

## PATIENT

ZombieCat BGVH-  
Dalosio

## SPECIES

Feline

## BREED

DSH

## SEX

Neutered Male

## AGE

10/5/11

## WEIGHT

7.4 kg

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Loetitia Saint-Jacques,  
LVT

## HOSPITAL NAME

Brighton Greens  
Veterinary Hospital

## REFERRING VET

Dr. Robin Janeway

## INVOICE

75496

## DATE

5/27/26

## PRESENTING CLINICAL SIGNS

Sedated-5/12/26 occasionally vomiting, blood in diarrhea started that weekend prior. eating and drinking, Indoor/outdoor. Brief u/s in house reveled soft tissue density to gall bladder and hyperechoic area of adjacent liver lobe- mass vs cholangiohepatitis? Lab work at that time was WNL. Pt tx with orbax x 10 days and cefovecin. Visbiome probiotic. 5/26/26 recheck- maintaining weight. Brief u/s- continued hyperechoic area of right liver lobe, gall bladder appears thickened and small/hyperechoic contents. Pt was previously evaluated for vomiting in January 2026- att lab work WNL except PSL 33. Radiograph report from that visit below. Working diagnosis. Open. Neoplasia, gall bladder rupture, mass, stone, blockage bile duct. Mucocele, other.

Abnormal PE/Chem/CBC/UA Results: LABS WNL

## 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 (4.7 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 (4.66 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 0.52 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 (1.02 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



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normal. There is a small hyperechoic nodule visualized on the left side measuring 0.40 cm and a larger, hyperechoic irregular mass effect in the mid caudal right side of the liver measuring 2.08 cm x 2.7 cm.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a hyperechoic shadowing structure visualized in the lumen, most consistent with a cholelith, measuring 1.0 cm in diameter. The cystic and common bile ducts are normal/not visible.

### ***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 0.22 cm. Visualized peristalsis appears appropriate. The small intestine is mildly diffusely thickened with a prominent muscularis layer.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. 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***

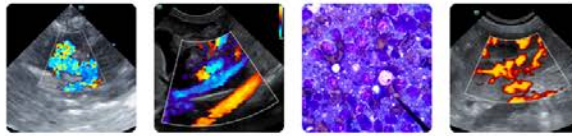
The pancreas is prominent and hypoechoic as compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

### ***Free Abdomen***

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are occasional prominent mesenteric lymph nodes. Examples of elongated mesenteric lymph nodes measure 0.41 cm and 0.36 cm. The omentum is generally normal in echogenicity.

## ULTRASONOGRAPHIC FINDINGS

- Pancreatic changes consistent with chronic pancreatic remodeling and chronic active pancreatitis.
- Hyperechoic mass effect in the right side of the liver and a smaller hyperechoic nodule – Findings could be consistent with an adenoma, carcinoma, cystadenoma, other.
- Cholelith visualized in the gallbladder. In the absence of liver enzyme elevations this likely represents an incidental finding.
- Diffuse small intestinal thickening 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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- Occasional prominent mesenteric lymph nodes – Findings are most consistent with reactive lymph nodes. Early neoplastic change cannot be ruled out.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The small intestine appears diffusely thickened with a prominent muscularis layer. These changes are most consistent with inflammatory type change, although early neoplastic change cannot be ruled out. The visualized areas of large intestine appear within normal limits. Unfortunately, ultrasound can be insensitive in detecting small mucosal colonic lesions, as gas in the colon often interferes with visualization.

The pancreas is prominent and hypoechoic. Correlate with a PLI level, as chronic active pancreatitis could be a concern. Consider the following:

- Consider a hydrolyzed protein prescription diet +/- fiber supplementation.
- 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.
- Consider screening panel for infectious causes of diarrhea.
- Recommend chronic probiotic therapy.
- Recommend symptomatic therapy for pancreatitis/gastroenterocolitis.

If symptoms are persistent, ultimately upper and lower GI endoscopy may be warranted to further evaluate and obtain biopsies.

There is a hyperechoic mass effect visualized associated with the right side of the liver. This could represent a benign or early neoplastic lesion. If a safe window for sampling is available, consider a fine needle aspirate. If surgical intervention would be considered, then a contrast CT scan should be performed to further evaluate margins, look for metastatic lesions, etc. It is possible that the hepatic lesion is not associated with the clinical signs exhibited at this time.

Additionally, there is a cholelith visualized in the gallbladder. These are often asymptomatic. In the absence of gallbladder wall thickening, inflammation, or liver enzyme elevations, this is likely incidental, but continued monitoring is warranted.

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

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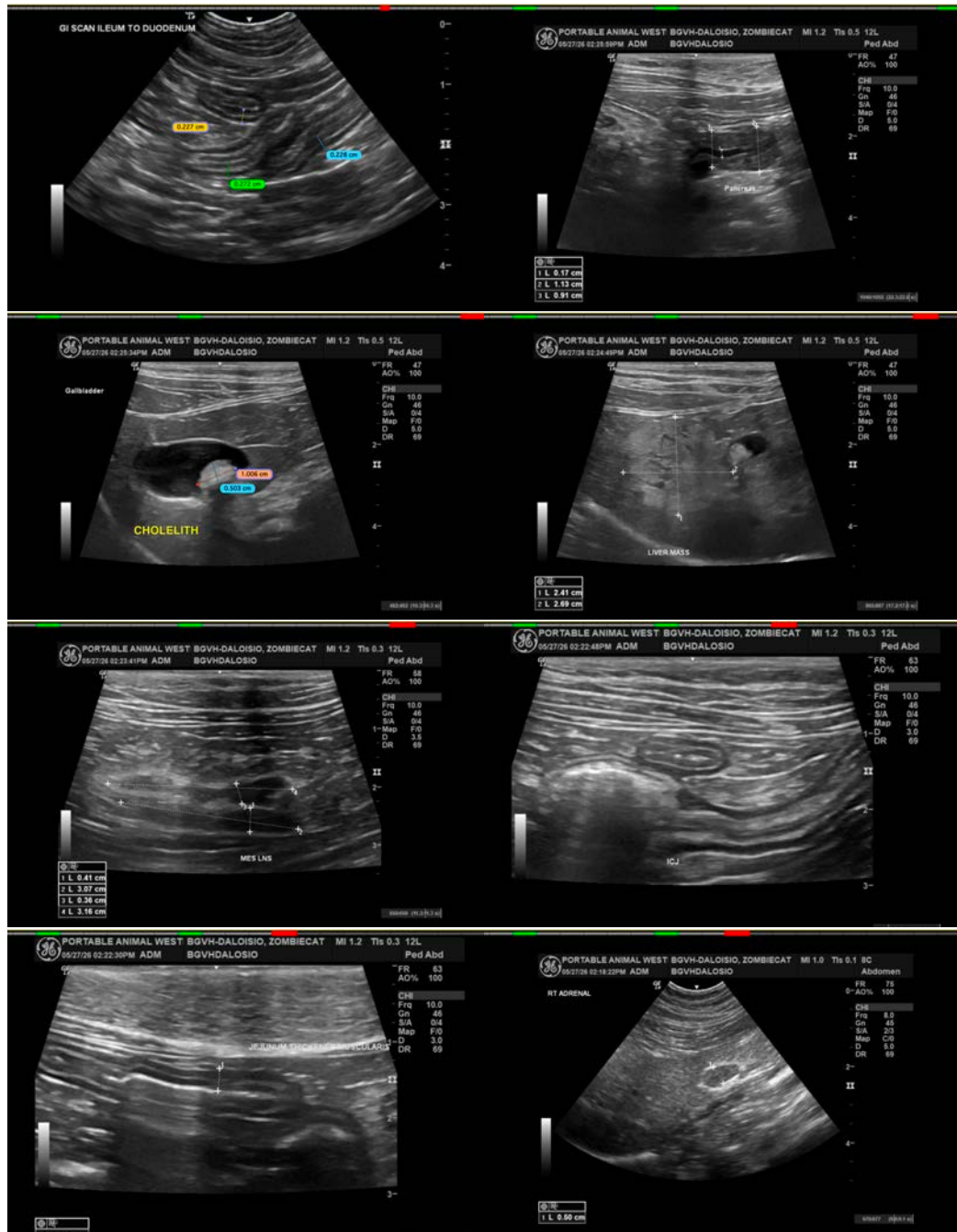
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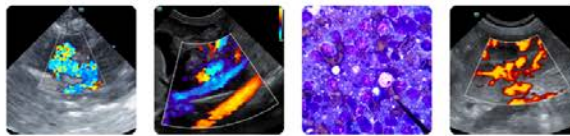
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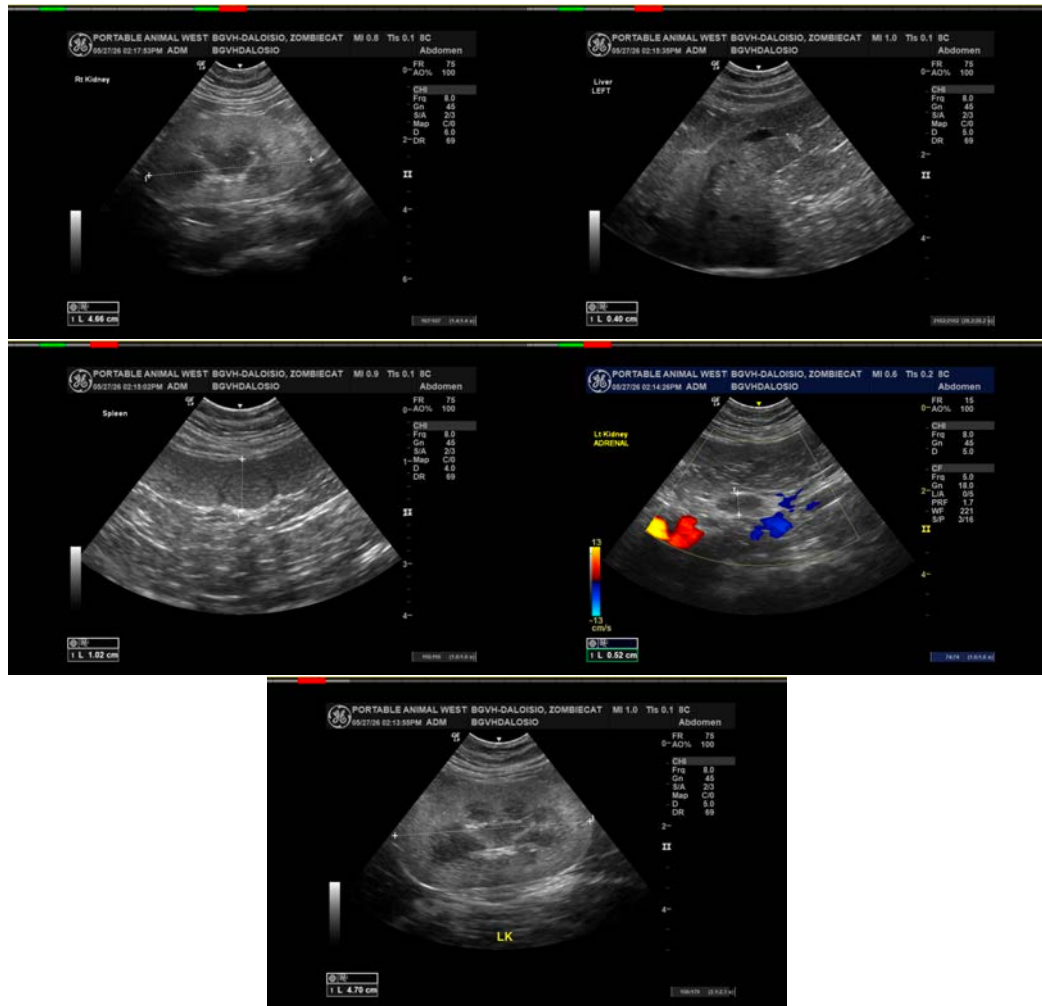
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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