



PATIENT

Dixie Herlehy

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

8

WEIGHT

9.2 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Shane Stafford

HOSPITAL NAME

West Newton Animal
Clinic

REFERRING VET

Dr. Shane Stafford

INVOICE

75146

DATE

5/14/26

PRESENTING CLINICAL SIGNS

Dixie was presented for an acute onset of vomiting today. The owner reports at least six to seven episodes of vomiting liquid and bile throughout the day, with some dry heaving. One vomit episode was described as green. She has not eaten at all today. The owner also notes that Dixie has been obsessively drinking water today and even attempted to drink from the toilet, which is abnormal behavior for her. There has been a general increase in the frequency of hairballs recently, which the owner attributes to what seems like an obsessive amount of grooming. Her appetite has been variable since starting the new diet, with good and bad days. A fresh fecal sample was provided by the owner.

Abnormal PE/Chem/CBC/UA Results: Vomiting, inappetence, polydipsia (acute) - R/O progression of hyperthyroidism, inflammatory bowel disease (IBD), pancreatitis, GI upset. Hyperthyroidism - Currently managed with diet. T4 remains slightly elevated. Systemic Inflammation - R/O IBD, other inflammatory conditions. Heart Murmur - R/O secondary to hyperthyroidism vs. primary cardiac disease. Increased hairballs - R/O secondary to increased grooming, underlying GI motility disorder Will send full labs but at the last visit T4 was still slightly elevated but SAA was abnormal from Vcheck machine which prompt AUS

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 (3.63 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 (3.69 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 0.47 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 0.50 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 (0.95 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.



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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 bile duct is slightly prominent at 0.27 cm.

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 relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.24 cm. Jejunum wall measures 0.22 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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 pancreas is prominent, hypochoic and mottled in both limbs. 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

- Pancreatic changes most consistent with chronic pancreatic remodeling/chronic active pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes observed on today's exam are relatively mild. Both limbs of the pancreas (particularly the left limb) are hypochoic, prominent and mottled, possibly with some mild reactive mesentery in the region. Correlate with a PLI level and consider empirical treatment for chronic pancreatitis. No focal lesions are visualized associated with the GI Tract, but a diffuse enteropathy or similar could still be present. Consider symptomatic treatment for gastroenteritis.

If current full lab work has not been performed, consider doing so, looking for metabolic causes of vomiting.

If symptoms are persistent despite symptomatic therapy, consider repeat imaging, looking for development of new lesions.



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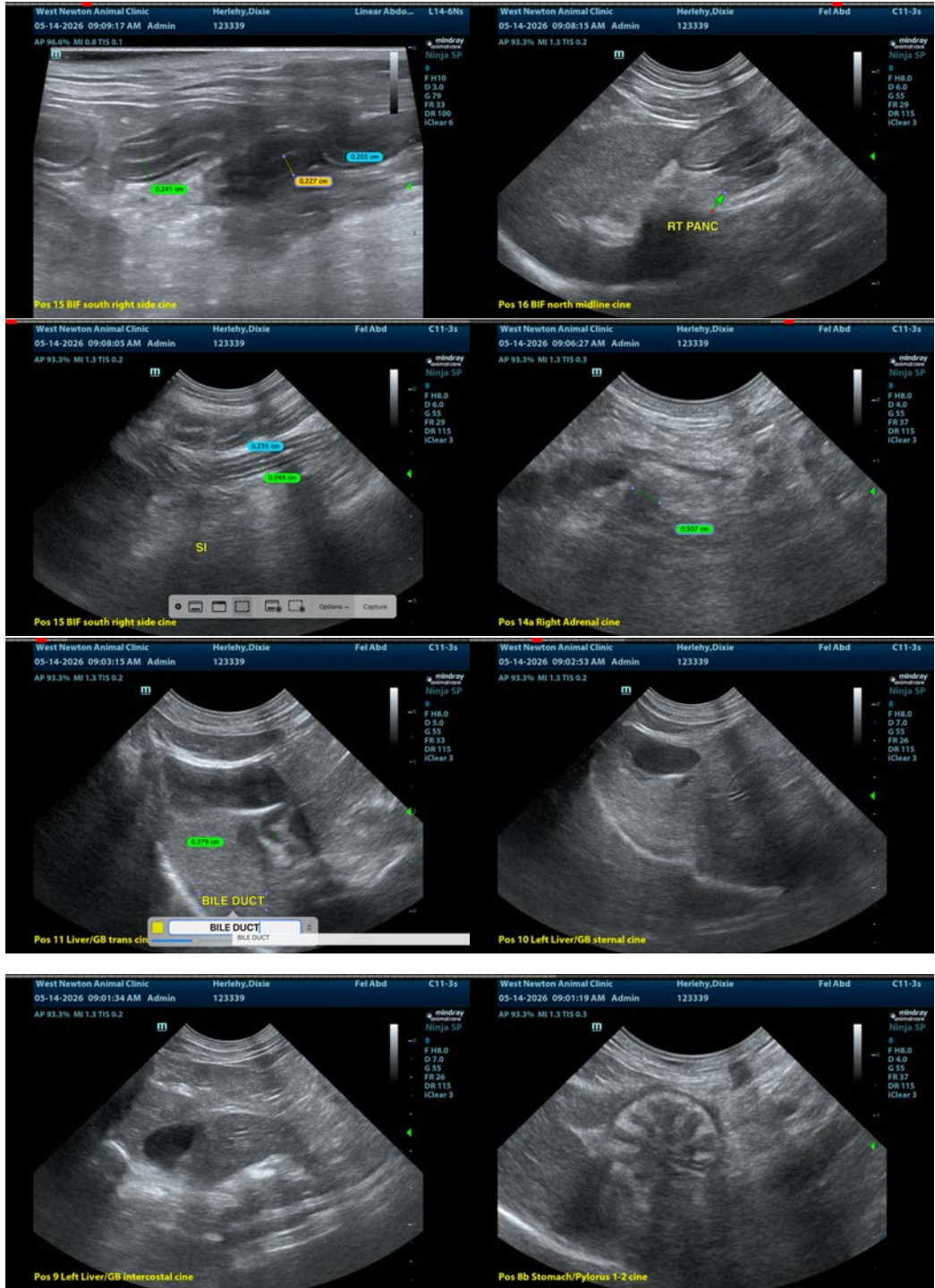
Dr. Shane Stafford

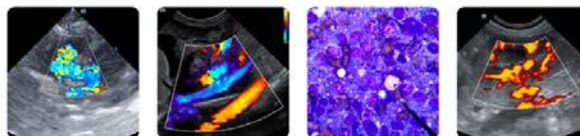
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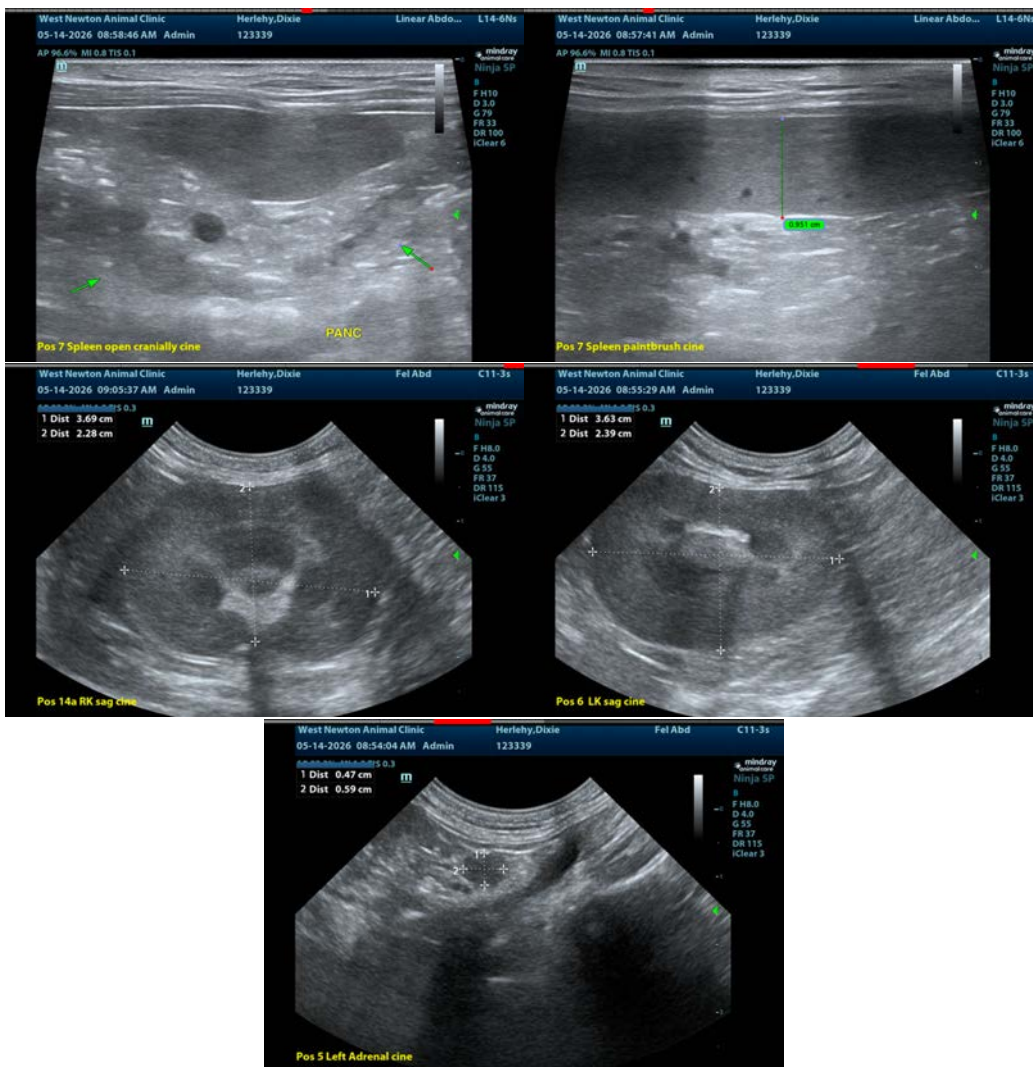
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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