



PATIENT

Eleanor Trepel

SPECIES

Feline

BREED

Siberian Forest Cat

SEX

Female

AGE

1 Year

WEIGHT

3.6 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Iacovides

HOSPITAL NAME

Tuxedo Animal
Hospital

REFERRING VET

Dr. Honton (Birchwood
Animal Hospital)

INVOICE

72859

DATE

12/20/25

PRESENTING CLINICAL SIGNS

Hx suspected FIP, mycoplasma carrier - treated with antiviral drug (finished July 17th) + doxycycline (finished early June) More lethargic, not eating as much (had a couple kibble today and no wet food), not as playful. Hesitant to jump on and off of couch. No v/d/c. Sneezed a couple of times. Indoor-only cat Prescribed last night: Cerenia 16mg - 1/2 tab SID Mirtazapine 1.85mg - 1 cap SID Note: cat ate this morning.

Abnormal PE/Chem/CBC/UA Results: Mild muscle atrophy mm slt tacky somewhat unkept haircoat abdm moderately tense TPR wnl CBC: WNL (platelets clumped) CHEM: mild elevation of TP (90, N = 57-89) + globulins (57, N = 28-51) fPL WNL FeLV/FIV -ve in Jan

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly 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. Lack of urine distention interferes with full evaluation of the urinary bladder.

The left kidney has a normal shape and size (3.25 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 (3.54 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 0.29 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 0.28 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 (0.77 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.

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 bile duct appears mildly prominent and tortuous proximally measuring at 0.25 cm.

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Gastrointestinal

The stomach contains moderate 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. Shadowing ingesta interferes with full evaluation of the stomach and some areas of the cranial abdomen.

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The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal to mild fluid/chyme 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 0.23 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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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.

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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. A prominent pancreatic duct is noted.

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Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are large, hypoechoic lymph nodes visualized at the ileocecal junction. Examples measure 0.75 cm x 2.4 cm and 0.46 cm x 1.29 cm. The omentum is generally normal in echogenicity.

IMAGING PERFORMED BY

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ULTRASONOGRAPHIC FINDINGS

- Pancreatic changes most consistent with chronic pancreatic remodeling +/- chronic active pancreatitis.
- Mildly tortuous/dilated proximal bile duct – The significance of this is uncertain at this time. Recommend continued monitoring.
- Moderate shadowing ingesta visualized within the gastric lumen – Correlate with feeding history. If the patient was adequately fasted, consider such differentials as delayed gastric emptying. No evidence of an outflow tract obstruction is visualized.
- Prominent lymph nodes at the ileocecal junction – Findings could be consistent with an inflammatory, infectious, or early inflammatory change.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No large focal lesions are visualized on today's exam. The pancreas appears prominent and mottled with prominent pancreatic duct in both limbs. Correlate with a PLI level. If this is significantly elevated, consider treatment for pancreatitis.



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There is a cluster of large hypoechoic lymph nodes at the ileocecal junction. If a safe window for sampling is available, consider a fine needle aspirate and/or continued monitoring of the lymph nodes for possible future sampling.

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There is minimal evidence for underlying small intestinal disease, but if this is strongly suspected, you could consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate. If these findings are indicative of a chronic enteropathy, further evaluation may be 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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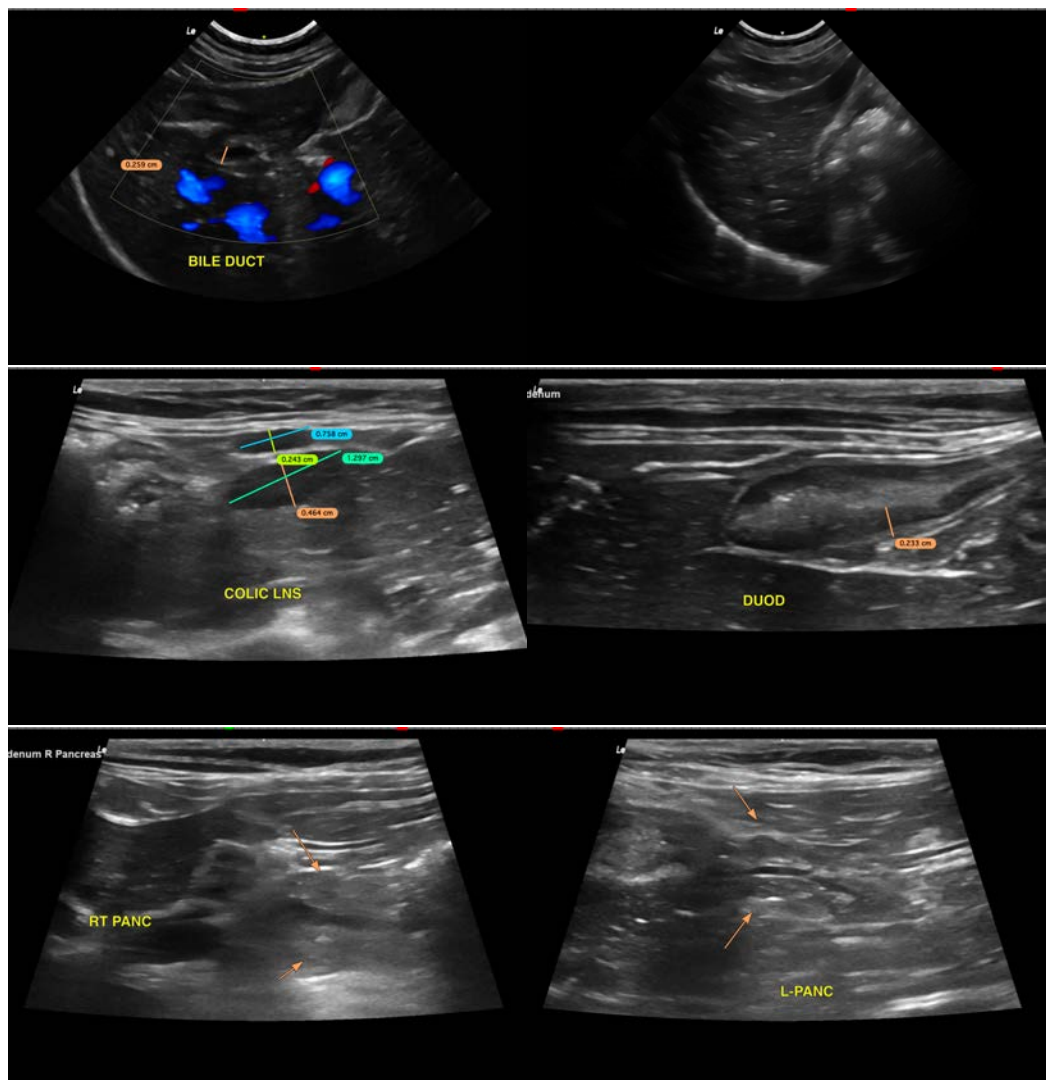
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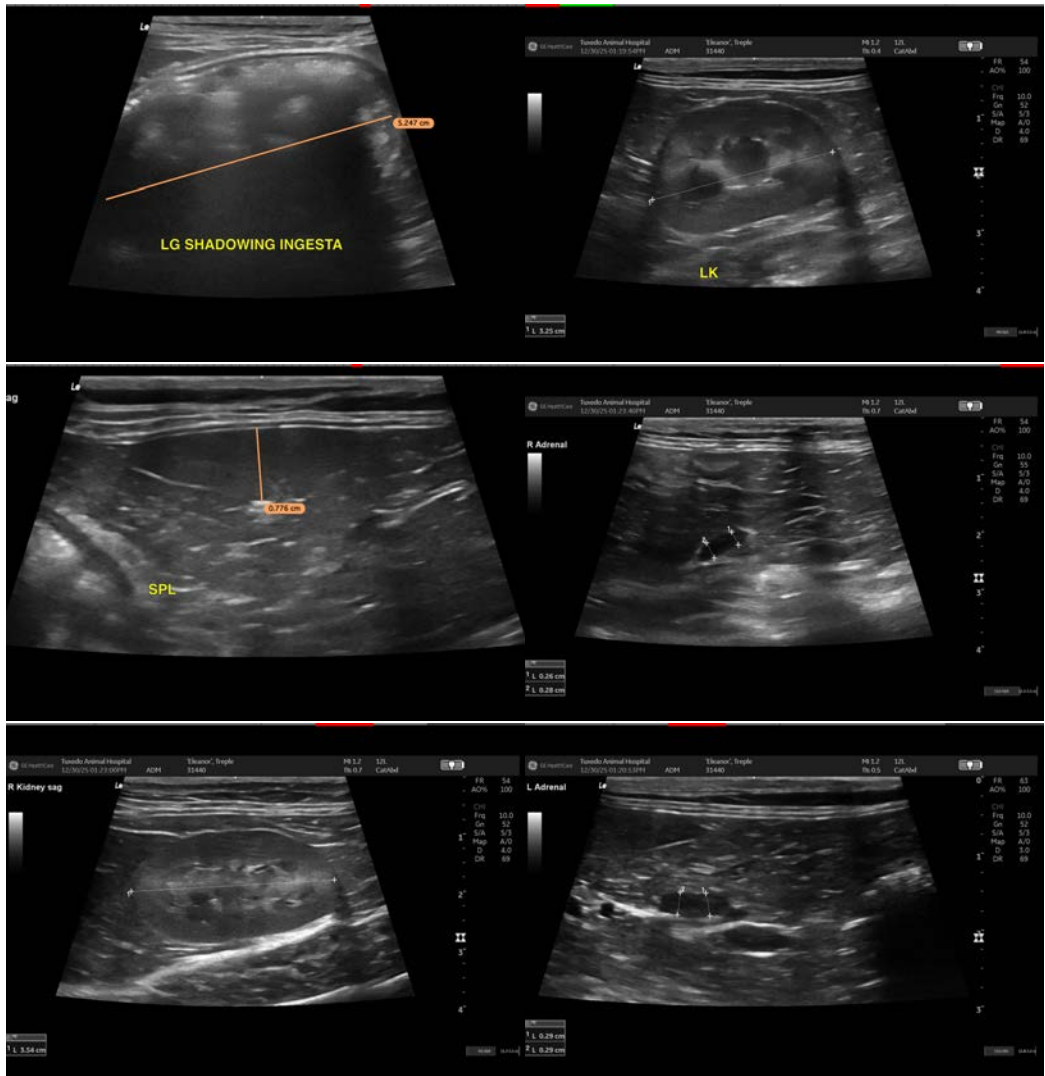
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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