



**PATIENT**

Holly Weeks

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Spayed Female

**AGE**

12 Years 2 Months

**WEIGHT**

17.48 lbs

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Rebecca Hamilton

**HOSPITAL NAME**

Ramapo Valley Animal  
Hospital

**REFERRING VET**

Dr. Katara

**INVOICE**

75069

**DATE**

5/12/26

**PRESENTING CLINICAL SIGNS**

Chronic D+. IBD vs. GI Lymphoma, diarrhea chronic. Owner having a hard time medicating, dispensed Flagyl, but not giving it consistently

Abnormal PE/Chem/CBC/UA Results: 4/7/26: ALT 247, ALP 302, TP 9.0, Glob 5.5

**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, or masses. In the dependent portion of the urinary bladder there is hyperechoic shadowing debris most consistent with sandy mineralizations.

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 (3.8 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 0.32 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 large in size, rounded, and irregular. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There are some focal lesions such as a hyperechoic shadowing lesion on the left side of the liver measuring 2.32 cm in diameter. Additionally, on the left side there is irregular, mottled, hypoechoic tissue creating an irregular mass effect measuring 6.12 cm x 4.06 cm. Similar abnormal/irregular tissue is visualized encompassing a large area of the right dorsal liver measuring 6.37 cm x 4.83 cm.

The gall bladder lumen is moderately distended. The gallbladder wall appears slightly thickened and hyperechoic, measuring 0.29 cm. Luminal contents are mild and likely incidental at this time. The bile duct appears mildly dilated and tortuous, measuring at 0.34 cm.



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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 increased. Bowel loops follow a typical curvilinear path. Jejunum wall measures 0.44 cm. Visualized peristalsis appears appropriate. The small intestine appears diffusely thickened with a very prominent muscularis layer and surrounding inflammation.

The ileocecal junction was visualized and appears diffusely thickened with a prominent muscularis layer. The distal ileum measures at 0.55 cm. Sections of colon are visualized with non-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 mottled in the region of the body. 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. No significant lymphadenopathy noted. The omentum is hyperechoic around many of the thickened bowel loops.

**ULTRASONOGRAPHIC FINDINGS**

- Dependent sandy debris visualized in the urinary bladder – Recommend urinalysis and culture.
- Pancreatic changes most consistent with chronic pancreatic remodeling.
- Large, irregular, heterogeneous liver with focal hyperechoic lesion and numerous large, irregular, mottled regions of liver suggestive of coalescing mass effects.
- Mildly thickened gallbladder wall with a tortuous bile duct – Dilation of the common bile duct could be consistent with a functional obstruction (i.e. primary hepatic disease resulting in hepatocellular swelling) or with an extrahepatic bile duct obstruction (ie. choledocholith, bile duct tumor, pancreatic disease, other).
- Diffusely thickened small intestine with a severely thickened muscularis layer – Findings are most consistent with severe inflammatory or early neoplastic change.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The small intestine appears diffusely thickened with a very prominent muscularis layer and surrounding inflammation. This is particularly evident in some focal areas and at the ileocecal junction. Additionally, the liver is large and irregular with coalescing irregular, mottled areas, suggestive of poorly defined mass lesions. Recommend a fine needle aspirate of abnormal areas of liver. A fine needle aspirate of the ileocecal junction could be considered. If cytologic diagnosis is not an option, surgical biopsies of the GI tract and liver would be recommended. Based on the extensive liver involvement, surgical options would likely be limited, but a contrast CT scan would likely be necessary to further evaluate.



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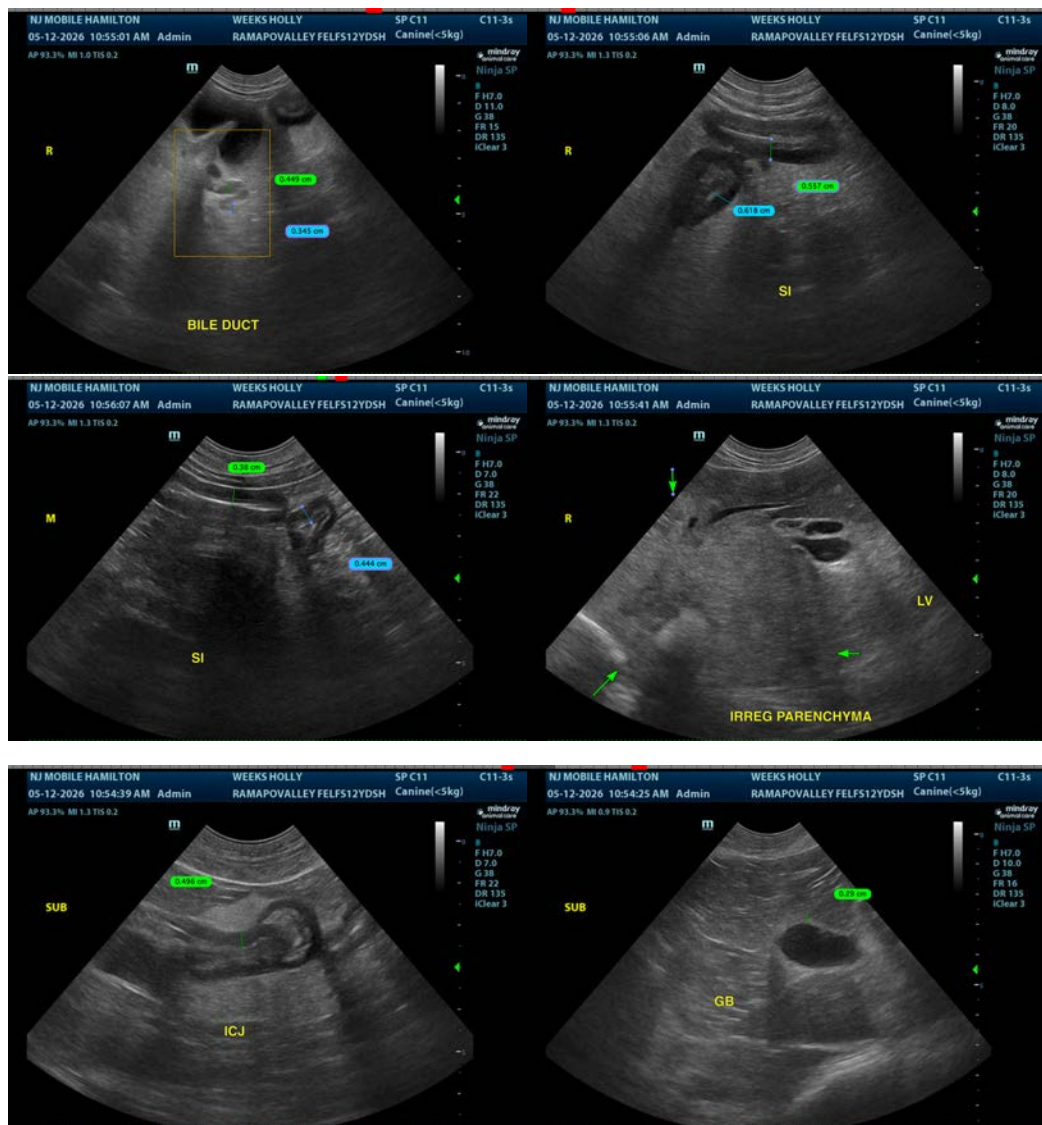
**DATE**

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Other options would include:

- 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.
- Recommend chronic probiotic therapy.

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





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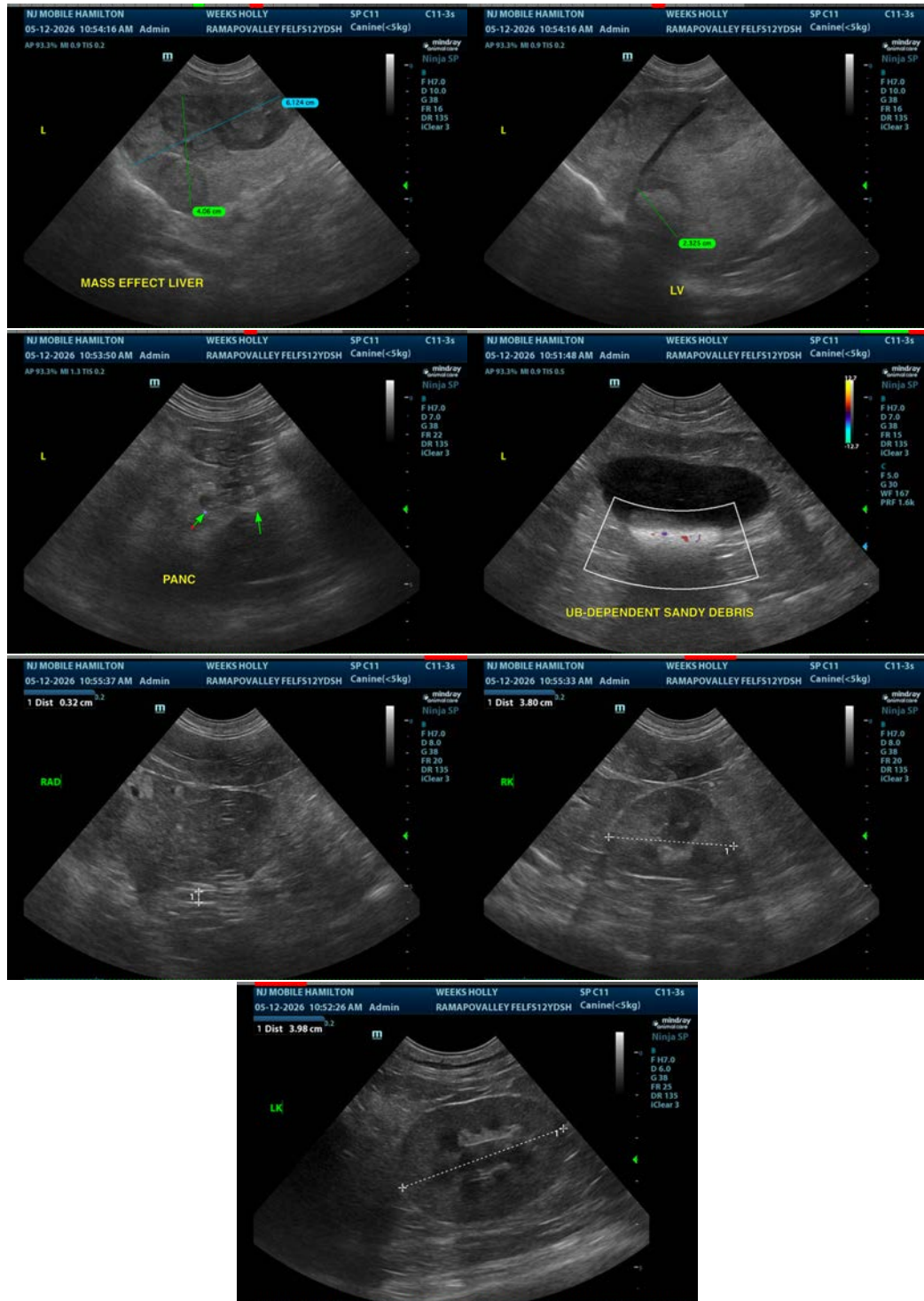
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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](mailto:info@sonopath.com)