



PATIENT

Dulcinea Garcia

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

14 Years

WEIGHT

8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Julia Bakker, DVM

HOSPITAL NAME

Orange Blossom
Veterinary Imaging

REFERRING VET

Kristen Hillard, DVM

INVOICE

73838

DATE

3/19/26

PRESENTING CLINICAL SIGNS

Mid abdominal mass effect present, AUS recommended to further define. FNA of SI mass and regional lymph nodes taken today. Considering surgery vs palliative care vs other.

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 (3.61 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 (3.56 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 0.39 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 0.47 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 (0.99 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.



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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.

Most of 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 0.27 cm. Jejunum wall measures 0.24 cm. Visualized peristalsis appears appropriate. There is a large, irregular, hyper- and hypoechoic mid/caudal abdominal bowel mass with complete loss of layering. The mass measures approximately 3.5 cm x 7.55 cm. The wall measures 1.5 cm in thickness (see under large intestine).

A normal ileocecal junction is not clearly visualized. The mass effect described above under small intestine is suspected to be the ileocecal junction, but this cannot be confirmed. Additionally, there is a focal section of colon that appears to have significant wall thickening and loss of layering, measuring at 0.26 cm.

Pancreas

The left limb of the pancreas is prominent and mottled compared to the surrounding isoechoic mesentery. There is a hypoechoic structure visualized towards the caudal aspect of the left limb measuring 0.74 cm in diameter, most consistent with a cyst or hypoechoic nodule. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

There is scant free fluid noted. There is a significant lymphadenopathy, particularly in the region of the focal bowel mass lesion with large, hypoechoic lymph nodes. Examples measure 1.45 cm x 1.05 cm and 1.58 cm x 1.56 cm. Additionally, there is a large, hypoechoic lymph node in the cranial abdomen. The omentum is hyperechoic around the abdominal mass lesion.

ULTRASONOGRAPHIC FINDINGS

- Prominent, mottled pancreas with a hypoechoic lesion – Findings are most consistent with chronic pancreatic remodeling. The hypoechoic lesion could represent a cyst, hypoechoic nodule, metastatic lesion, etc.
- Diffusely prominent/thickened small intestine with a 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.
- Focal bowel mass lesion with complete loss of layering and severe wall thickening – Findings are most concerning for infiltrative neoplasia (round cell neoplasia, carcinoma, other). The ileocecal junction is suspected.
- Thickened colon wall with loss of layering – Findings are most concerning for infiltrative neoplasia, although severe inflammation is possible.
- Large, hypoechoic mesenteric lymph nodes – Findings are most consistent with metastatic lymph nodes.



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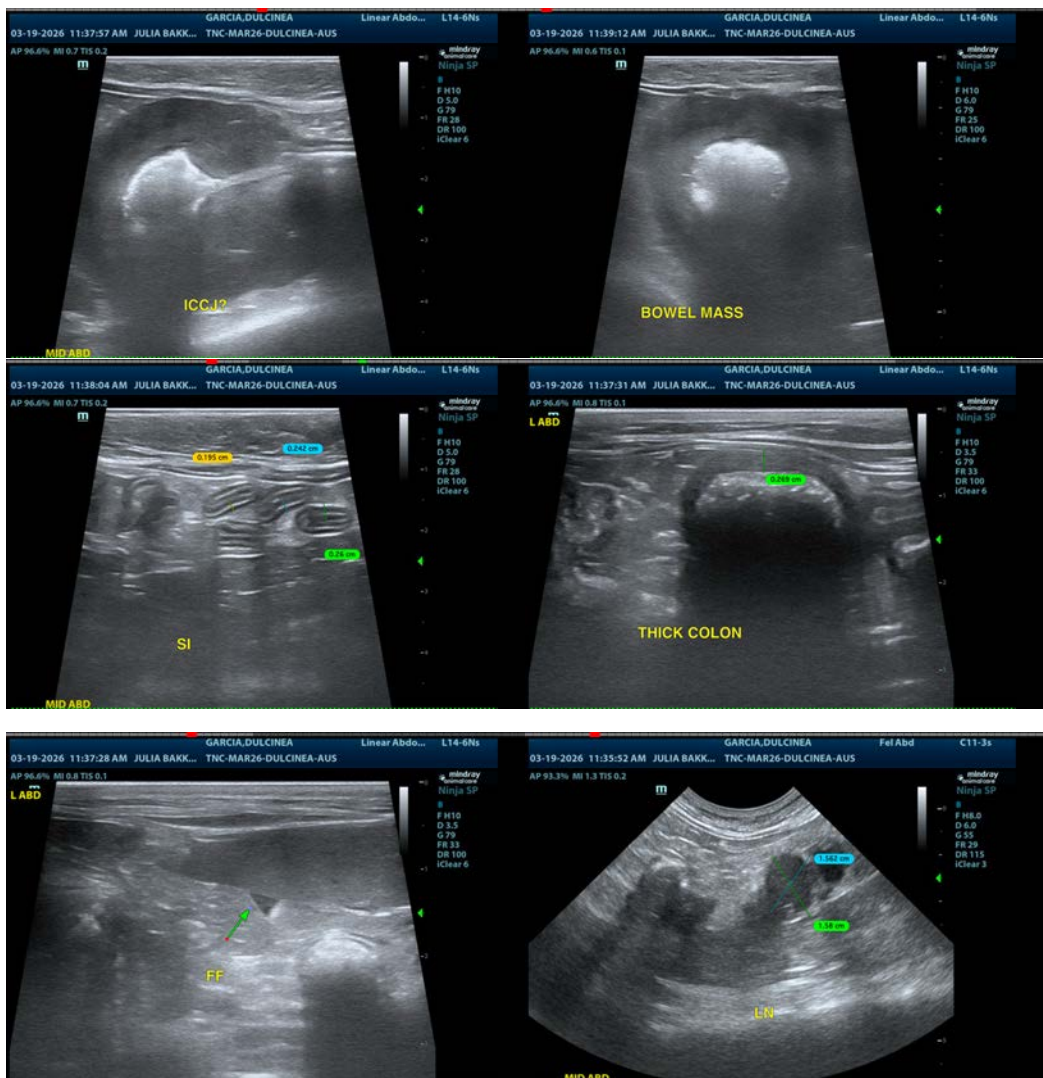
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a very large mid/caudal bowel mass lesion with severe wall thickening and loss of layering. This is suspected to be the ileocecal junction. A neoplastic process is strongly suspected with additional surrounding large, hypochoic lymph nodes. Recommend a fine needle aspirate of the bowel mass lesion and the lymph nodes. If cytologic diagnosis can be obtained, recommend consultation with a veterinary oncologist regarding best treatment options and prognosis.

There is a hypochoic lesion visualized associated with the pancreas. This could represent a cystic lesion, a hypochoic nodule, or even a metastatic lesion. A fine needle aspirate of this lesion could be considered if this would change the therapeutic plan.

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





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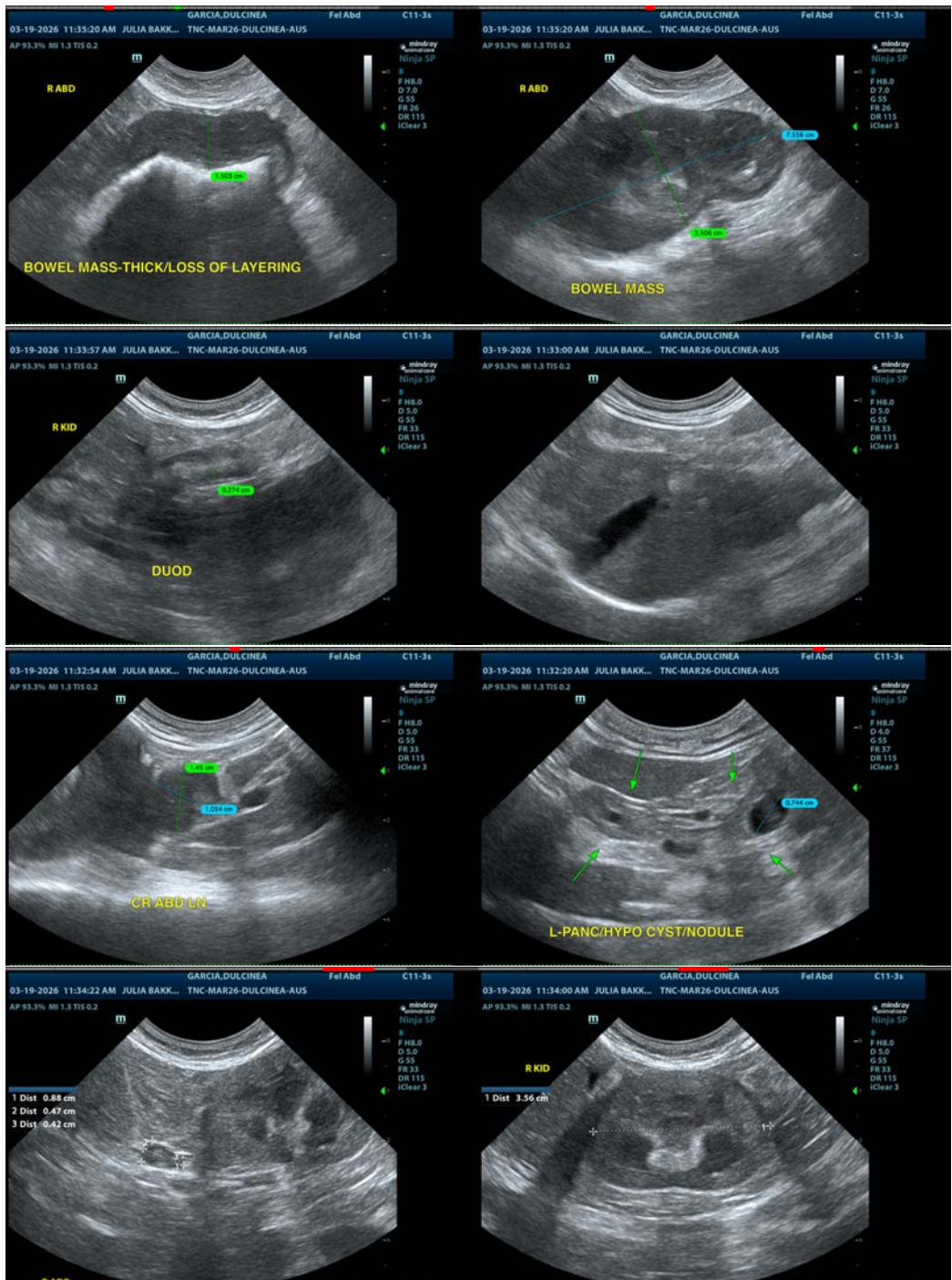
Kristen Hillard, DVM

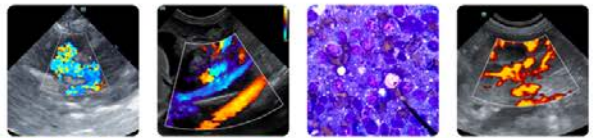
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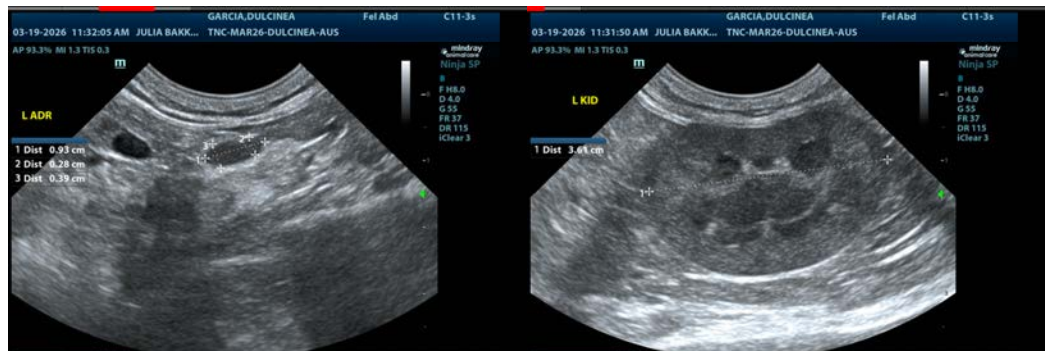
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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