



PATIENT

Tuxy Altman

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

13 Years

WEIGHT

6.2 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Elaine Petrone

HOSPITAL NAME

Long Branch Animal
Hospital

REFERRING VET

Dr. Elaina Petrone

INVOICE

75077

DATE

5/12/26

PRESENTING CLINICAL SIGNS

Geriatric cat. History of bilateral mandibulectomy due to spindle cell tumor in 2023. Polyphagia, weight loss. No vomiting or diarrhea. No PU/PD. Creatinine 2.5, BUN 50, SDMA 30 USG: 1.016

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 (3.46 cm). Overall echogenicity is slightly hyperechoic with poor 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 (3.74 cm) with pyelectasia at 0.19 cm. Overall echogenicity is slightly hyperechoic with poor 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 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 (0.90 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, 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 wall of the gall bladder appears hyperechoic and somewhat thickened, measuring up to 0.19 cm with a smooth mucosal surface. Luminal contents are mild. There are additional anechoic structures that appear biliary in nature, possibly consistent with duplicate gallbladder or distention of the bile duct. The bile duct appears dilated and tortuous. There is a small mineralization visualized within the bile duct measuring 0.25 cm. The distal bile duct is suspected to be significantly distended, measuring at 0.54 cm near the duodenal papilla.



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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 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. Jejunum wall measures 0.30 cm. Duodenum wall measures 0.23 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

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Age related changes visualized associated with both kidneys with mild right-sided pyelectasia.
- Prominent mottled left limb of the pancreas – Findings are most consistent with pancreatic remodeling +/- chronic pancreatitis.
- Large, heterogeneous liver – Hepatic changes are non-specific and could be consistent with inflammation/infection (cholangiohepatitis), infiltrative neoplasia, lipidosis or other hepatopathy.
- Dilated gallbladder with a thickened, hyperechoic wall and suspected duplicate gallbladder(?) with bile duct dilation – Findings are concerning for cholecystitis, infiltrative disease, etc. 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/ropey 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.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine appears diffusely thickened and ropey. These changes are most consistent with inflammatory type change, but early neoplastic change cannot be ruled out.

Additionally, the biliary tract appears abnormal. The gallbladder appears to have a thickened wall and there are numerous dilations, some of which are suspicious for a duplicate gallbladder as well as bile duct dilation and a small cholelith. Correlate with current lab work, as the liver appears somewhat heterogeneous as well, but there would be concern for cholecystitis. Consider empirical treatment with Ursodiol and Denamarin +/- antibiotics. Additionally, a fine needle aspirate of the liver could be considered.

The left limb of the pancreas is prominent and mottled, most consistent with pancreatic remodeling +/- chronic pancreatitis. Correlate with a PLI level, looking for evidence of active inflammation.

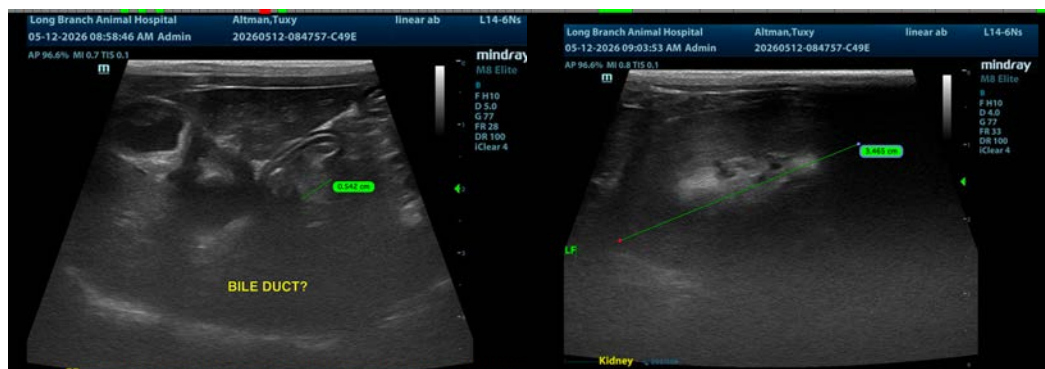
The combination of the pancreatic, biliary, and small intestinal changes increase concerns for possible Triaditis.

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.
- Recommend chronic probiotic therapy.

If symptoms are persistent, ultimately surgical biopsies of the GI tract, liver and pancreas may be warranted. If biliary changes are progressive, a contrast CT scan may be recommended to look for a small focal obstructive lesion that is not seen on today's exam.

Both kidneys have changes consistent with chronic renal disease. Recommend blood pressure, urinalysis and culture as a baseline.





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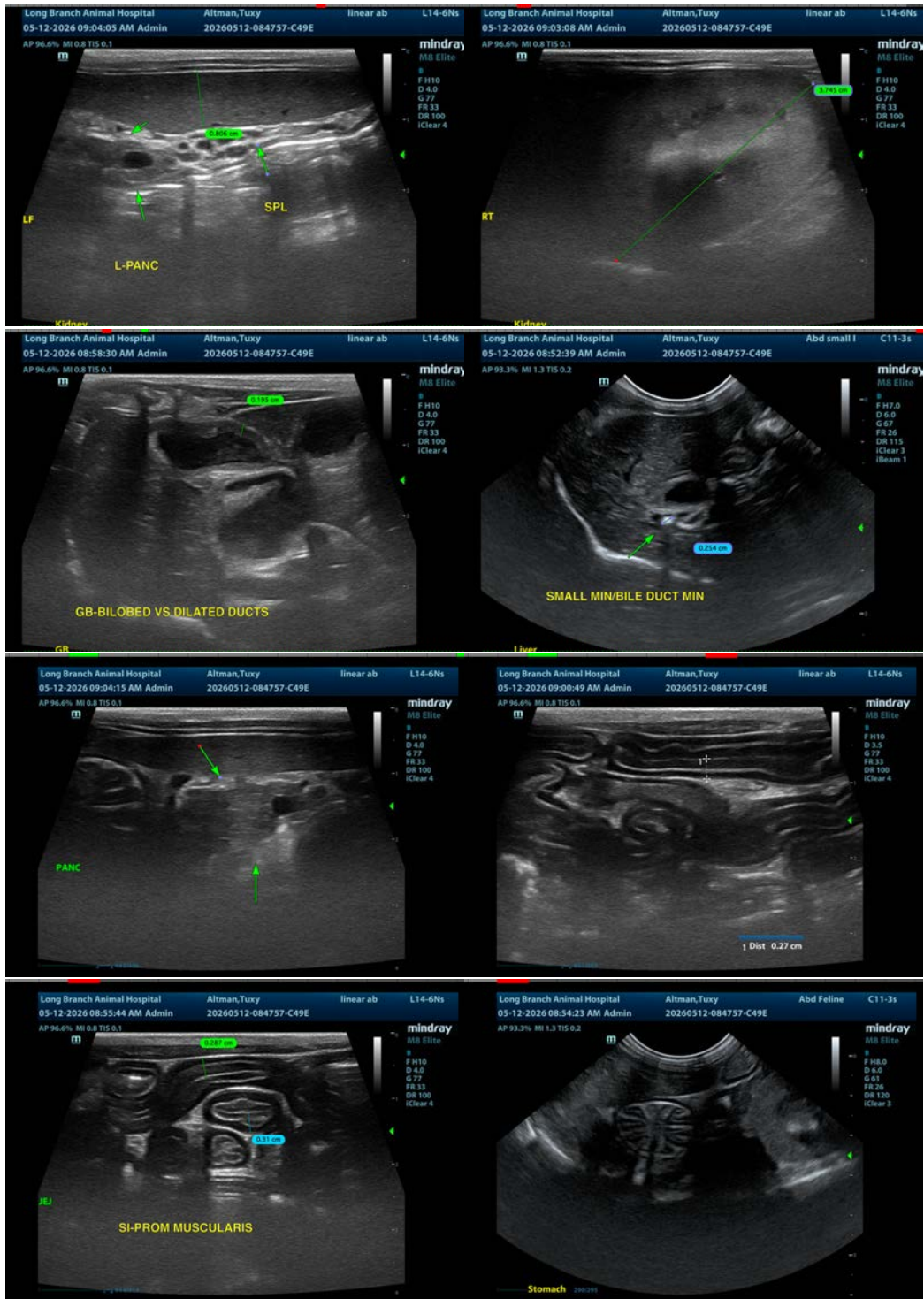
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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