



## PATIENT

Binx Pound Project

## SPECIES

Feline

## BREED

DSH

## SEX

Neutered Male

## AGE

4 Years

## WEIGHT

9.8

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Heather

## HOSPITAL NAME

Animal Care Clinic of  
Flanders

## REFERRING VET

Dr. Villari

## INVOICE

73068

## DATE

2/19/26

## PRESENTING CLINICAL SIGNS

Possible FB ingestion. Vomit blood, inappetence.

Abnormal PE/Chem/CBC/UA Results: cbc-wnl, chem - pending

## 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 (4.26 cm) with a small amount of sandy, shadowing mineralization within the medulla. 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 (4.16 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 region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

### *Spleen*

The spleen is subjectively normal in size (1.04 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.

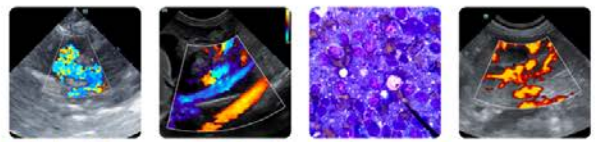
### *Liver*

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.

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 mild/moderate fluid. 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



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there is no impression of reduced peristaltic activity. There is some non-shadowing echogenic material visualized within the stomach, possibly consistent with ingesta, irregular tissue, etc. There is a small focal shadowing area measuring 0.46 cm, which could be consistent with medication, ingested foreign material, etc.

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 0.34 cm. Jejunum wall measures 0.35 cm. Visualized peristalsis appears appropriate. The small intestine appears diffusely thickened with a prominent muscularis layer.

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 left limb of the pancreas is prominent and hypoechoic as 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 diffuse lymphadenopathy with prominent, hypoechoic mesenteric lymph nodes. An example measures 0.66 cm x 2.07 cm, 0.43, and 0.53 cm. The omentum is hyperechoic around the prominent lymph nodes.

## ULTRASONOGRAPHIC FINDINGS

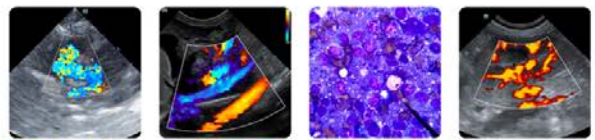
- Pancreatic changes consistent with mild pancreatitis in the left limb.
- Mild/moderate gastric distention with fluid and some amorphous non-shadowing material – A definitive obstruction is not visualized. Findings are suggestive of ileus and non-shadowing ingesta. Ingested foreign material cannot be definitively ruled out.
- Diffusely thickened/ “ropey” small intestine with prominent 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.
- Mild/moderate mesenteric lymphadenopathy – Findings are most consistent with a reactive lymphadenopathy, although an early lymphadenopathy cannot be ruled out.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of a GI obstruction is visualized on today’s exam. There is some fluid and non-shadowing material visualized within the stomach. The nature of this material is uncertain. A degree of gastric ileus is suspected, but continued monitoring of this region is warranted.

The small intestine appears diffusely thickened and ropey, most consistent with a chronic enteropathy.

The left limb of the pancreas is prominent and somewhat hypoechoic, possibly consistent with mild pancreatitis.



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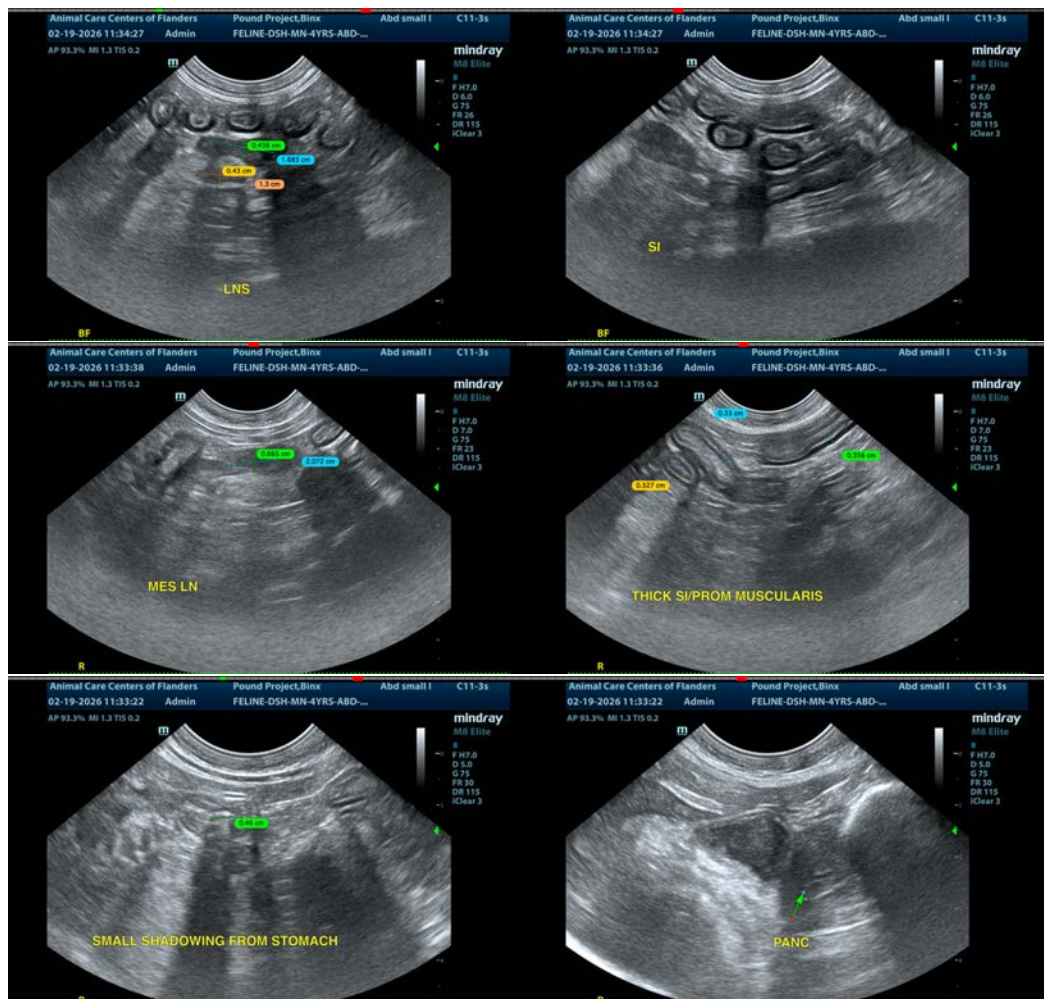
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Recommend treatment for acute gastroenteritis/pancreatitis. Additionally consider the following:

- 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
- If not already done, recommend empirical deworming and testing for GI parasites.
- Recommend chronic probiotic therapy.

Correlate today's findings with abdominal radiographs, and if symptoms are persistent, consider repeat imaging, looking for the development of a more distinctive obstructive pattern or similar. Additionally, upper GI endoscopy could be considered to further evaluate the stomach for any focal mucosal lesions, foreign material, and to obtain biopsies of the proximal GI tract.

There are prominent mesenteric lymph nodes visualized throughout the abdomen. I suspect these are too small to easily aspirate for cytology. Continued monitoring for further enlargement is warranted.





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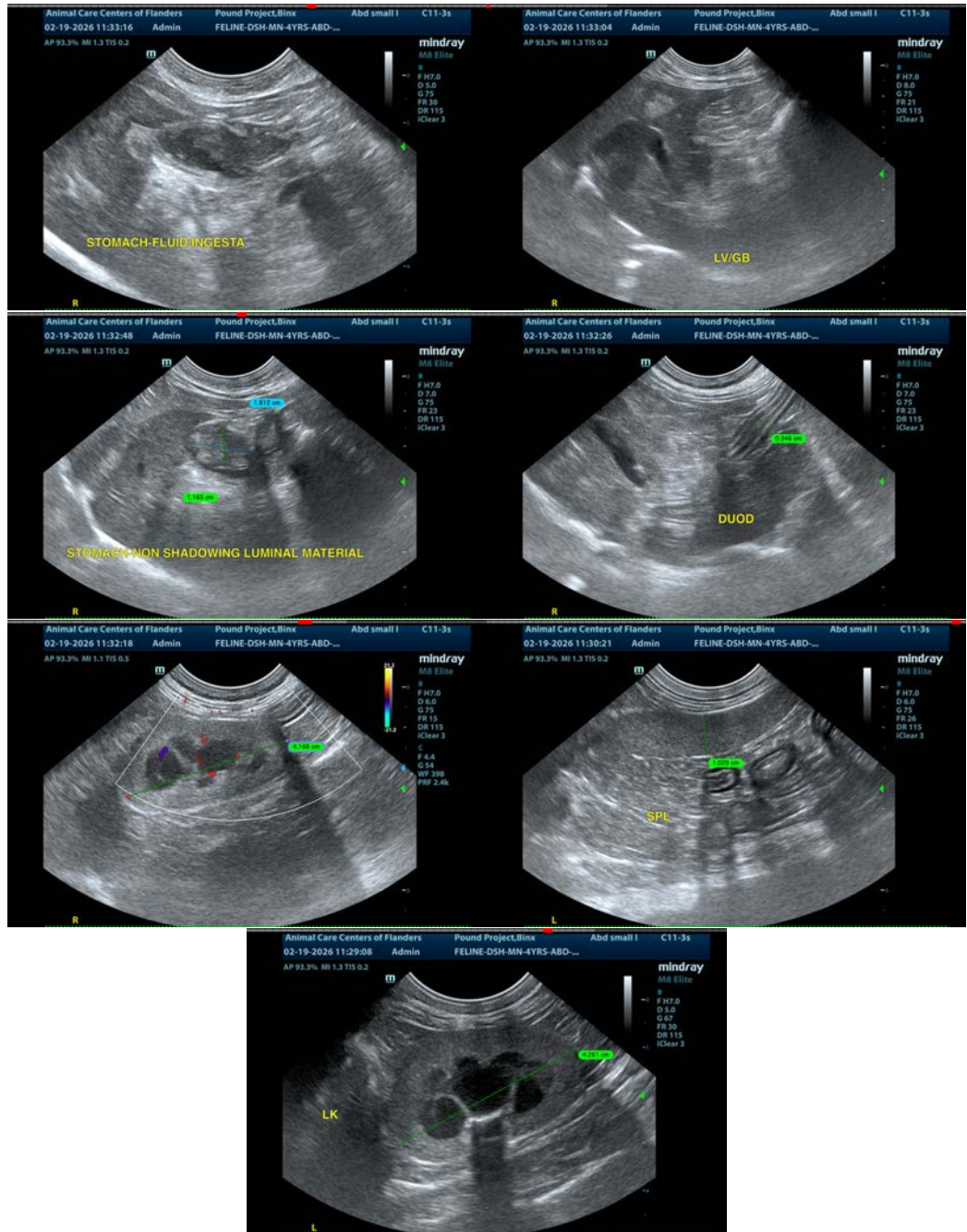
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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