



PATIENT

Samson Dierolf

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

12 Years

WEIGHT

6.2 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

Blue Pearl Wyomissing

INVOICE

71744

DATE

11/12/25

PRESENTING CLINICAL SIGNS

AUS to further evaluate for GI foreign material. Presented to the ER after ingestion of a rubber/stretchy/band material and the owner noted rubber string coming out of rectum. Asymptomatic. Material was removed from the rectum in the ER. AXR showed a mildly distended SI loop - r/o earl/partial SIMO vs GE/ileus.

Abnormal PE/Chem/CBC/UA Results: AXR (DACVR) - . The mildly distended loop of small intestine in the right mid abdomen may represent early/partial small intestinal mechanical obstruction, or changes associated with gastroenteritis. Abdominal ultrasound can be considered for further evaluation of this finding. Alternatively, repeat radiographs following a 12-18 hour controlled fast can be considered for further evaluation.

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 (4.22 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 (4.57 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 left adrenal gland is normal in size measuring 0.34 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 0.36 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 (0.86 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 cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains mild fluid. 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. At the pyloroduodenal junction there is asymmetrical wall thickening of the distal pylorus/proximal duodenum. In this area of the bowel wall measures 0.61 cm in thickness with reduced detail of wall layering, and is 1.07 cm in width.

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. Duodenum wall measures 0.24 cm. Jejunum wall measures 0.18 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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

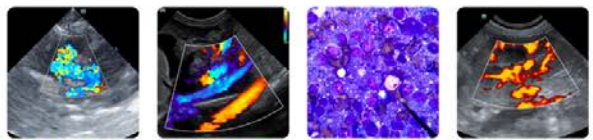
The pancreas is visible/mildly mottled in the left limb. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is no evidence of a diffuse lymphadenopathy. A cranial abdominal lymph node near the stomach is prominent measuring 0.57 cm x 0.68 cm. There is reactive mesentery near the pyloroduodenal junction.

ULTRASONOGRAPHIC FINDINGS

- Mild suspended echogenic debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.
- Pancreatic changes most consistent with mild pancreatic remodeling.
- Asymmetrical wall thickening of the distal pylorus/proximal duodenum – This could represent imaging artifact, inflammation, or early infiltrative disease (neoplasia, eosinophilic infiltrates, etc.).



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- Mildly diffusely “ropey” small intestine with some areas exhibiting a prominent muscularis layer – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no evidence of a focal obstruction on today’s exam and no evidence of ingested foreign material. Recommend close continued monitoring, as passing ingesta can sometimes lodge and cause a delayed problem.

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DSH

In the general, the small intestine appears somewhat “ropey”, with some areas exhibiting a mildly prominent muscularis layer. Additionally, there is a focal area at the proximal duodenum/distal pylorus where there is some asymmetrical wall thickening. The significance of this is uncertain. Ideally sampling of this thickening would be performed, although this is a challenging location. If a window for a fine needle aspirate is available, consider this option. Otherwise, recommend reevaluation in 4-6 weeks. If this is persistent, surgical biopsies may be considered.

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A lymph node near the pyloroduodenal junction is prominent and enlarged, but I suspect this is too small to easily sample as well.

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If there have been chronic GI signs suggestive of underlying inflammatory bowel disease or similar, you could consider 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.

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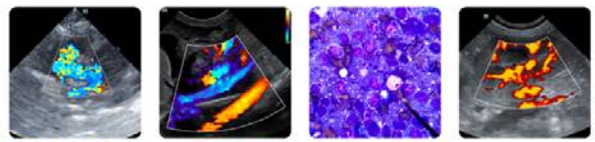
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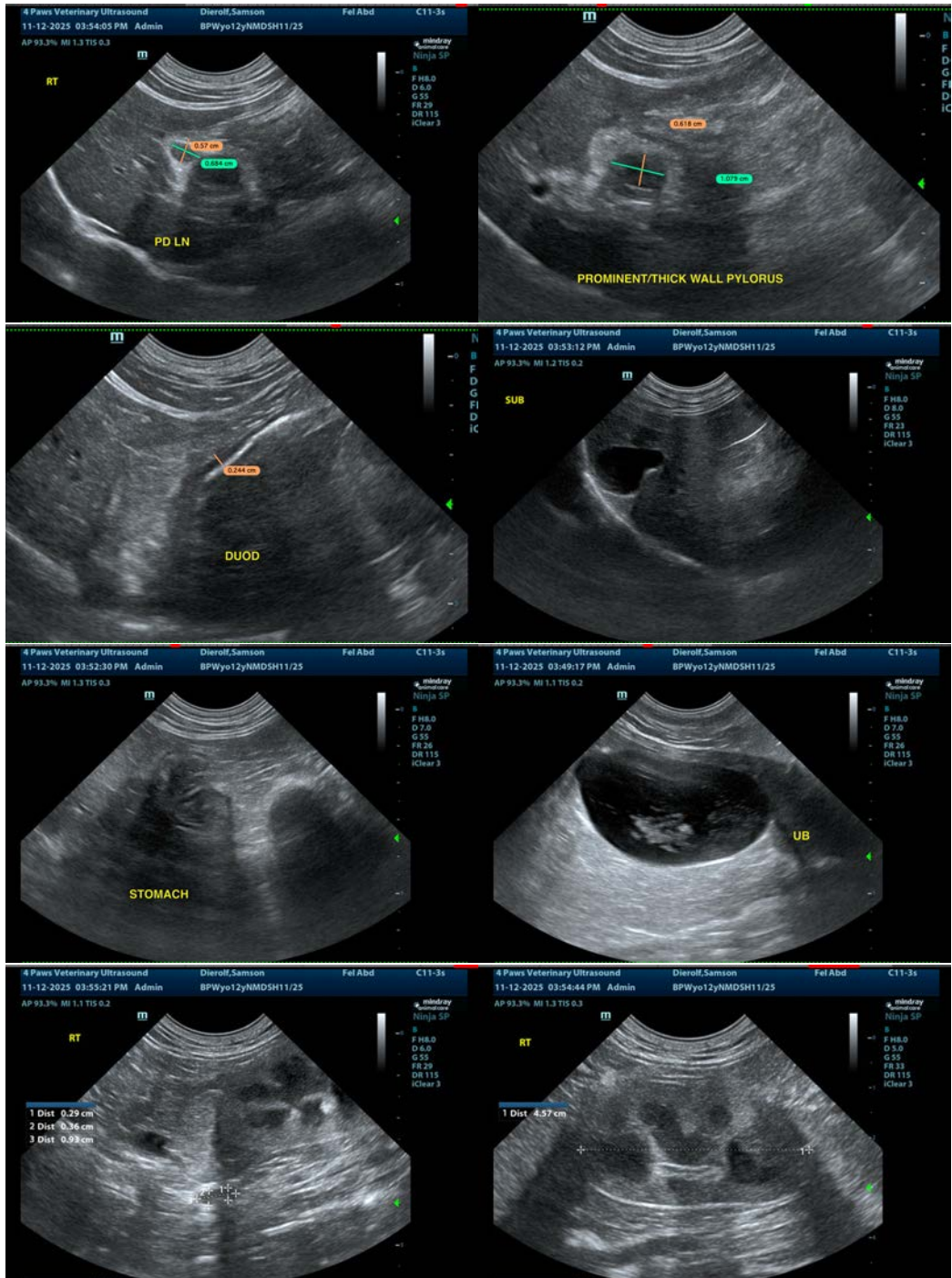
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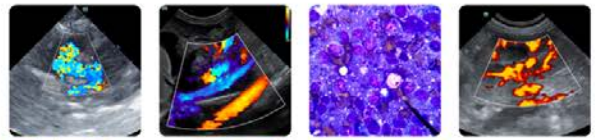
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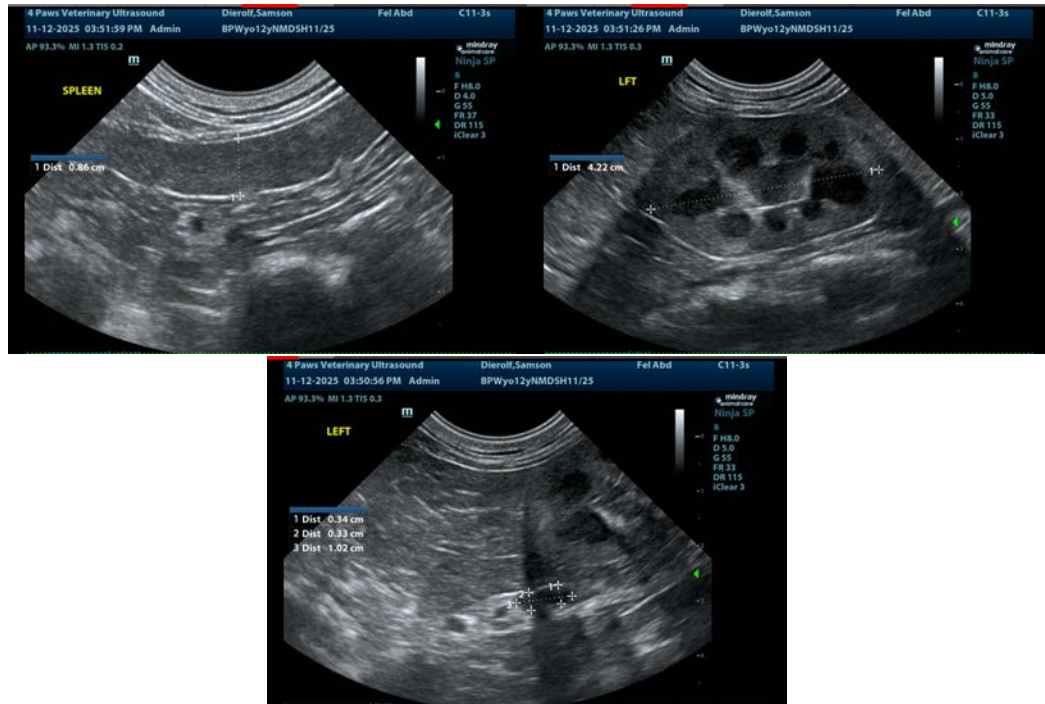
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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