



## PATIENT

Oreo Tiger Fehr

## SPECIES

Feline

## BREED

DSH

## SEX

Neutered Male

## AGE

9 Years

## WEIGHT

4.36 kg

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Carlie Koltek, RVT

## HOSPITAL NAME

Tuxedo Animal  
Hospital

## REFERRING VET

Dr. Kristin Buchanan

## INVOICE

71953

## DATE

11/19/25

## PRESENTING CLINICAL SIGNS

Cat has been vomiting at home more frequently, has been a few times a day for the last few days, but has been vomiting a lot for "awhile" before this. Is still eating and drinking. Owner unsure litterbox habits, as she has 5 cats. All are indoor cats. Weight loss present: was 5.15kg on last weigh in (in 2022) Given convenia and maropitant injection \*Stomach initially very full of ingesta on US - cat supposedly fasted appropriately, waited 5 more hours to re-image stomach + left panc\*

Abnormal PE/Chem/CBC/UA Results: T: 37.8 P: 200bpm R: n Appears well hydrated grade 2 dental disease no murmur or arrhythmia soft, non-painful abdominal palpation Nov 18th: radiographs: good serosal detail, NSF in chest. Some feces present in the colon, but does not look constipated. Stomach full of food, overall good serosal detail CBC: Neut  $18.59 \times 10^9/L$  (2.3-10.29) Chem: GLOB 56 U/L (28-51) PLi, T4 and SDMA all WNL

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder is moderately distended with mild/moderate 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 (3.96 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 (4.11 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 0.35 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 0.40 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 (0.71 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 moderate fluid/shadowing ingesta. 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.

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 0.30 cm. Jejunum wall measures 0.26 cm. Visualized peristalsis appears appropriate. The muscularis layer is diffusely prominent in the small intestine.

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.

## 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

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a significant lymphadenopathy in the region of the ileocecal junction with large, hypoechoic, rounded lymph nodes. Examples measure 1.66 cm x 1.51 cm and 0.68 cm and 0.53 cm in diameter. The omentum is hyperechoic around the prominent lymph nodes.

## 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.
- Pancreatic changes most consistent with chronic pancreatic remodeling +/- mild chronic pancreatitis.
- Moderate fluid/ingesta visualized within the gastric lumen – Correlate with feeding history. If the patient was adequately fasted this could represent delayed gastric emptying.



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- Diffusely prominent muscularis layer of the small intestine – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.
- Moderate lymphadenopathy at the ileocecal junction – Findings are most consistent with either severely reactive or early neoplastic lymph nodes.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

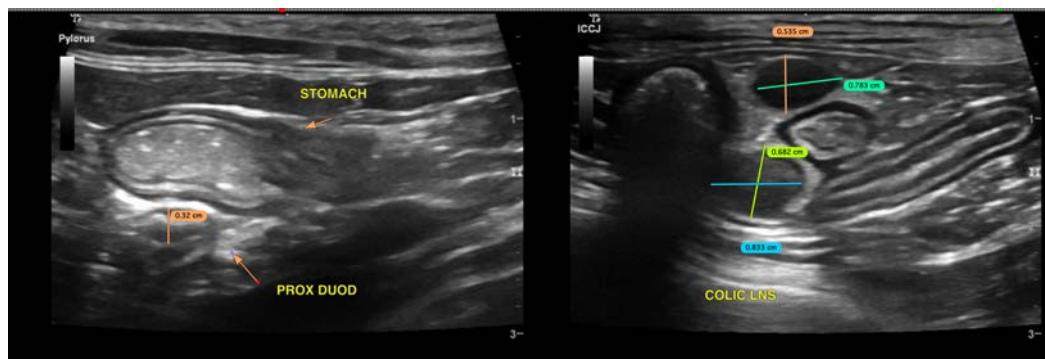
The small intestine appears diffusely “ropey” with a prominent muscularis layer. These changes are most consistent with inflammatory type change, although the lymphadenopathy in the region of the ileocecal junction is significant, which could increase the likelihood of an early neoplastic process. Recommend a fine needle aspirate of one of the colic lymph nodes for cytologic evaluation.

A chronic enteropathy is suspected. Consider the following:

- Recommend changing to a hydrolyzed protein prescription diet.
- 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.

Recommend symptomatic treatment for non-specific gastroenteritis/pancreatitis.

If symptoms are persistent and cytologic evaluation of the lymph nodes is not helpful, then biopsies of the GI tract may be warranted to further evaluate. You could consider endoscopic biopsies or ideally surgical biopsies of the GI tract and mesenteric lymph nodes.





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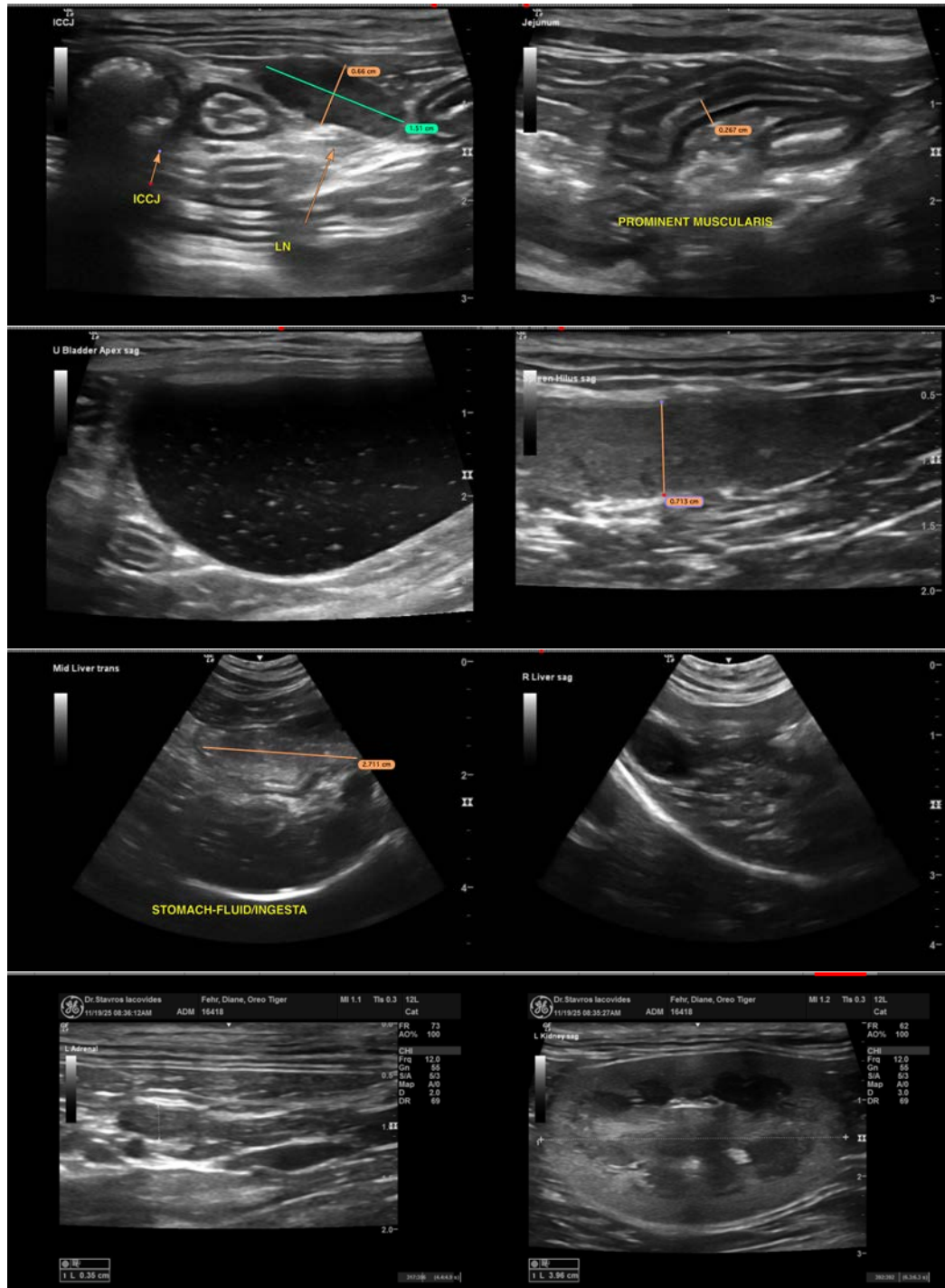
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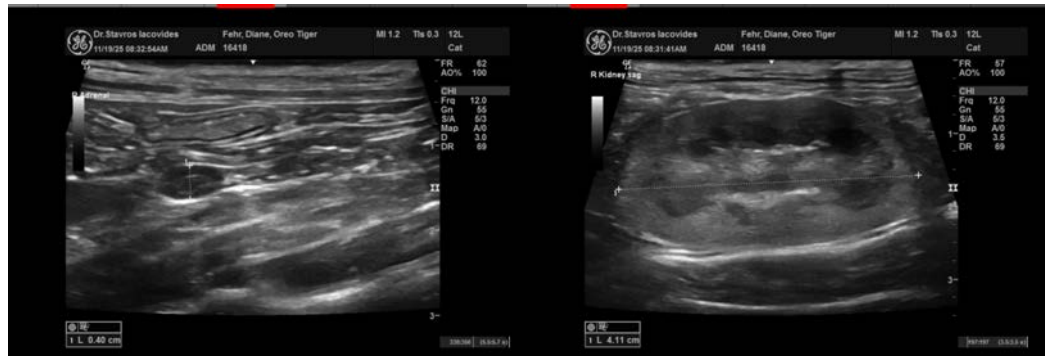
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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