



**PATIENT**

Ari Jansen

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

8 Years 2 Months

**WEIGHT**

9.5 lbs

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Shari Reffi, CVT

**HOSPITAL NAME**

VCA Northside Animal  
Hospital

**REFERRING VET**

Dr. Fusselman

**INVOICE**

72244

**DATE**

12/2/25

**PRESENTING CLINICAL SIGNS**

Elevated lymphocytes. COHAT scheduled for Thursday. Dental dz. No current medications other than Gaba for scan.

**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 (3.98 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 (3.78 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 0.48 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 0.57 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 (0.76 cm). The spleen echotexture is mildly mottled (when viewed with the high frequency probe), 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. There is a small, irregular, hypoechoic nodule visualized in the mid caudal region of the liver measuring 0.66 cm x 0.43 cm.

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.



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***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 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 0.28 cm. Jejunum wall measures 0.21 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 and slightly hypoechoic. 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 visible elongated mesenteric lymph nodes. Examples measure 0.26 cm x 1.7 cm and 0.38 cm x 1.42 cm. The omentum is of normal echogenicity.

**ULTRASONOGRAPHIC FINDINGS**

- Questionably mildly mottled spleen – 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.
- Mild pancreatic remodeling.
- Small, hypoechoic nodule visualized in the liver – Findings could be consistent with benign or early neoplastic lesion.
- Mildly “ropey” small intestine – Findings could be consistent with mild inflammatory type change. A neoplastic process seems much less likely.
- Visible, likely reactive mesenteric lymph nodes.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

No focal mass lesions are observed on today’s exam. The mesenteric lymph nodes are visible but elongated and isoechoic, most consistent with reactive lymph nodes.



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The spleen is normal in size and shape but mildly mottled when viewed with the high frequency probe. Options would include continued monitoring or a fine needle aspirate of the spleen for further evaluation.

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There is a small hypochoic nodule in the liver. Based on the location and size of this lesion, I suspect a fine needle aspirate would be very challenging. If this is not possible, recommend continued monitoring with ultrasound (recheck in 2-3 months).

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The small intestinal changes are mild. In the absence of underlying gastrointestinal symptoms, recommend continued monitoring.

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Depending on the severity of the lymphocytosis reported, additional evaluation may be warranted. Recommend pathologist review of a blood smear to better determine if aspirates, flow cytometry, etc. are warranted.

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

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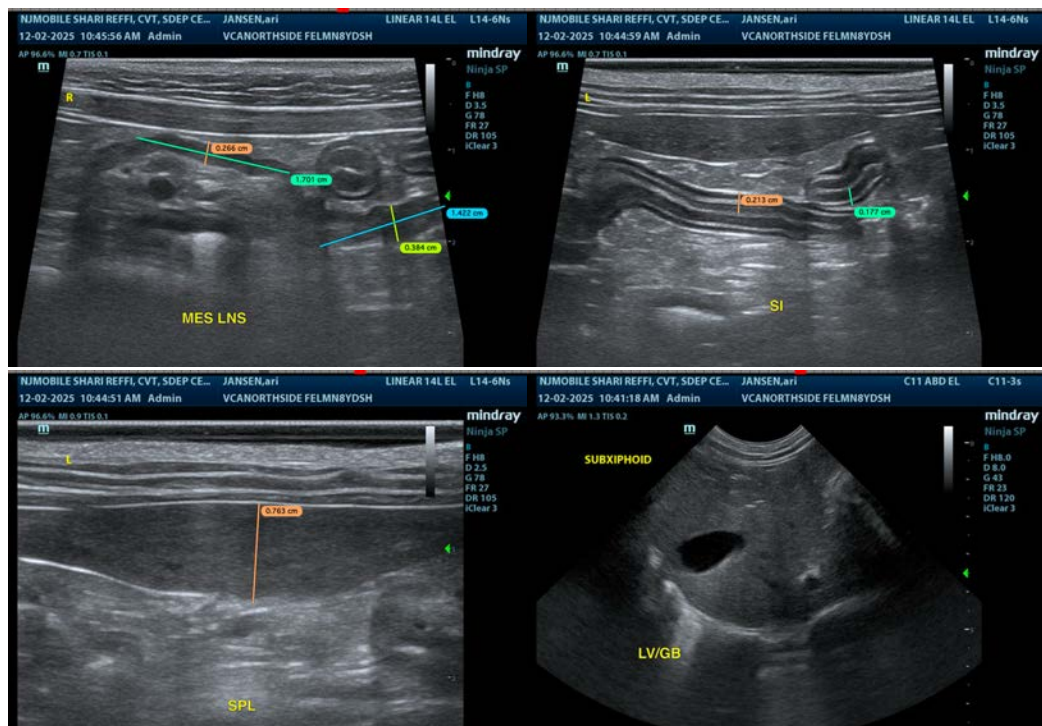
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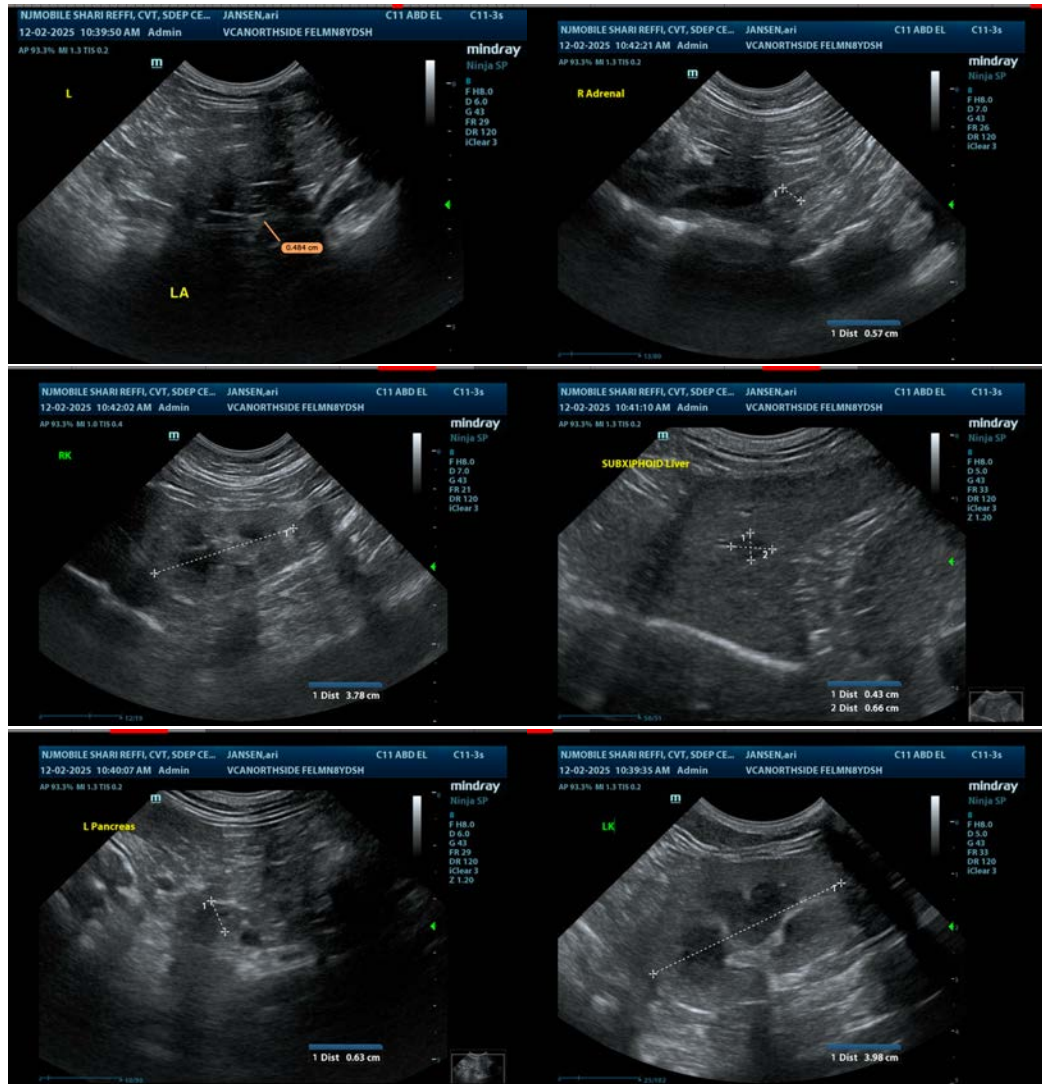
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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