



## PATIENT

Ash Doyle

## SPECIES

Feline

## BREED

Bengal

## SEX

Neutered Male

## AGE

2.5 Years

## WEIGHT

2.4 kg

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Dr. Goeres

## HOSPITAL NAME

Kelowna Veterinary  
Hospital

## REFERRING VET

Dr. Little

## INVOICE

74860

## DATE

4/30/26

## PRESENTING CLINICAL SIGNS

4.53 lbs weight loss since Jan 2025, elevated ALT on BW, had exposure to FeLV as a kitten but was tested negative and vaccinated, febrile today (39.9), eating well. DDX: infectious (FIP, toxoplasmosis, liver abscess, FeLV/FIV), inflammatory (cholangiohepatitis, pancreatitis), toxin, neoplasia, EPI, unlikely hepatic lipidosis since eating well

Abnormal PE/Chem/CBC/UA Results: BC -Moderate leukocytosis (23.8), mild to moderate neutrophilia (14.76) mild lymphocytosis (9.04). lymphocytes small to intermediate with increased amounts of pale to medium blue cytoplasm, high N:C ratios, round to oval to occasionally indented nuclei, stippled chromatin and no visible nucleoli. Reactive lymphocytes. -Normal hct (44.6%) -Mild thrombocytopenia (clumped plt) Smear: No significant morphologic changes seen. No infectious organisms or atypical cells U/A (cysto): pH: 6, USG 1.034 1+ proteinuria, inactive sediment Mild hypoalbuminemia (24.5) Low Alb/Glob ratio (0.4) Mild hyperbilirubinemia (12) Markedly elevated ALT (710) Normal GGT, ALP Normal T4 Sample slightly icteric and hemolyzed

## 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 (3.18 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 (3.77 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 right adrenal gland is normal in size measuring 0.42 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 borderline "plump" and slightly irregular, measuring 1.0 cm in width at the level of the hilus. The blood flow through the hilus and splenic parenchyma appears normal. There is an isoechoic "bleb" of tissue visualized near the hilus, most consistent with an accessory spleen, measuring 1.42 cm x 0.53 cm.



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## Liver

The liver is large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. 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 gallbladder wall is hyperechoic and prominent/mildly thickened at 0.15 cm. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

## Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of 0.22 cm 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 0.29 cm. Jejunum wall measures 0.24 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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 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

There is a small amount of free fluid. There are occasional prominent mesenteric lymph nodes. Examples of jejunal lymph nodes measure 0.54 cm x 1.38 cm and 0.58 cm x 1.34 cm. A pancreaticoduodenal lymph node measures 0.43 cm x 0.88 cm. The omentum is generally of normal echogenicity.

## ULTRASONOGRAPHIC FINDINGS

- Borderline "plump" spleen with an accessory spleen – Findings could be consistent with anatomic variation, congestion, splenitis, lymphoid hyperplasia, or less likely infiltrative neoplasia.
- Pancreatic changes consistent with chronic pancreatic remodeling +/- chronic pancreatitis in the left limb.
- Large, heterogeneous liver – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.
- Prominent, hyperechoic gallbladder wall – Findings could be consistent with mild cholecystitis.



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- “Ropey” small intestine with some areas exhibiting mild thickening of the 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 mesenteric lymphadenopathy – The appearance is most consistent with reactive lymph nodes, although early neoplastic change cannot be ruled out.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No significant focal lesions are visualized associated with the liver, but it does appear somewhat enlarged and heterogeneous. These are non-specific findings. Additionally, the gallbladder wall appears slightly prominent/mildly thickened, possibly consistent with cholangitis. Recommend a liver function and a fine needle aspirate of the liver for cytologic evaluation. Recommend supportive care and empirical treatment for acute liver injury/cholangiohepatitis with a course of Ursodiol, Denamarin, antibiotics. If cytology is not helpful, and this initial treatment does not result in improvement, biopsies of the liver would be recommended for cultures and histopathology.

The spleen subjectively appears somewhat “plump” with a round isoechoic “bleb” of tissue most consistent with an accessory spleen. If cytology of the liver is not diagnostic and there is concern for underlying round cell neoplasia or similar, fine needle aspirate of the spleen could be considered.

The left limb of the pancreas is prominent and hypoechoic. Correlate with PLI level. If significant elevations are present, consider treatment for chronic pancreatitis.

Some areas of the small intestine appear segmentally thickened with a prominent muscularis layer. These changes are most consistent with inflammatory type change, although early neoplastic change can be difficult to differentiate. Additionally, there is a mild lymphadenopathy present. If a safe window for sampling is available, a fine needle aspirate of a prominent lymph node could be considered, although this may be challenging, as they are not severely enlarged. If an underlying enteropathy is suspected, consider a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate, looking for additional evidence of underlying gastrointestinal disease. Consider evaluation of a urinalysis +/- urine protein to creatinine ratio, looking for excessive proteinuria, trying to decide if the hypoalbuminemia is secondary to liver disease, a protein losing enteropathy, or if there is any additional renal disease present. Initially a diet trial with a hydrolyzed protein prescription diet could be considered. If a protein losing enteropathy is strongly suspected, ultimately biopsies of the GI tract would be recommended to further evaluate. If this is done, consider surgical biopsies of the GI tract, lymph nodes, and liver +/- pancreas for full evaluation.





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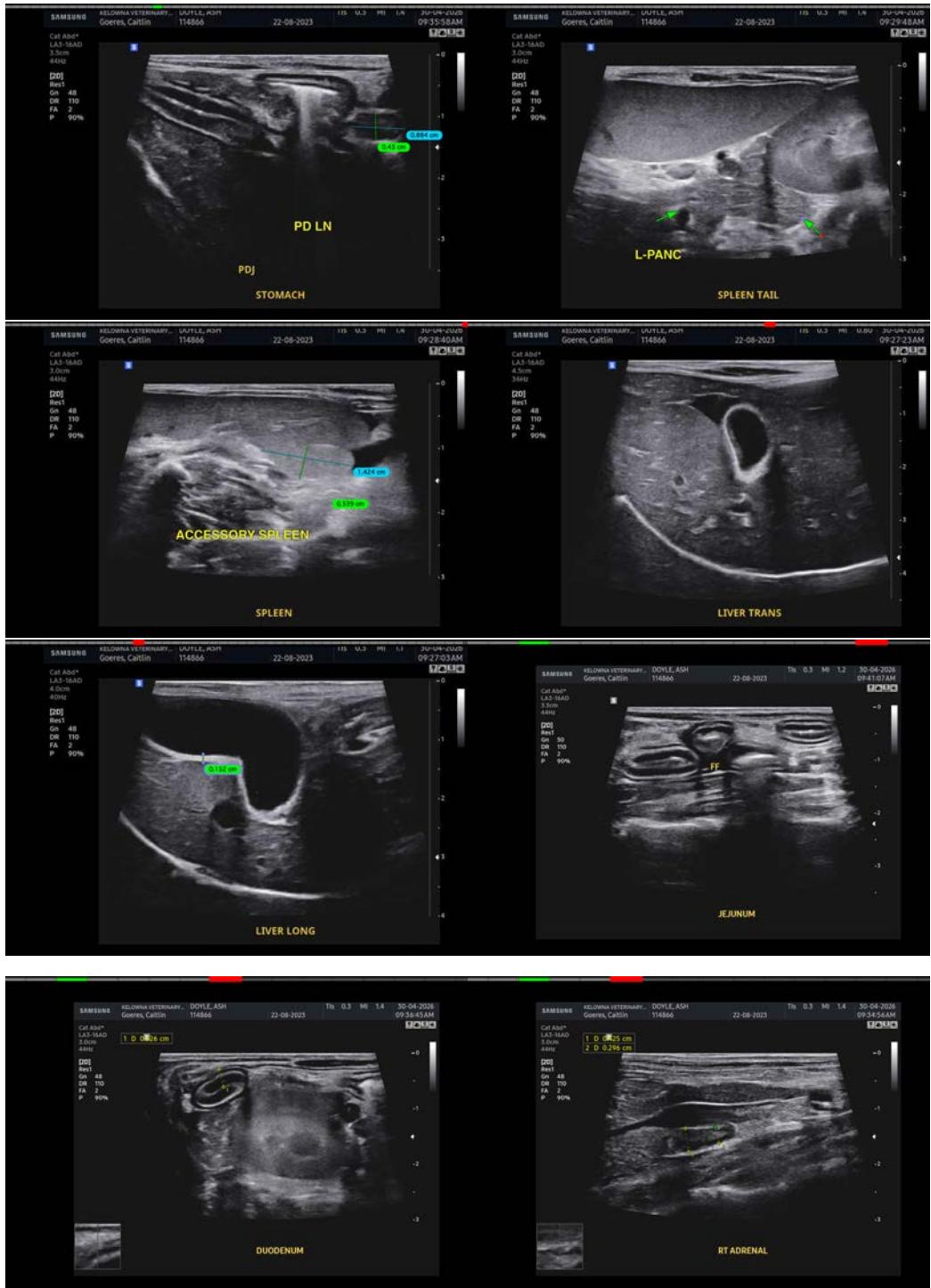
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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