

**PATIENT**

Tosha Vasilevskaya

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

16 Years

**WEIGHT**

4.42 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Crystal Hill

**HOSPITAL NAME**

Governors Road  
Animal Hospital

**REFERRING VET**

Dr. Dogar

**INVOICE**

75246

**DATE**

5/19/26

**PRESENTING CLINICAL SIGNS**

BAR, HR 190, RR 30, E/D normally, no C/S/V/D. Fresh blood seen in stools since May 13th, urinating outside of litterbox as of last night, suspected inflammation of colon. Has been on Gabapentin and Restoralax.

Abnormal PE/Chem/CBC/UA Results: BUN 17.0 (5 - 12.9 mmol/L) Creatinine 223 (53 - 212 umol/L) Glucose 10.7 (3.5 - 9.4) Neutrophils 90 (35 - 75 %) Lymphs 5 (20 - 45 %) Absolute Neutrophils 8.82 (2.5 - 8.5) Absolute Lymphs 0.49 (1.2 - 8)

**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 (3.04 cm) with mild pyelectasia at 0.26 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 a shadowing nephrolith that appears to be within a portion of the renal pelvis, measuring at 0.48 cm. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.76 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.

**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.

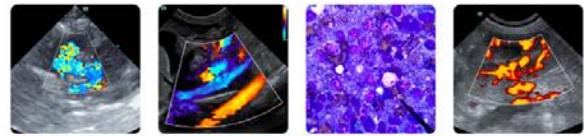
The right adrenal gland is normal in size measuring 0.45 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

**Spleen**

The spleen is subjectively normal in size (0.86 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.



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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.

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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 0.26 cm. Jejunum wall measures 0.20 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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The descending colon appears mildly thickened with intact wall layering at the very distal region, with intraluminal gas and fecal material. Just proximal to this near the apex of the urinary bladder there is focal thickening and reduced detail of wall layering. In this area the bowel wall measures between 0.49-0.60 cm.

**WEIGHT**

4.42 kg

***Pancreas***

The pancreas is prominent, hypoechoic and mottled in both limbs. In some regions (particularly in the right limb), the mottling is almost nodular. There is an ill-defined hypoechoic nodule on the right side measuring 0.52 cm. There is no evidence of regional mesenteric inflammation or fluid.

**INTERPRETED BY**

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***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.

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**ULTRASONOGRAPHIC FINDINGS**

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- Age related changes visualized associated with both kidneys as well as a left-sided nephrolith and mild pyelectasia – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. The shadowing nephrolith appears concerning for possible mildly obstructive lesion.
- Pancreatic changes most consistent with chronic pancreatic remodeling and chronic pancreatitis, possibly with lymphoid nodules.
- Focal thickening and reduced detail of wall layering in the descending colon – Findings are concerning for severe inflammatory change or a benign or neoplastic mass effect.

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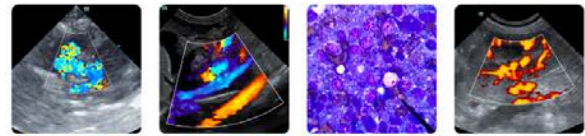
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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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There is focal thickening and reduced detail of wall layering in the distal colon. These changes could be consistent with severe focal colitis, an adenoma, granuloma, or a neoplastic lesion such as round cell neoplasia, carcinoma, other.



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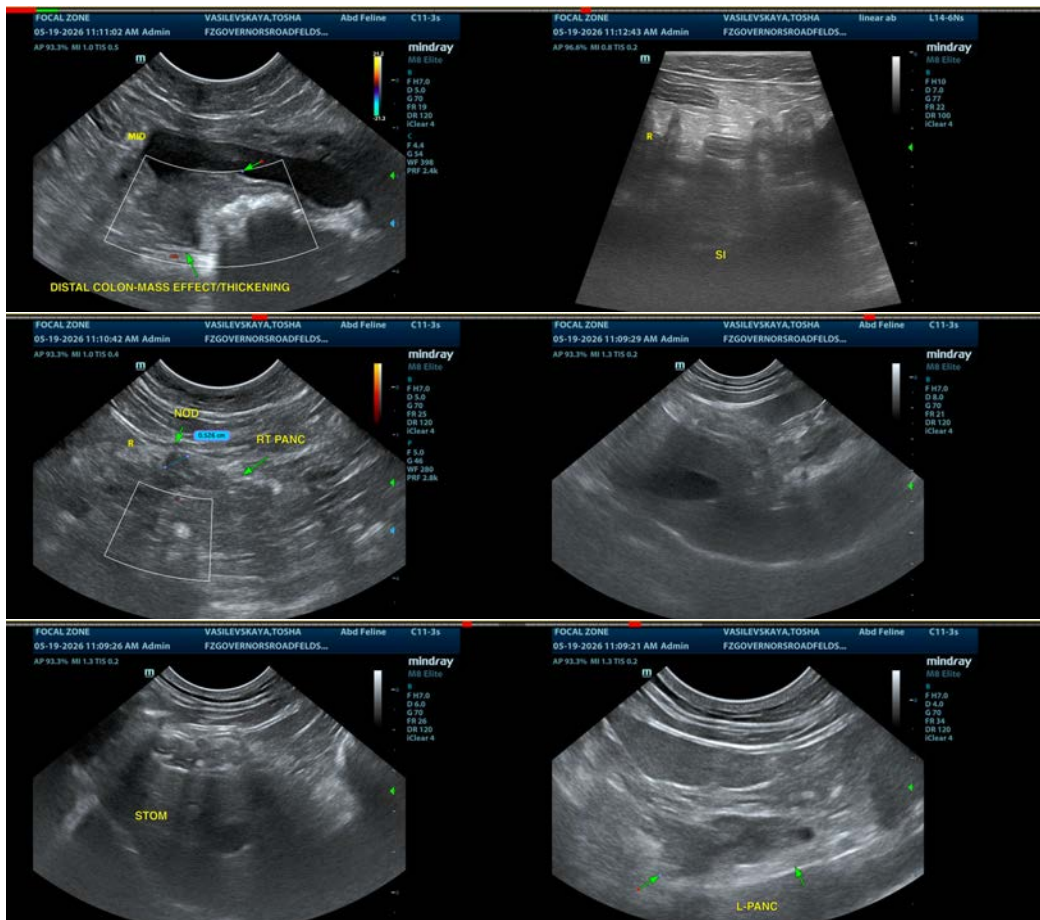
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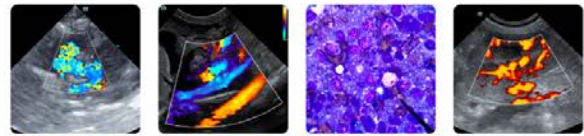
Options would include a colonoscopy for further visualization and to obtain biopsies. If a more conservative approach is desired, you could consider continued treatment for colitis and repeat imaging in 3-4 weeks (sooner if concerned), with the intention to pursue biopsies if the condition progresses. If this route is taken, close monitoring is recommended for the patient's decline, an obstruction, etc.

There are bilateral changes visualized associated with the pancreas that are consistent with chronic pancreatic disease, most likely chronic pancreatic remodeling and chronic pancreatitis. Correlate with PLI level and consider empirical treatment for pancreatitis.

There is a nephrolith visualized in the left kidney that is concerning for a possible partially obstructive lesion. Correlate with blood pressure, urinalysis and culture, and continued monitoring of the left kidney for progressive dilation, movement of the stone, etc.

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





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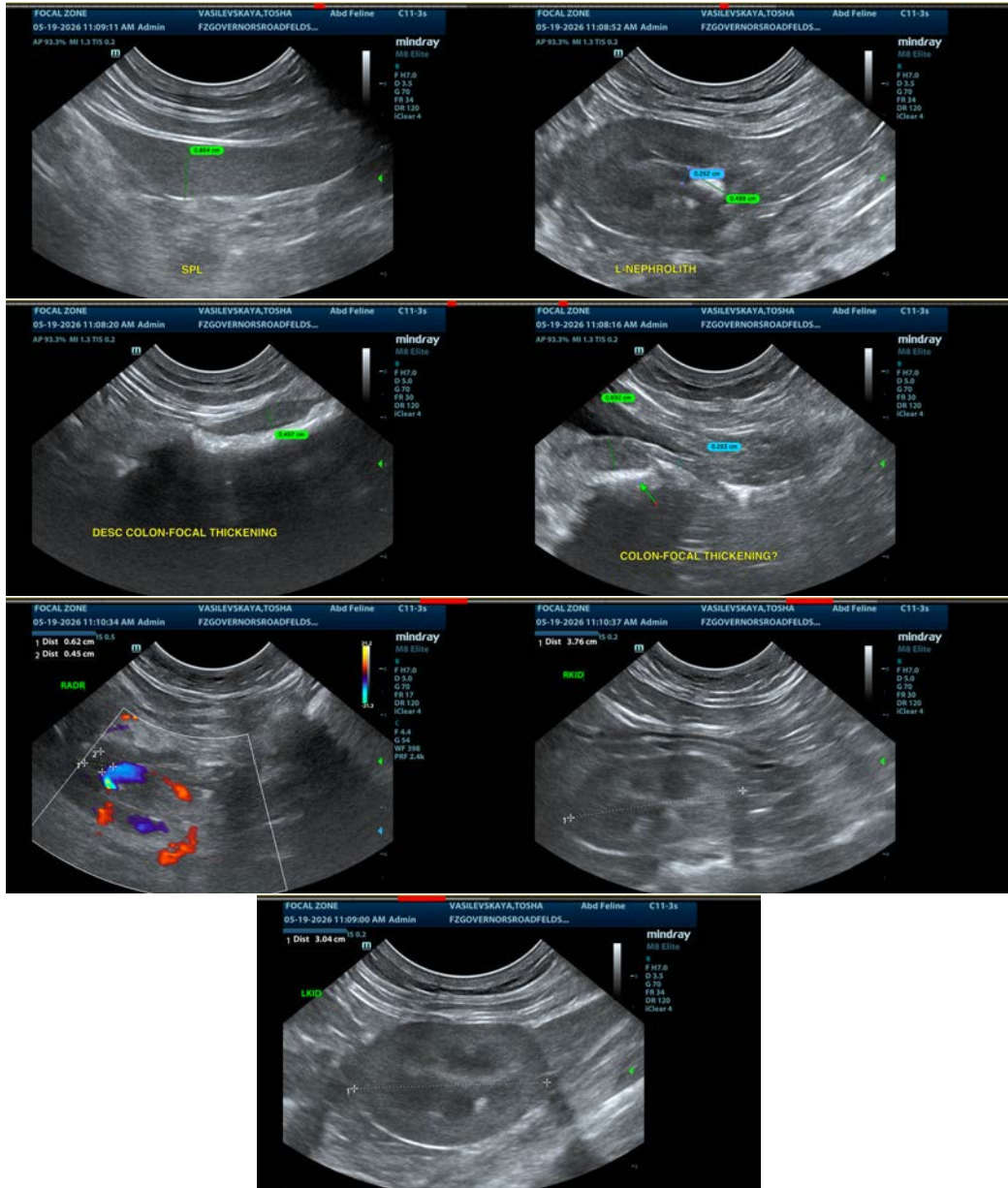
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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