



PATIENT

Cosmo Goldstein

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

4 Years 7 Months

WEIGHT

4.8 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Stan Gira

HOSPITAL NAME

Cranston Veterinary
Hospital

REFERRING VET

Dr. Melissa Huet

INVOICE

72018

DATE

11/20/25

PRESENTING CLINICAL SIGNS

Cosmo has had chronic vomiting and recently has had blood in his stool (today runny malodorous diarrhea). He is indoor only. Decreased energy levels. He is eating Hills oral care and Whiskas food.

Abnormal PE/Chem/CBC/UA Results: BW, UA and fecal PCR attached Feline Coronavirus RealPCR Positive C. perfringens Alpha Toxin (CPA) Gene Quant RealPCR Positive C. perfringens Enterotoxin (CPE) Gene Quant RealPCR Positive

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 (3.51 cm) with trace pyelectasia at 0.11 cm. The cortex is of increased echogenicity, with poor 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 hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (3.34 cm) but slightly irregular in shape, with pyelectasia at 0.32 cm. The cortex is of increased echogenicity, with poor 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 hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.28 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 0.44 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 small/contracted, measuring 0.50 cm. The 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.



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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 mild and likely incidental at this time. The cystic duct appears prominent and dilated, measuring at 0.30 cm. Visualization of the bile duct is lost distally.

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.

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 0.24 cm. Jejunum wall measures 0.17 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized. There is the impression of a bowel wall thickening associated with the ileocecal junction, suspicious for possible thickening of the cecum. The wall in this region measures 0.24 cm with decreased wall layering. The descending colon is visualized and appears distended with non-formed fecal material. Colon wall measures at 1.4 cm with intact wall layering.

Pancreas

The left limb of 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 are occasional mild reactive lymph nodes visualized near the ileocecal junction. Examples measure 0.31 cm and 0.28 cm. A pancreaticoduodenal lymph node is visualized measuring 0.31 cm. A prominent sublumbar lymph node is visualized measuring 0.54 cm. The omentum is generally of normal 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.
- Age related changes visualized associated with both kidneys as well as bilateral pyelectasia – Pyelectasia of the kidney(s) could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.
- Pancreatic changes most consistent with chronic pancreatic remodeling. Chronic concurrent pancreatitis is possible.
- Prominent cecum at the ileocecal junction – Findings could be consistent with inflammation, early infiltrative disease, etc.
- Reactive lymphadenopathy at the ileocecal junction, and a prominent hypoechoic sublumbar lymph node.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is echogenic debris in the urinary bladder, and both kidneys are hyperechoic with mild pyelectasia. Consider a urinalysis, culture and blood pressure as a baseline.

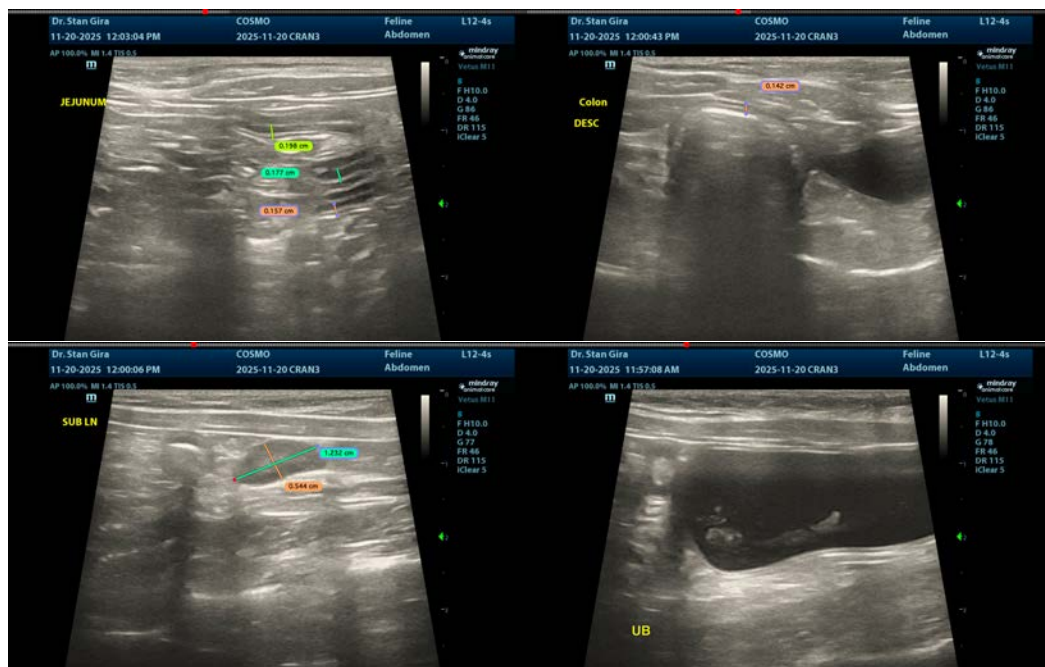
The left limb of the pancreas is mildly mottled. Correlate these findings with a PLI level. If this is significantly elevated, consider treatment for chronic pancreatitis.

No focal small intestinal lesions are visualized, although this does not rule out the possibility of an enteropathy. Additionally, the ileocecal junction appears slightly thickened. 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.
- Based on your previous testing, treatment for clostridium could be considered, as well as fiber supplementation (this can help some individuals but make others clinically worse).

There is evidence of thickened bowel at the ileocecal junction. I suspect this is the cecum. Consider treatment for colitis and reevaluation. If symptoms are persistent, upper and lower GI endoscopy may be warranted to further investigate. Additionally, you could consider follow up ultrasound evaluation to determine if there is any progressive change in these regions.

The sublumbar lymph node is very prominent. Recommend continued monitoring.





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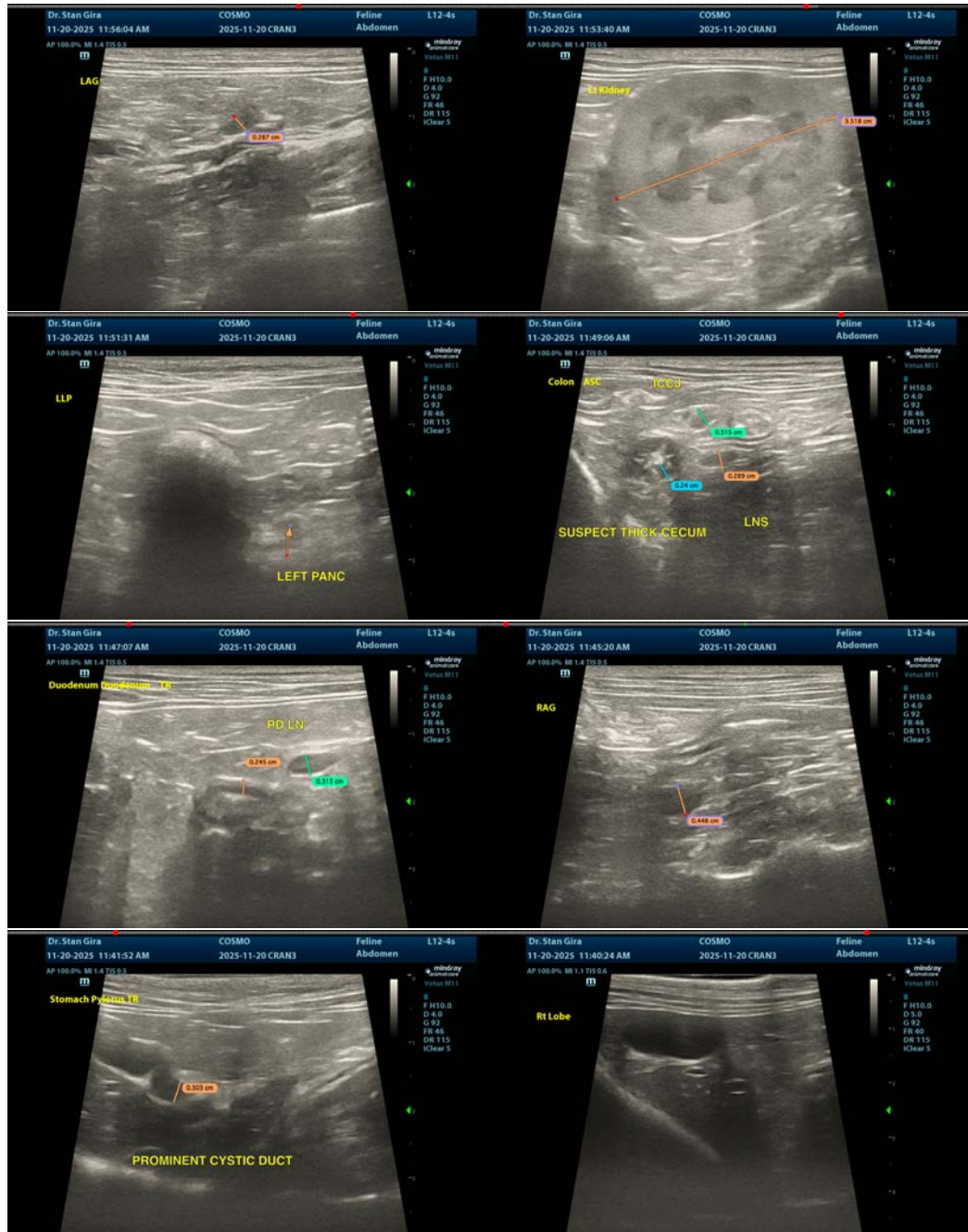
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com