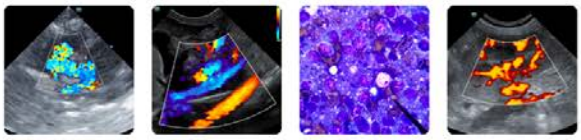


DATE

12/12/25

PATIENT

Boopdie McCraw

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

8/12/12

WEIGHT

9.75 lbs

INTERPRETED BY

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

HOSPITAL NAME

Cat Sense Feline Hospital and Boarding

REFERRING VET

Dr. Sinclair

INVOICE

72532

PRESENTING CLINICAL SIGNS

Patient History: Boopdie is a ckd kitty who has had a significantly decreased appetite that hasn't responded to Mirataz, Elura, ondansetron, omeprazole and cerenia, since 12/5. There were no significant new findings on PE on 12/9 and bloodwork performed didn't show any acute-on-chronic kidney disease that was suspected. An abdominal radiograph showed a possible suspicious soft tissue density in the cranioventral area that might be the pylorus or just the way the intestinal tract was turned but it could be something else (she was not amenable for a v/d and there wasn't the time to sedate her). She had been seen by Dr. Petrus at AVIM in the summer for doing odd movements with her mouth and swallowing oddly. It was suspected to be GERD and that was when the omeprazole was started.

Current Medications: None listed.
Labwork Results: Labwork attached, reported as: BUN=44, Creat=2.6, SDMA=18
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: STAT requested.
Imaging Performed by: Rachel Brilhart, RDMS.

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 (3.44 cm). The medulla is increased in echogenicity, 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.

The right kidney has a normal shape and size (3.58 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 0.43 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 region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

Spleen

The spleen is subjectively normal in size (1.0 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.

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.

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. Duodenum wall measures 0.32 cm. Jejunum wall measures 0.26 cm Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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.

Pancreas

The pancreas is prominent and mottled 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, 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.

Other

The right auricle and pericardium were visualized and were unremarkable. No obvious pathology is visualized, but there is a scant amount of pericardial effusion. Recommend full cardiac ultrasound to further evaluate.

ULTRASONOGRAPHIC FINDINGS

- Bilateral renal changes consistent with chronic renal disease.
- Pancreatic changes most consistent with chronic pancreatic remodeling. Mild pancreatitis cannot be definitively ruled out.
- Segmental thickening of the small intestine with some areas exhibiting 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

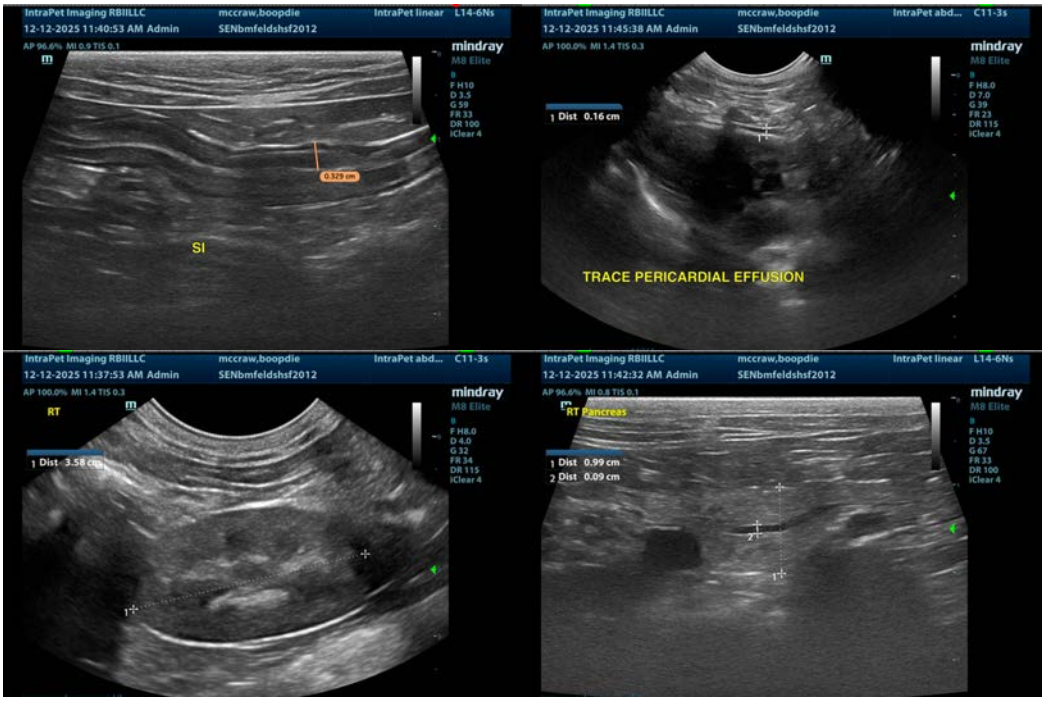
No focal lesions are visualized associated with the GI tract to explain the decrease in appetite reported. There is a diffuse mild "ropey" appearance, with some areas exhibiting a mildly prominent muscularis layer. This could be indicative of mild inflammatory type change. Additionally, the pancreas is visible, although not overtly inflamed, likely consistent with pancreatic remodeling. Correlate with PLI level. If this is significantly elevated, treatment for chronic pancreatitis could be considered.

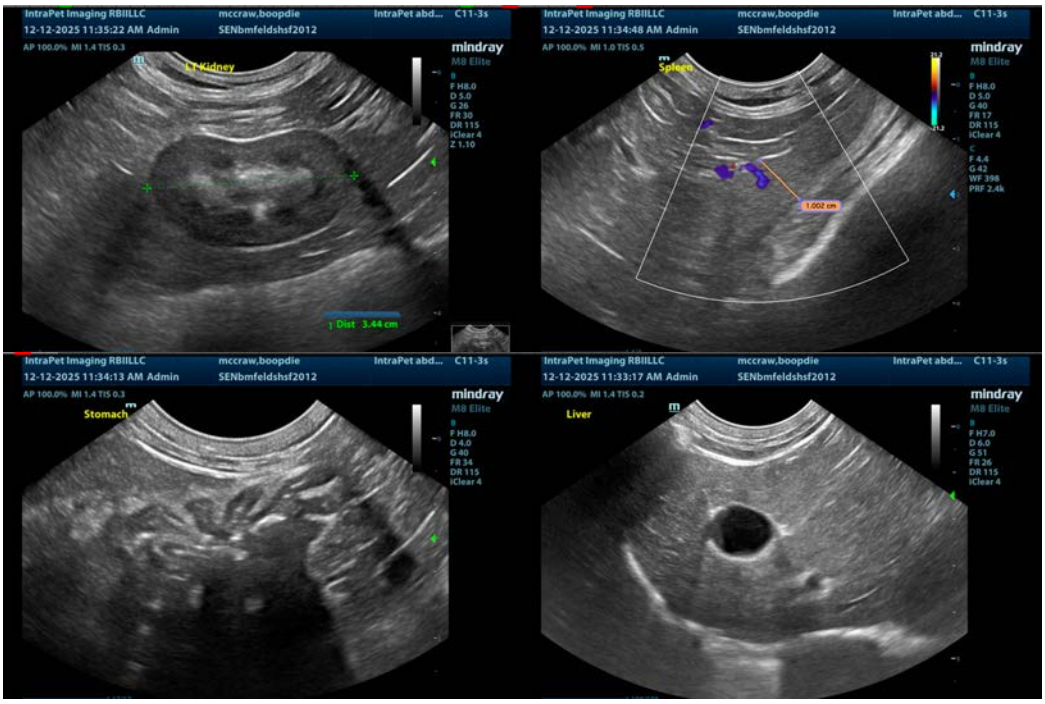
If an underlying enteropathy is suspected, consider:

- A hydrolyzed protein prescription diet.
- 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.
- Recommend chronic probiotic therapy.

If the GI panel is indicative of an underlying enteropathy and there is no clinical response to therapy, then biopsies of the GI tract may eventually be warranted.

Both kidneys have changes consistent with chronic renal disease. If not already done, recommend a blood pressure, urinalysis, culture, and a urine protein to creatinine ratio as a baseline, or reevaluation.





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