is an indoor/outdoor cat who voluntarily stopped going outside approximately three weeks ago. The owner observed that her hips appeared sunken and her spine was more prominent. She has been lethargic and has shown a decrease in grooming habits, resulting in a matted and dirty haircoat. For the past 1.5-2 weeks, the patient has had diarrhea. Yesterday, the stool was noted to be a bright orange color. Her appetite was decreased, and she was only consuming soft food, though her food intake has reportedly improved over the last few days. Water intake is normal. There has been no vomiting reported. Diet: Soft food primarily, with recent re-introduction of hard food. HW/ flea + tick preventative: Nexgard, recently administered. Current Medications/ supplements: None. Any vaccine or medication reactions: None reported. What is the main concern of coming in today: Significant weight loss, lethargy, poor grooming, and diarrhea over the past 2.5-3 weeks.

Abnormal PE/Chem/CBC/UA Results: ****Marked weight loss (41% of body weight)**** - ****Chronic diarrhea**** - Lethargy - Inappetence (improving) - Poor haircoat - ****Differentials****: Primary gastrointestinal disease is highly suspected. Differentials include Inflammatory Bowel Disease (IBD), gastrointestinal lymphoma, and intestinal parasites. Secondary causes of GI signs (hyperthyroidism, renal disease, pancreatitis) are less likely given the unremarkable bloodwork. Intestinal obstruction is also less likely given the chronic nature of signs and lack of vomiting. Labwork is attached

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 (3.17 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 (3.62 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 is visualized.

The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.



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Spleen

The spleen is large, mottled and irregular, measuring 1.35 cm at the level of the hilus. The blood flow through the hilus and splenic parenchyma appears normal. There are occasional small, ill-defined, hypoechoic nodules. A larger poorly defined nodule is visualized measuring 0.54 cm x 0.87 cm.

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

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.

Some of the visualized areas of duodenum, jejunum and ileum 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. Duodenum wall measures 0.25 cm. Jejunum wall measures 0.23 cm. Visualized peristalsis appears appropriate. The ileum appears severely thickened with a very prominent muscularis layer, measuring at 0.51 cm.

The ileocecal junction was visualized. Both the ileum and proximal/ascending colon appear severely thickened. The colon wall measures at 0.31 cm with reduced detail of wall layering. Sections of colon are visualized with non-formed fecal material and gas shadowing distally.

Pancreas

The pancreas is prominent and mottled 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

There is a small amount of free abdominal fluid. There are occasional prominent, rounded, isoechoic lymph nodes. Examples measure 1.21 cm x 1.55 cm and 1.41 cm x 1.35 cm. The omentum is diffusely hyperechoic and, in some areas, appears somewhat nodular.

Ringdown artifact is seen at the level of the diaphragm. Findings are most consistent with pulmonary pathology.

ULTRASONOGRAPHIC FINDINGS

- Large, mottled, irregular spleen with ill-defined hypoechoic nodules – The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.



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- Pancreatic changes most consistent with pancreatic remodeling.
- Prominent ileocecal junction with a severely thickened ileum and proximal ascending colon – Wall layering in this area appears somewhat diminished but is intact. Findings are concerning for an early neoplastic process, although severe inflammation is possible.
- Small volume free abdominal fluid, nodular omentum, and prominent mesenteric lymph nodes – Findings are concerning for metastatic disease, although highly reactive lymph nodes are possible.

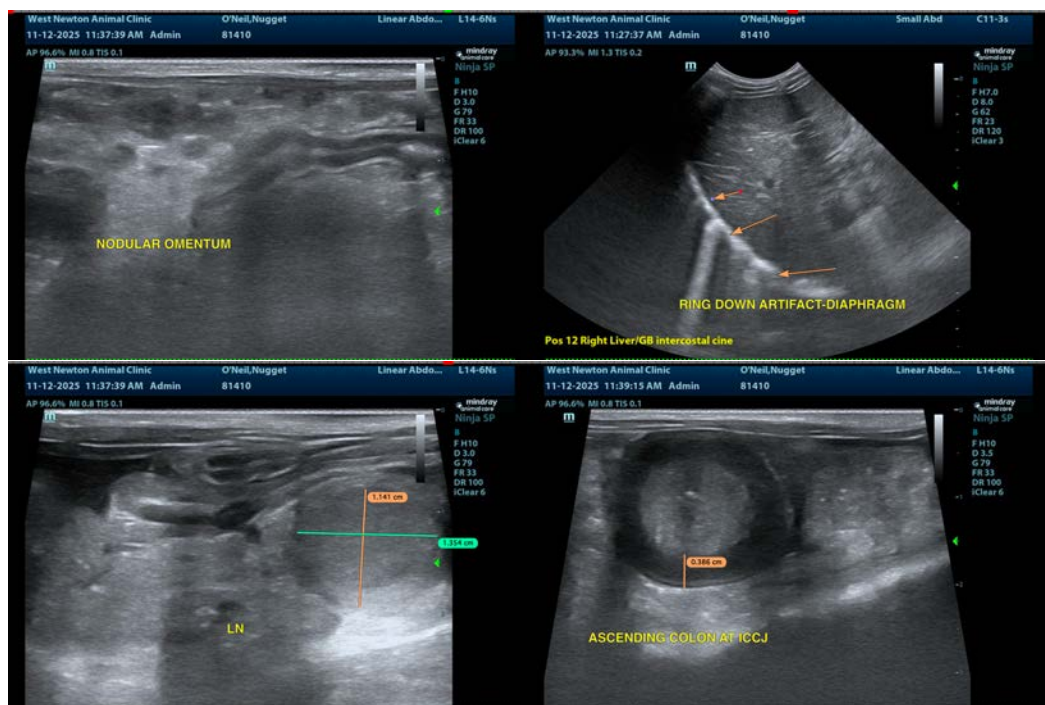
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The spleen is large, irregular and mottled with some ill-defined hypoechoic nodules. This could be concerning for an underlying neoplastic process. Recommend a fine needle aspirate for further evaluation.

The ileocecal junction is very prominent with both a thickened distal ileum and proximal colon. Consider a fine needle aspirate of the proximal colon wall for cytologic evaluation. Additionally, there are large mesenteric lymph nodes visualized. A fine needle aspirate could be considered.

If a cytologic diagnosis cannot be obtained, surgical biopsies may be warranted. A neoplastic process is thought most likely, but other differentials such as eosinophilic infiltrates, FIP, etc. are possible and can have a similar presentation.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement (disregard if this has already been done).





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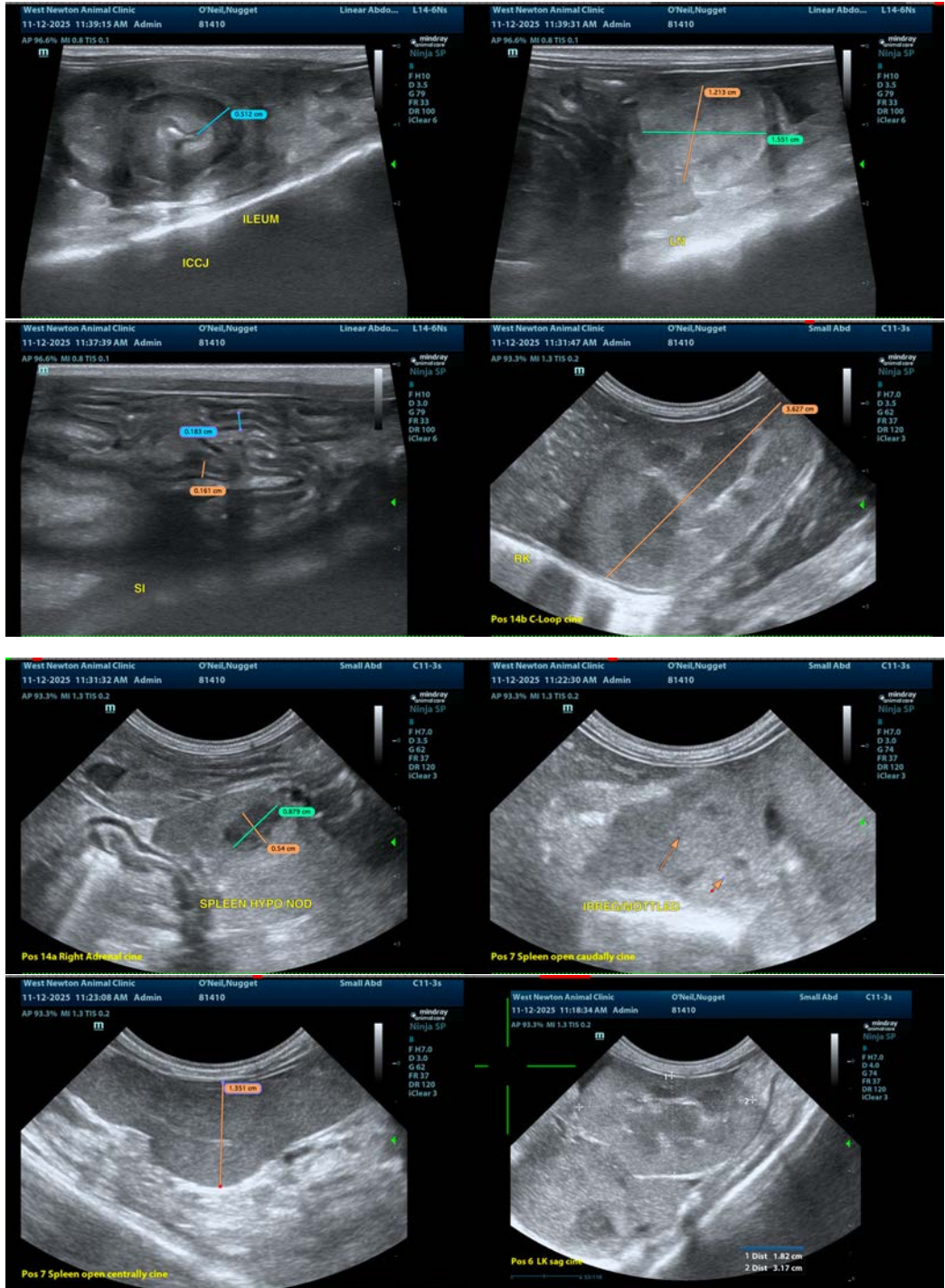
Dr. Shane Stafford

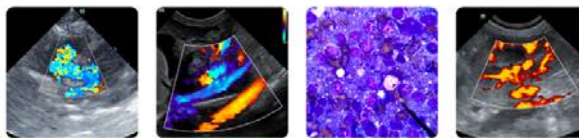
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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