



PATIENT

Tiny Hou

SPECIES

Feline

BREED

DMH

SEX

MN

AGE

2 years 7 months

WEIGHT

8.78 lbs

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Loetitia Saint-Jacques,
LVT

HOSPITAL NAME

Fairgrounds AH

REFERRING VET

Dr. RCK

INVOICE

12010

DATE

5/27/2026

PRESENTING CLINICAL SIGNS

Reason for ultrasound: weight loss of unknown cause. In this patient, blood work results showed total protein at 6.1, low AST at 12, and elevated urine protein:creatinine ratio confirming proteinuria of unknown etiology. Proteinuria may be secondary to glomerular disease, tubular disease, or feline lower urinary tract disease. There are weight loss concerns and multiple differentials including neoplasia, inflammatory bowel disease, lymphoma, and dietary issues. Previously offered enalapril to address proteinuria, which client declined pending definitive diagnosis. Noted improvement in tail hair loss. Explained need for abdominal ultrasound to evaluate internal organs for masses or lymph node enlargement.

Plan: Abdominal ultrasound to survey internal organs and assess for masses or lymphadenopathy. Diet change from CD food to hydrolyzed plus CD. Patient noted to be fractious for handling during procedures (P will be on pregabalin).

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mild primarily suspended echogenic debris present. 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 calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney is borderline large in size, and somewhat rounded/swollen in appearance. 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 mild pyelectasia noted measuring 0.28 cm. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is large in size and somewhat rounded/swollen in appearance (5.12 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 mild pyelectasia measuring 0.16 cm. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

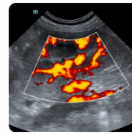
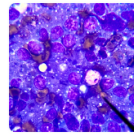
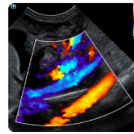
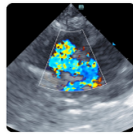
Adrenal Glands

The left adrenal gland is normal in size measuring 0.27 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 0.29 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 large (1.48 cm in width at the level of the hilus), 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 gallbladder has a bilobed confirmation. 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 appears dilated and tortuous measuring at 0.25 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.

Some of 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. The duodenum measured as normal (0.24 cm in wall thickness) and the jejunum measured as normal (0.14 cm.) Visualized peristalsis appears appropriate. There is a focal section of jejunum which appears to have asymmetrical wall thickening with a very prominent muscularis layer. In this area the wall measures at 0.28 cm. This thickening extends for approximately 1.5 cm to 2.0 cm of jejunum with reduced detailed wall layering.

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 and mottled in the right limb. 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. There are occasional prominent mesenteric lymph nodes. Some lymph nodes near the ileocecal junction are particularly prominent measuring 0.36 cm and 0.51 cm. The omentum is of normal uniform echogenicity.

PRIMARY FINDINGS

- Bilaterally plump kidneys with mild pyelectasia. Pyelectasia of the kidney(s) could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.
- Large spleen. Possible differentials include anatomic variation, congestion (heart disease, sedation, etc.), splenitis, lymphoid hyperplasia, or infiltrative neoplasia
- Bilobed gallbladder with a prominent/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).



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- Focal asymmetrical wall thickening of the jejunum with reduced detailed wall layering. Findings could be consistent with focal enteritis; early infiltrative neoplasia would be a significant concern.

- Prominent mesenteric lymph nodes. Findings are most consistent with reactive lymph nodes, although early neoplastic change cannot be ruled out.

SECONDARY FINDINGS

- Pancreatic changes most consistent with chronic pancreatic remodeling.
- Suspended echogenic debris in the urinary bladder. The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus. Recommend urinalysis and culture.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Both kidneys appear somewhat rounded and borderline large with very mild pyelectasia. If not already done recommend a urine culture and possibly a blood pressure (if patient temperament will permit.) Additionally, if it's possible to get a free catch sample (saran wrap in the litter box.) This may be more accurate in a fractious individual as the stress from sampling and sedation can cause significant proteinuria.

The spleen appears relatively normal but measures as large. The significance of this is uncertain. Options include continued monitoring or a fine needle aspirate looking for infiltrative neoplasia, etc.

The bile duct appears mildly dilated and tortuous. In the absence of elevated liver values, the significance of this is uncertain. Recommend continued monitoring.

There's a focal section of jejunum with asymmetrical wall thickening and reduced detailed wall layering. This could be concerning for an early mass lesion. In the absence of underlying GI signs, consider reevaluation in 6-8 weeks to determine if this lesion is persistent or progressing. If this is persistent and/or progressing, surgical evaluation would likely be recommended.

There are prominent lymph nodes visualized at the ileocecal junction. At this time these have somewhat of a reactive appearance and are likely too small to easily sample. Continued monitoring of these lymph nodes is recommended as sampling could be considered in the future.





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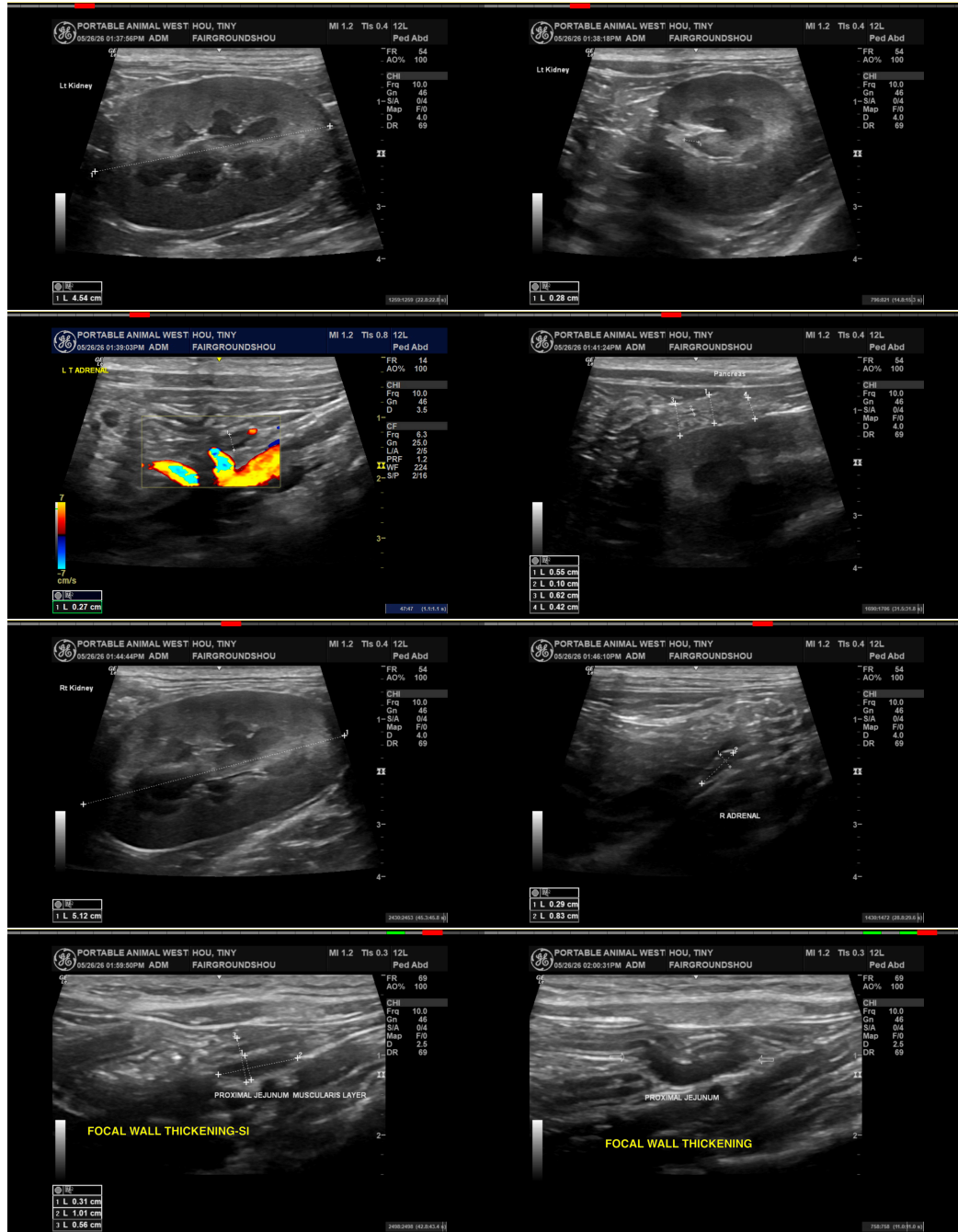
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pawsonography@gmail.com
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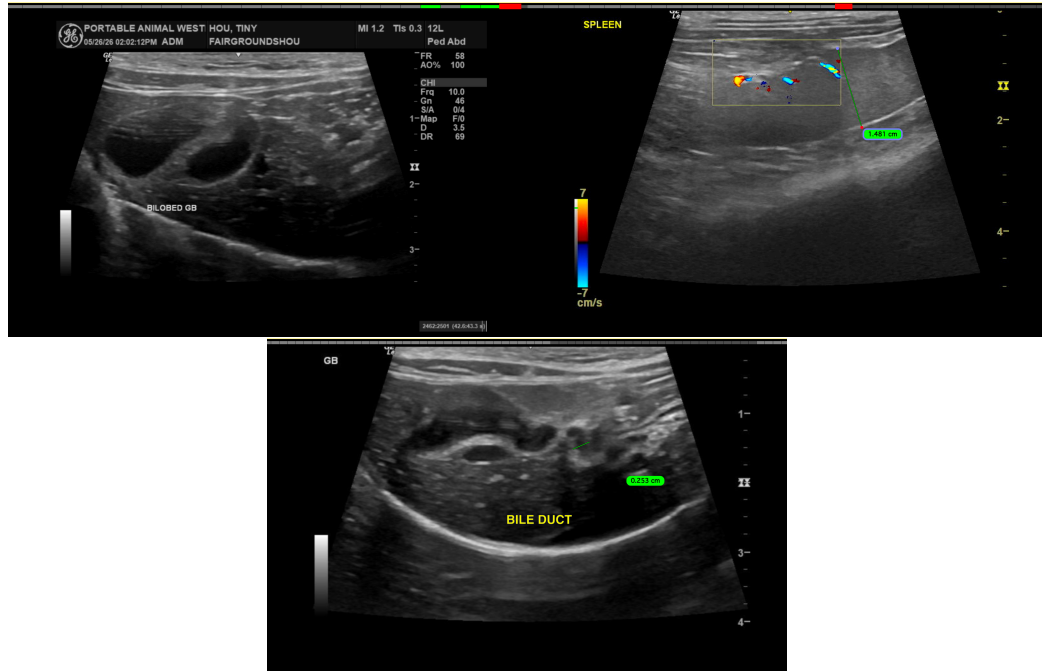
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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