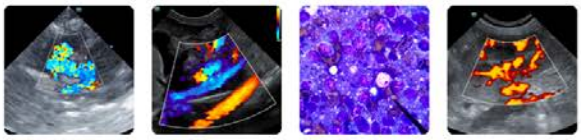


DATE

3/17/26

PATIENT

Corduroy Ostrynskyy

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

6/1/14

WEIGHT

7.5 lbs

INTERPRETED BY

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

HOSPITAL NAME

Greenbrier Veterinary Clinic

REFERRING VET

Dr. Dellinger

INVOICE

73755

PRESENTING CLINICAL SIGNS

Patient History: Presented on 3/09/2026 for weight loss. CRF and current HMG3/6, appetite is decreased, suspect from renal disease

Current Medications: SQ LRS 50cc on 3/16/26, Cerenia 3mg on 3/16/26, Famotidine 3mg on 3/16/26
Labwork Results: Labwork attached, reported as: BUN 125, Creat 9.2, SDMA 46, phos 10.8, K 3.5. Cardiopet BNP >1500. UA SpG 1.013
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not 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 is normal in size but irregular in shape (likely due to previous infarct), measuring 3.46 cm with mild pyelectasia at 0.15 cm and medullary mineralization. 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 infarcts or hydroureter. Renal vasculature is normal.

The right kidney is small, measuring 2.5 cm, with mild pyelectasia at 0.24 cm and medullary mineralization at 0.53 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 infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.45 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 0.48 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 (0.79 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. Jejunum wall measures 0.22 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 left limb of 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. Prominent pancreatic duct noted at 0.14 cm.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is no evidence of a significant lymphadenopathy. There is a small cluster of prominent lymph nodes at the mesenteric root measuring 0.40 cm and 0.69 cm. The omentum is of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Decreased corticomedullary distinction in both kidneys with a likely previous infarct in the left kidney, bilateral pyelectasia, and medullary mineralization, and a small right kidney – Findings are most consistent with significant chronic renal disease. Pyelectasia may be secondary to PU/PD, less likely pyelonephritis, but further evaluation is warranted.

- Pancreatic changes consistent with chronic pancreatic remodeling +/- chronic pancreatitis.

- Diffusely “ropey” small intestine 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.

- Occasional prominent mesenteric lymph nodes – Findings are most consistent with reactive lymph nodes, although early neoplastic lymph nodes cannot be ruled out.

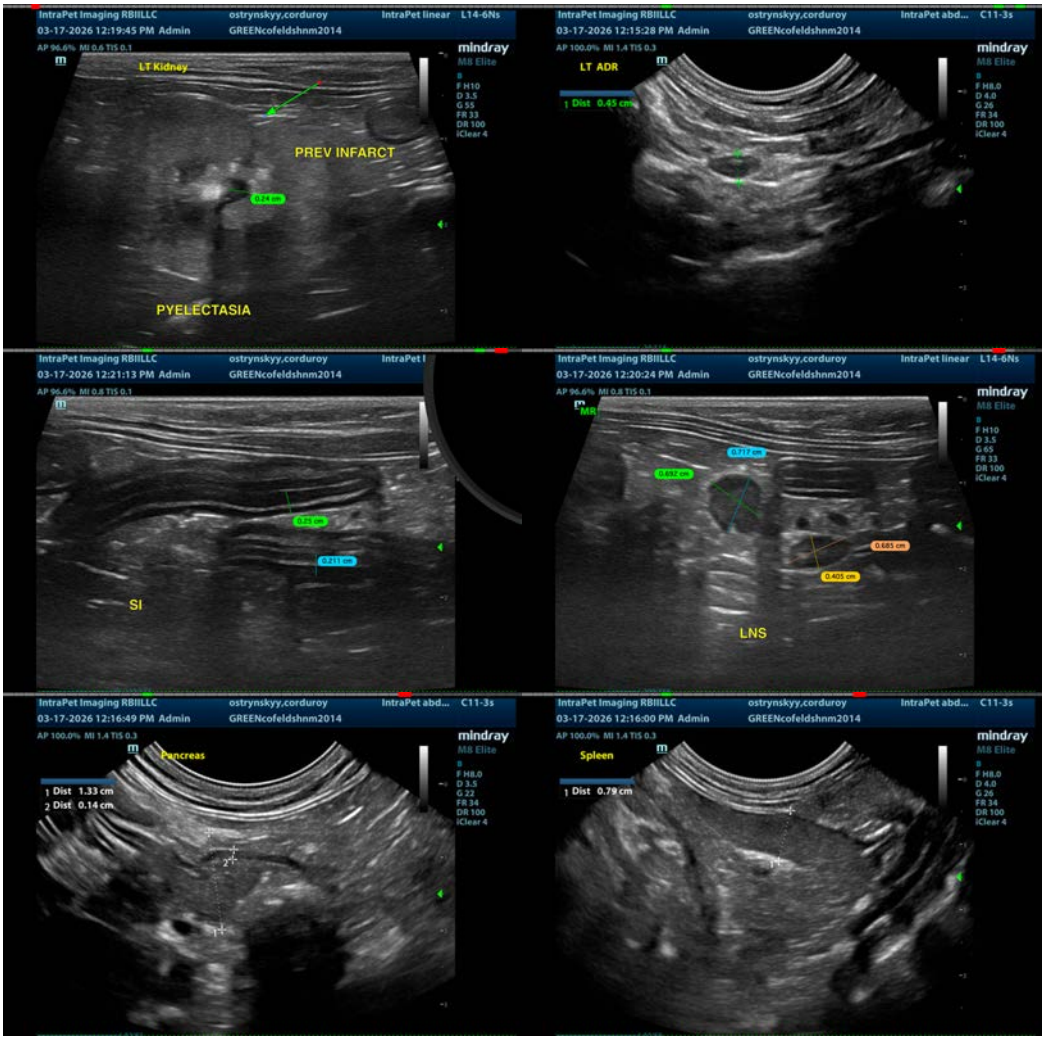
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

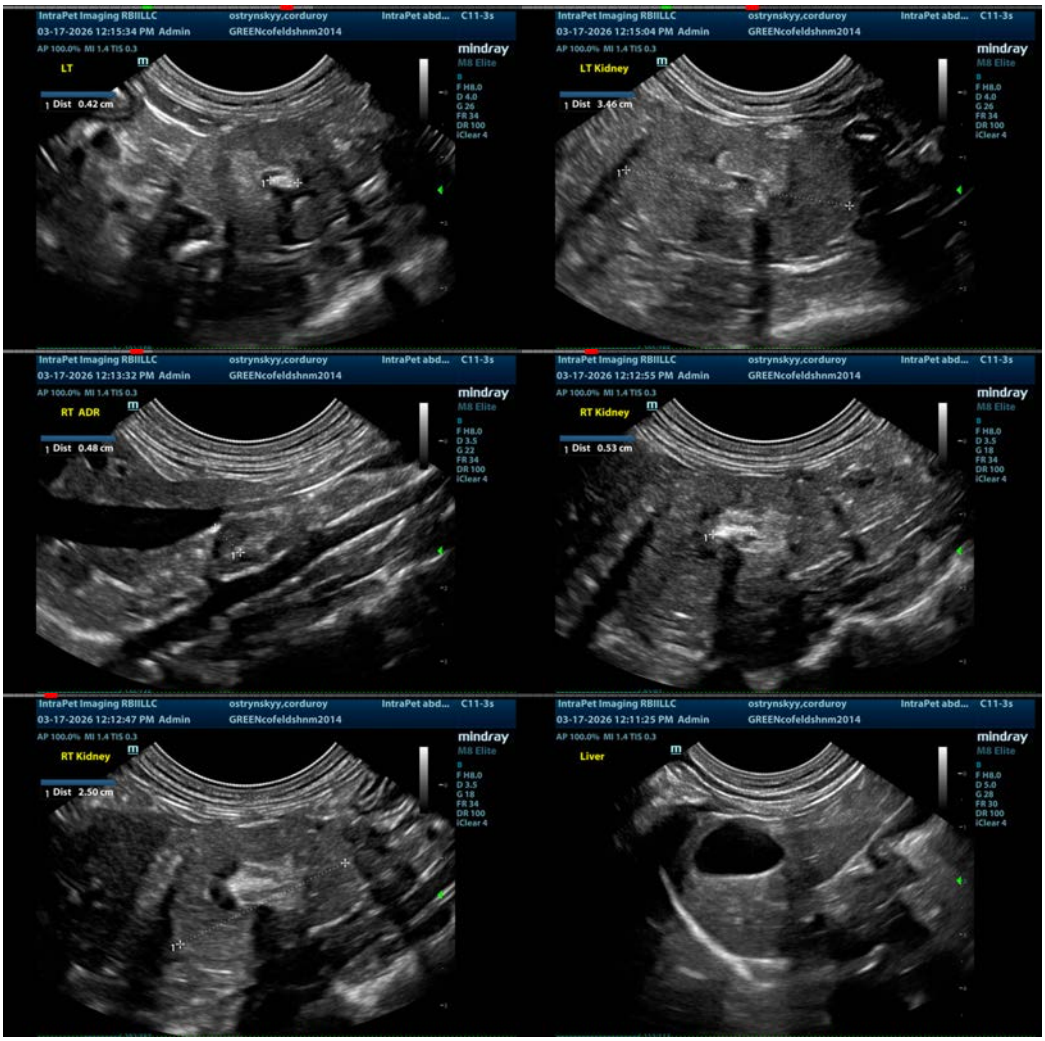
Both kidneys have significant changes consistent with chronic progressive renal disease. There is some mineralization and pyelectasia present. The right kidney is significantly smaller. If not already done, recommend a urine culture and a blood pressure evaluation, looking for concurrent issues related to chronic

renal disease. If an acute on chronic crisis is suspected, consider diuresis and treatment for uremia.

The left limb of the pancreas is somewhat prominent and mottled. This is most consistent with chronic pancreatic remodeling, but mild active inflammation cannot be ruled out. Correlate with quantitative fPLI level, looking for concurrent pancreatitis. Additionally, the small intestine appear somewhat ropey, most consistent with inflammatory type change, although early neoplastic change cannot be ruled out.

Given the severity of the azotemia reported, the majority of the clinical signs are likely secondary to the renal disease present. The clinical significance of the pancreatic and gastrointestinal changes observed is uncertain at this time.





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