



PATIENT

Winston Franz

SPECIES

Feline

BREED

DSH x Maine Coon

SEX

Neutered Male

AGE

12 Years

WEIGHT

13.3 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Gabrielle Iannuzzi

HOSPITAL NAME

Greater Staten Island
Veterinary Service

REFERRING VET

Dr. Donna Coogan

INVOICE

71620

DATE

11/6/25

PRESENTING CLINICAL SIGNS

Winston presented for an episode of vomiting frank blood this morning. One of owner's cats has been vomiting intermittently for the past 3 weeks - first clear with hairballs, then bile. Owner started giving the cats hairball treats after the vomiting began. Winston has been eating and drinking normally. No lethargy. No diarrhea. No melena. No coughing or sneezing. No diet change or history of dietary indiscretion. No rodenticide exposure. Previous medical history: asthma - treated with a course of prednisolone when he has an episode. The last episode was ~1.5 years ago. No current medication. Indoor only.

Abnormal PE/Chem/CBC/UA Results: PE: cachexic, 2/6 HM, QAR, no oral lesions Diagnostics: CBC: Eos 0.0 (0.17-1.57), nRBCs suspected, PLT 109 (151-600) Blood smear: lots of platelet clumps Chemistry: Phos 2.7 (3.1-7.5) Feline pro-BNP: normal TT4 (in house): 2.2 (0.8-4.7) Blood pressure: 130 mmHg #3 L medial pedal PCV/TP: 36%, 6g/dL PT/PTT (in house): PT: 17.2 sec (15-21); PTT: 110.5 sec (86-137)

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 (3.34 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 (4.28 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 0.31 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 0.49 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 (0.83 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 borderline large in size with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in 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. There is a hypoechoic structure visualized adjacent to the gallbladder, but smaller, which could be consistent with a small duplicate gallbladder or dilation of the cystic duct. This measures at 0.50 cm. The distal bile duct is visualized at the level of the duodenal papilla and is mildly dilated, measuring at 0.32 cm.

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 uniform diameter with minimal fluid distension. Wall thickness is increased. Bowel loops follow a typical curvilinear path. Some areas have reduced detail of wall layering. Duodenum wall measures 0.40 cm. Jejunum wall measures 0.27 cm. Visualized peristalsis appears appropriate. Some sections of bowel appear more significantly thickened. The ileum is very prominent at 0.45 cm. The muscularis layer is diffusely very prominent.

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 with clusters of large, hypoechoic, irregular mesenteric lymph nodes. An example of a pair measures 0.73 cm x 2.68 and 0.74 cm x 1.85 cm. The omentum is diffusely hyperechoic.

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.
- Prominent, mottled pancreas – Findings are most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.
- Large, hyperechoic liver – Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- Duplicate gallbladder versus dilated cystic duct and a mildly dilated terminal bile duct – Dilation of the common bile duct could be consistent with a functional obstruction (i.e. primary



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hepatic disease resulting in hepatocellular swelling) or with an extrahepatic bile duct obstruction (ie. choledocholith, bile duct tumor, pancreatic disease, other).

- Diffusely thickened small intestine with an increased 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.
- Moderate mesenteric lymphadenopathy – Findings are concerning for possible metastatic lymph nodes, although highly reactive lymph nodes are possible.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine is diffusely thickened, and there are clusters of large, hypoechoic mesenteric lymph nodes. These changes are most consistent with either highly inflammatory lymph nodes/IBD, or possible round cell neoplasia. Based on the size of the lymph nodes, a metastatic process is the primary concern. Recommend a fine needle aspirate of a mesenteric lymph node for cytologic evaluation.

While awaiting cytologic results, 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.

If cytologic diagnosis is not able to be obtained, biopsies of the GI tract and lymph nodes may be warranted.

The bile duct appears somewhat dilated. No evidence of an obstruction at this time. Consider chronic Ursodiol therapy and continued monitoring of the gallbladder and bile duct.

The liver appears somewhat hyperechoic. Correlate with liver values. In the absence of liver enzyme elevations, this could be consistent with fatty deposition or infiltrative neoplasia.

Both limbs of the pancreas are prominent and mottled. Correlate with PLI level. If this is elevated, consider concurrent treatment for chronic pancreatitis.

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



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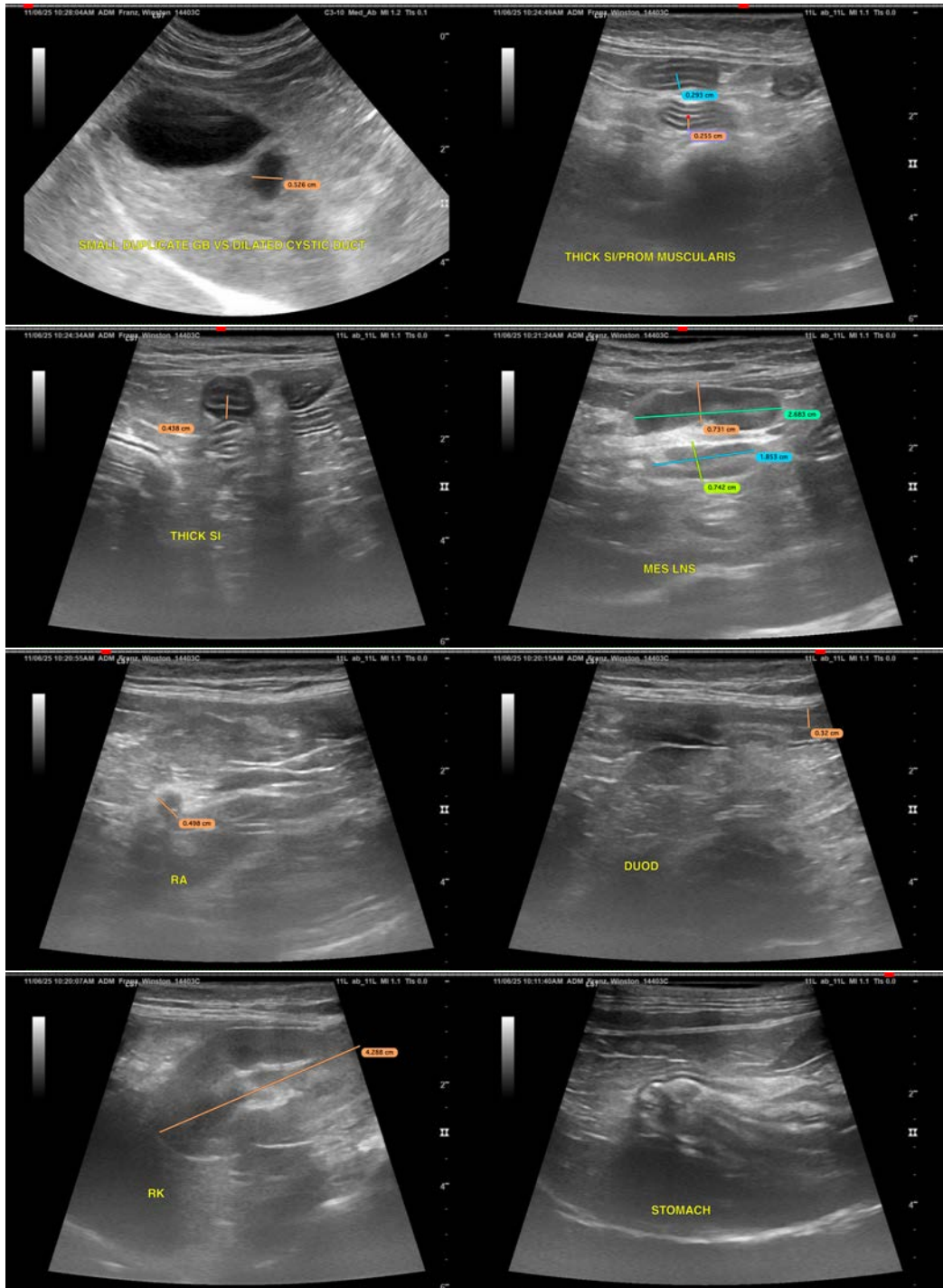
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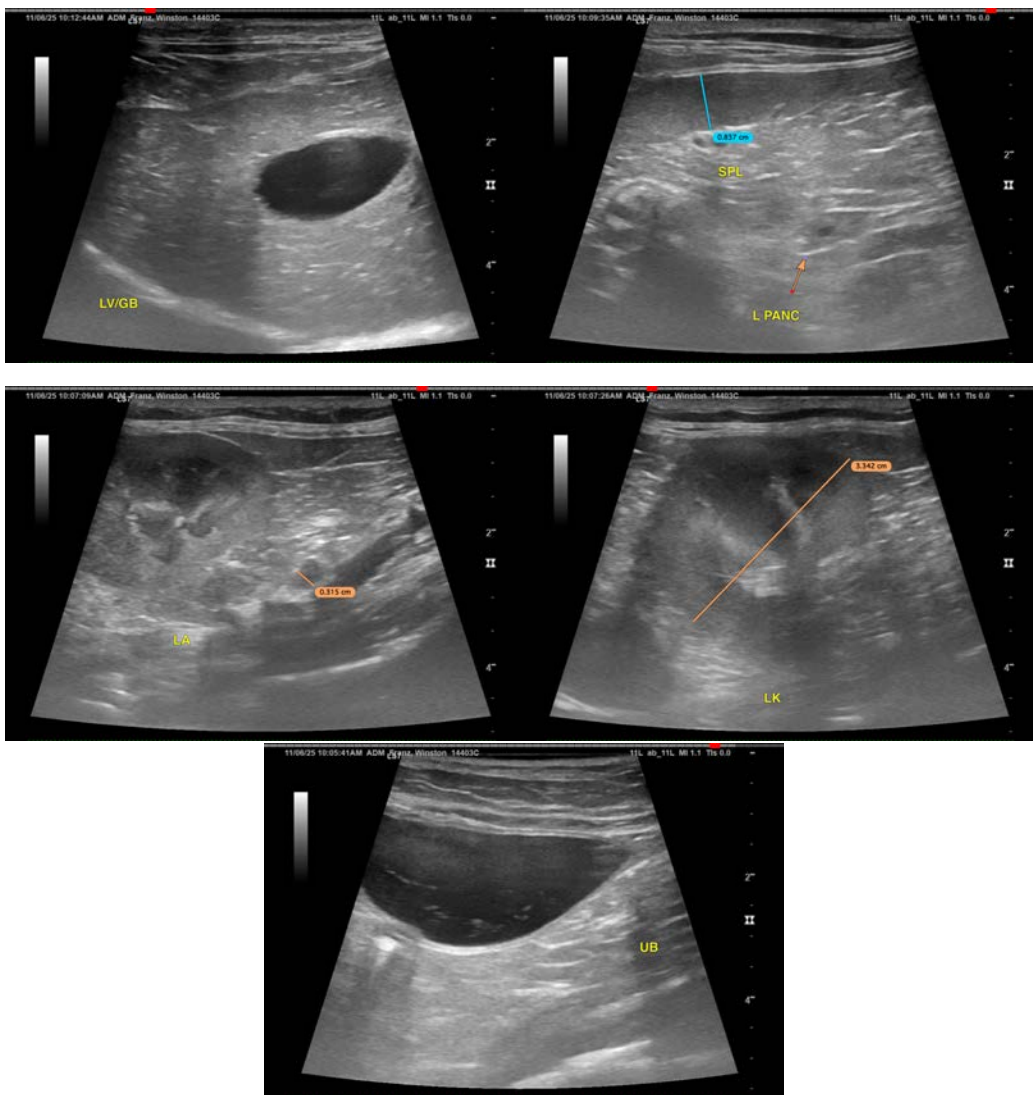
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com