



PATIENT

Gremlin Jansen

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

19 Years

WEIGHT

3 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Rebecca Hamilton

HOSPITAL NAME

BPH North Eugene

REFERRING VET

Dr. Schmidt

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72336

DATE

12/4/25

PRESENTING CLINICAL SIGNS

3/6 R parasternal murmur. Ropey intestines, generalized hind limb muscle atrophy. Meds: Mirataz, methimazole

Abnormal PE/Chem/CBC/UA Results: Neut 11.89 (1.84-11.01) Lymph 0.86 (0.95-6.83) HCT 29 (30.3-49.7) IOF: Creat 1.8 (0.8-2.4) Lytes: K 3.4 (3.5-5.8) SDMA 15 (0-14) Urine: 0-5/hpf RBC, 0.2 Squamous epithelial cells, rare trans and renal cells, 0-1 non granular casts- Dipstick: +++200 occult blood, PH 5, +++500 Leukocytes, USG 1.019

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 is severely reduced in size and slightly irregular, measuring 1.67 cm with severely reduced detail of corticomedullary distinction. The cortex is generally of increased echogenicity. 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 is small in size but normal in shape, measuring 3.01. Overall echogenicity is 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 0.29 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 0.33 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 (0.63 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 bile duct appears mildly dilated and tortuous at 0.29 cm with no obstruction visualized.

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Gastrointestinal
The stomach contains moderate shadowing material. 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. Some of the intraluminal material appears somewhat hyperechoic, possibly mineralized (possibly kitty litter or similar?).

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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 0.21 cm. Jejunum wall measures 0.25 cm. Visualized peristalsis appears appropriate. The small intestine appears diffusely “ropey” with prominent muscularis layer. Some focal sections of bowel appear more significantly thickened, an example of which measures 0.27 cm.

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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. The ascending colon appears prominent at the ileocecal junction, measuring at 0.40 cm.

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Pancreas

The left limb of 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.

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Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is no significant lymphadenopathy. There is a small region of hyperechoic mesentery adjacent to the ileocecal junction with small lymph nodes measuring 0.22 cm and 0.27 cm.

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ULTRASONOGRAPHIC FINDINGS

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- Small right kidney with significantly decreased corticomedullary distinction and a fibrotic, small left kidney with minimal normal renal architecture – Findings are most consistent with chronic renal disease.

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- Pancreatic changes most consistent with pancreatic remodeling.
- Mildly dilated/tortuous bile duct. No focal lesion is visualized. The significance of this in the absence of liver enzyme elevations is uncertain.

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- Shadowing ingesta visualized within the gastric lumen – Correlate with feeding history. If the patient was adequately fasted, consider the possibility of delayed gastric emptying, ingested foreign material, etc. Shadowing ingesta may interfere with full evaluation of the stomach.

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- Diffusely thickened small intestine with 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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- Prominent/mildly thickened proximal ascending colon – Findings could be consistent with mild colitis, early infiltrative disease, etc.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine appears diffusely “ropy” with a prominent muscularis layer. Some sections of small intestine appear more significantly thickened. At this time these changes are most consistent with significant inflammatory disease, but early neoplastic disease is possible.

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Additionally, both kidneys are small with reduced corticomedullary distinction, and the left kidney in particular is shrunken with minimal normal architecture, most consistent with a fibrotic kidney.

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Recommend a sterile urine sample, a culture, blood pressure, and urine protein to creatinine ratio to further evaluate the kidneys.

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For further evaluation of the gastrointestinal changes, consider the following:

- If possible, consider a combination hydrolyzed protein/renal diet (Royal Canin may have one).
- 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.

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Biopsies of the GI tract may be necessary if there is no response to initial therapy.

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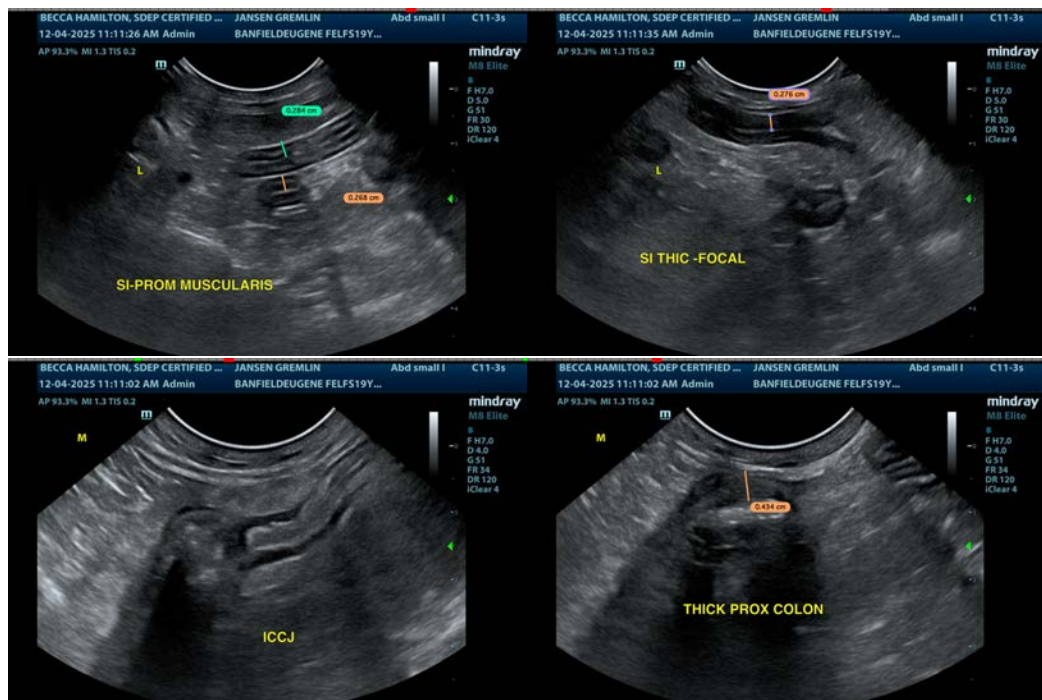
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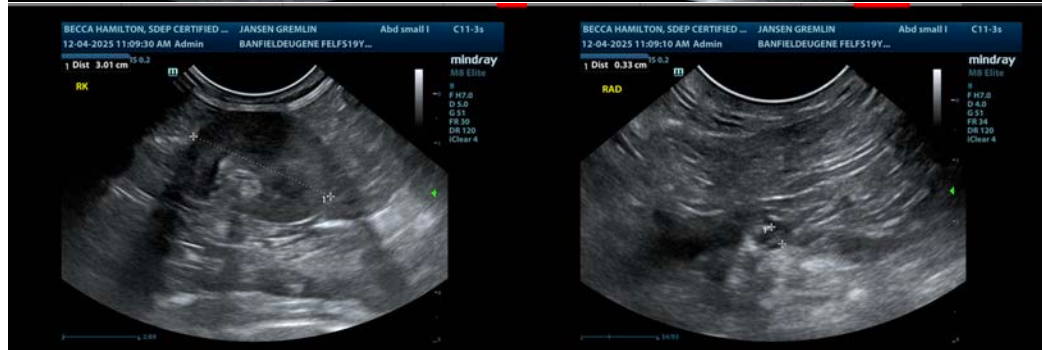
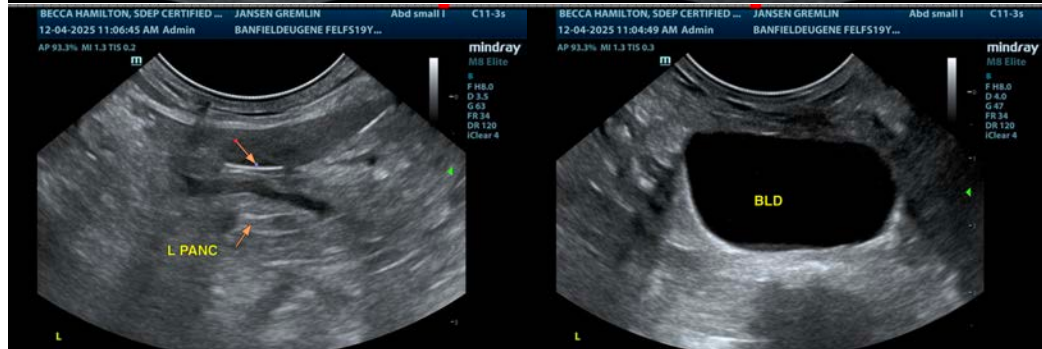
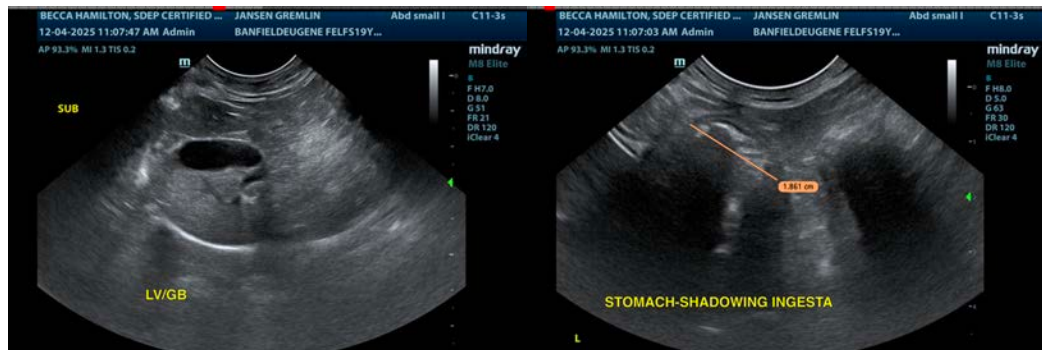
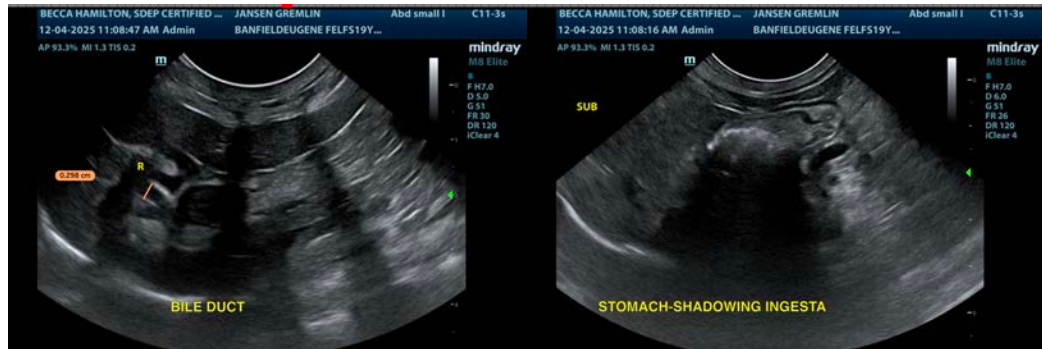
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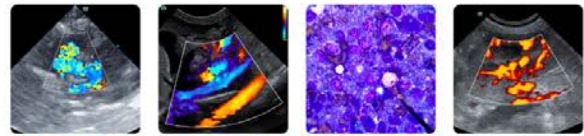
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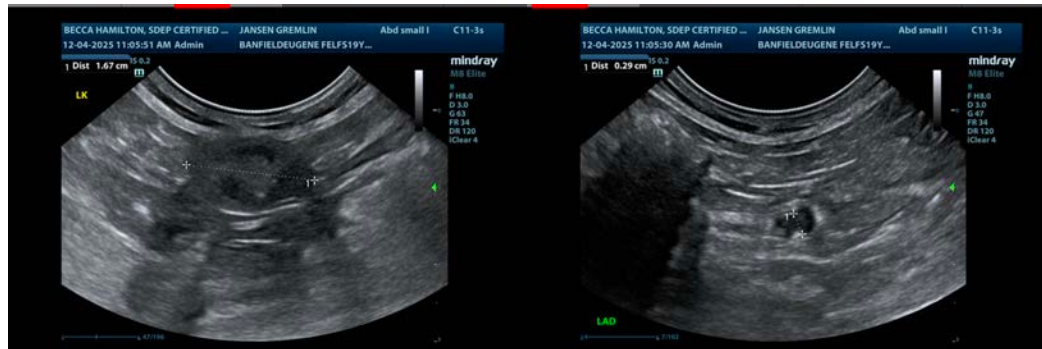
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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