



**PATIENT**

Murphy Kelleher

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

16 Years

**WEIGHT**

10.4 Pounds

**INTERPRETED BY**

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

**IMAGING  
PERFORMED BY**

Dr. Tam Mengine

**HOSPITAL NAME**

Stoney Creek VH

**REFERRING VET**

Dr. Tam Mengine

**INVOICE**

35133

**DATE**

1/27/22

**PRESENTING CLINICAL SIGNS**

Prior diagnosis of presumptive IBD (ultrasound elsewhere) in 2020, controlled on hydrolyzed diet and 2.5mg pred q24h. Recently began losing weight, appetite stable, no vomiting or diarrhea. CBC / Chem / T4 / U/A unremarkable except BUN 44, Creat 1.6, Urine SpGr 1.017. Urine culture pending

**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 (4.29 cm) with mild pyelectasia at 0.20 cm. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.64 cm) with pyelectasia at 0.27 cm. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is normal in size measuring 0.34 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 0.32 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 (0.72 cm 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.

**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 lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

**Gastrointestinal**

The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. 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 layering 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 measured 0.21 cm. Jejunum wall measured 0.17, 0.22 cm. Generally, visualized peristalsis appears appropriate, but the duodenum appears corrugated and somewhat spastic and inflamed. There were no focal lesions consistent with obstruction or mass effect observed.

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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. Colon wall measures 0.10 cm.

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**Pancreas**

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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.

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**Free Abdomen**

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a cluster of large mesenteric lymph nodes near the root of the mesentery in addition to some large cystic lymph nodes. Examples of lymph nodes measured at 0.3, 0.35 cm, and a cystic lymph node and 0.69 cm x 1.7 cm. The omentum is of increased echogenicity around these clusters of prominent mesenteric lymph nodes.

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**PRIMARY FINDINGS**

- Decreased corticomedullary distinction in both kidneys – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. Pyelectasia of the left/right kidney could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.
- Clusters of prominent mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Corrugated duodenum – Most consistent with regional inflammation/irritation.

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**SECONDARY FINDINGS**

- Prominent, hypoechoic pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Moderate distention of the gastric lumen with ingesta – Moderate amount of shadowing material in gastric lumen - Correlate with feedings history and abdominal radiographs. If adequately fasted then consider such differentials as delayed gastric emptying or a partial outflow tract obstruction (none visualized).

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The changes observed in the kidneys are consistent with the chronic renal disease reported in the history. Recommend urinalysis and culture (I believe this is pending), blood pressure evaluation and urine protein/creatinine ratio.

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The small intestine measures relatively normal in thickness, but it appears prominent, and there is corrugation of the duodenum, consistent with inflammation. This could be due to an acute enteritis event, or due to lack of control of the current IBD. You could consider a GI panel to Texas A&M to see if there is evidence of a cobalamin deficiency, dysbiosis, etc., which may point to relapse of the IBD type disease. Alternately, I do suspect the renal disease is significant enough to be causing some degree of weight loss.

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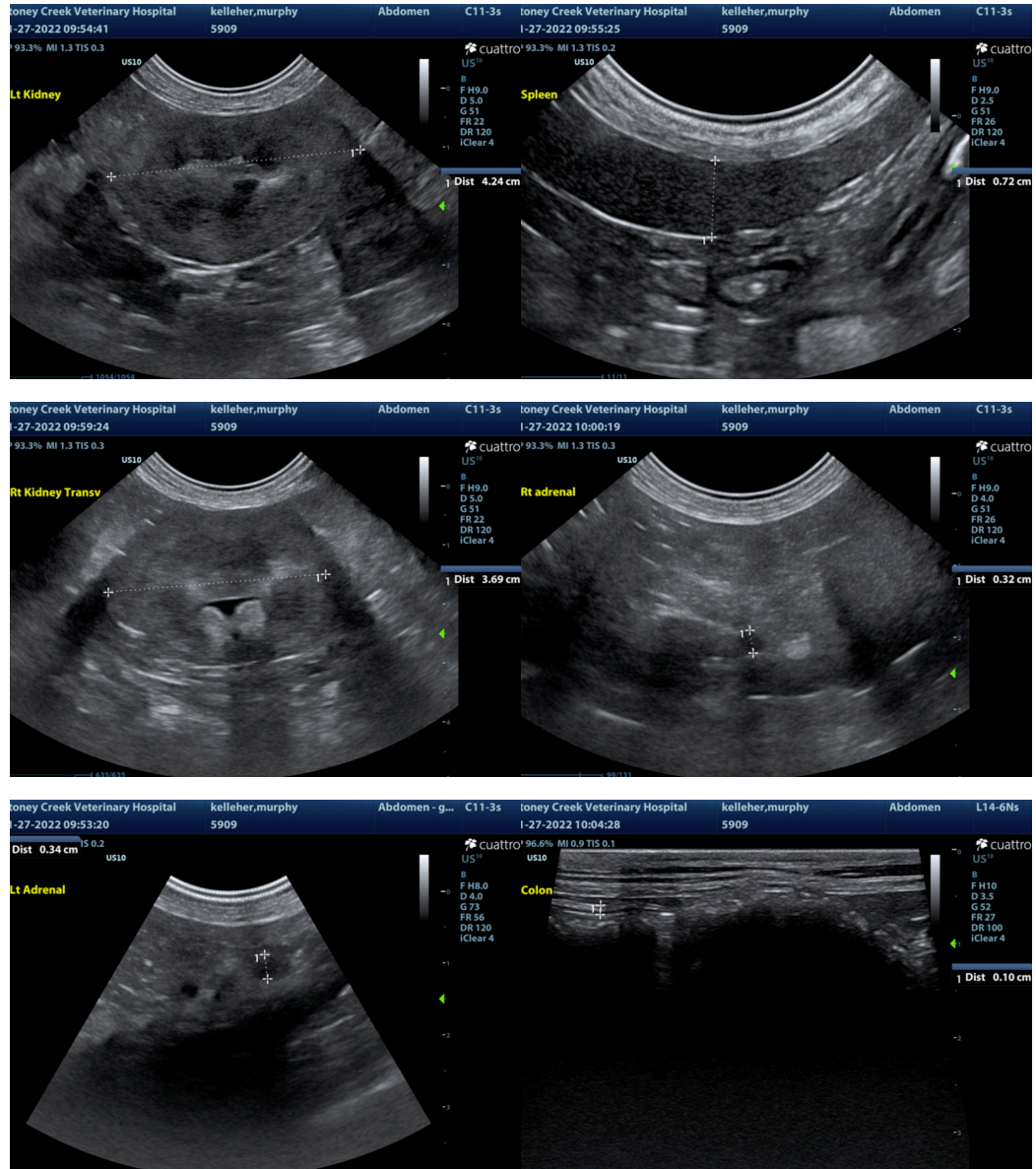
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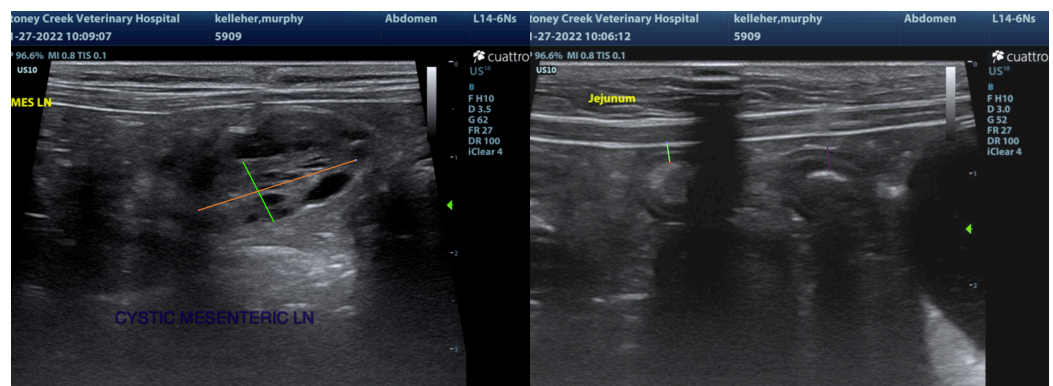
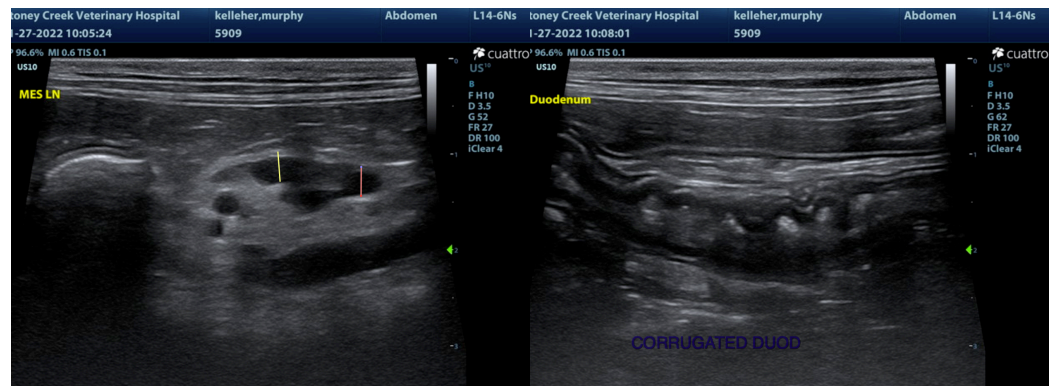
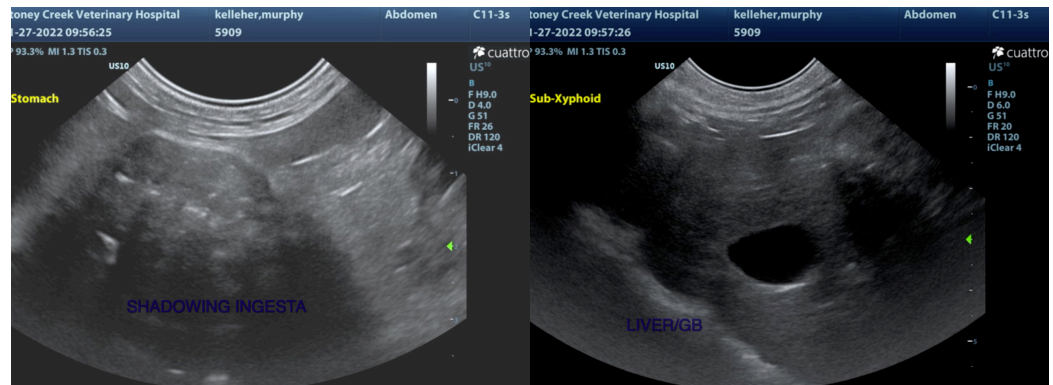
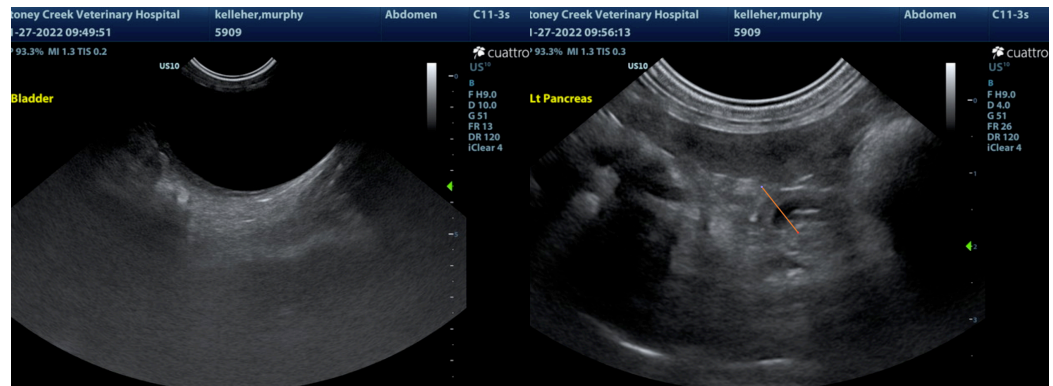
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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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)

kathleen.sennello@sonopath.com