



PATIENT

Morty Cooper

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

19.5 Years

WEIGHT

5.5 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Chippawa Animal
Hospital

REFERRING VET

Dr. Kilkenny

INVOICE

73724

DATE

3/17/26

PRESENTING CLINICAL SIGNS

History of pancreatitis. Not eating well for weeks. Weight loss of 0.6kg in 1 month. No vomiting or diarrhea noted. Has been on Mirtazapine, Cerenia and Buprenorphine

Abnormal PE/Chem/CBC/UA Results: Bloodwork and U/A unremarkable

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall appears slightly irregular and mildly thickened, particularly in the apical region where it measures 0.32 cm. In the dependent portion of the urinary bladder there is a small amount of hyperechoic material possibly consistent with dependent hyperechoic debris or a small amount of mineralized debris. The region of the trigone, ureteral papillae and proximal urethra appear free of any mass lesions or calculi.

The left kidney has a normal shape and size (3.5 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 (3.67 cm) with a small cortical cyst. 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 0.33 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 0.40 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 large and irregular in shape, measuring up to 0.49 cm in width. The blood flow through the hilus and splenic parenchyma appears normal. The margins of the spleen appear scalloped in the more thickened regions.

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.



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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 0.29 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.

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.

ULTRASONOGRAPHIC FINDINGS

- Mildly thickened/irregular urinary bladder wall – The bladder mucosal changes could be consistent with cystitis or artifactual due to lack of adequate luminal distension. Bladder neoplasia cannot be ruled out but is considered unlikely in this patient.
- Large, thickened spleen with some areas exhibiting scalloped margins – Possible differentials could include anatomic variation, congestion, splenitis, lymphoid hyperplasia, or infiltrative neoplasia.
- Pancreatic changes most consistent with chronic pancreatic remodeling +/- mild pancreatitis in the left limb.
- Diffusely thickened 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The spleen appears large and has scalloped margins in some regions. Given the current symptoms, recommend a fine needle aspirate of the spleen for cytologic evaluation, looking for any evidence of underlying neoplasia.



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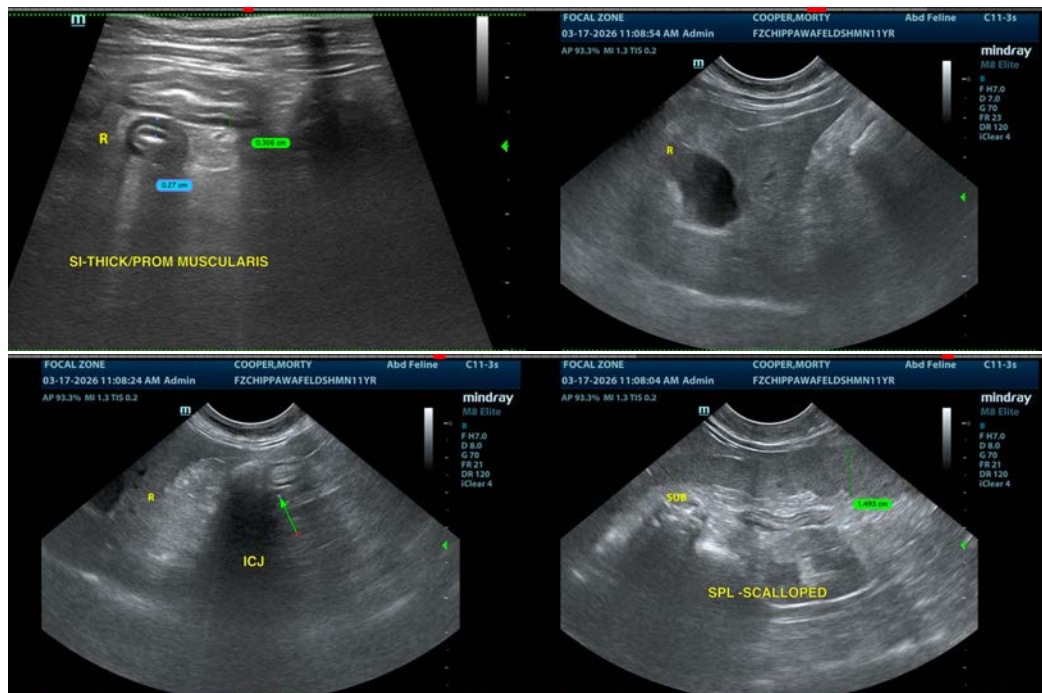
The left limb of the pancreas is somewhat prominent and mottled. Correlate with PLI level. If there are significant elevations, consider concurrent treatment for mild chronic pancreatitis.

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. Further initial evaluation for an enteropathy could include the following:

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- 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 symptoms are persistent despite supportive care and non-specific therapy, and cytology of the spleen is benign, then ultimately biopsies of the GI tract may be warranted. You could consider repeat imaging prior to this to look for possible progression of current lesions or development of new lesions.

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





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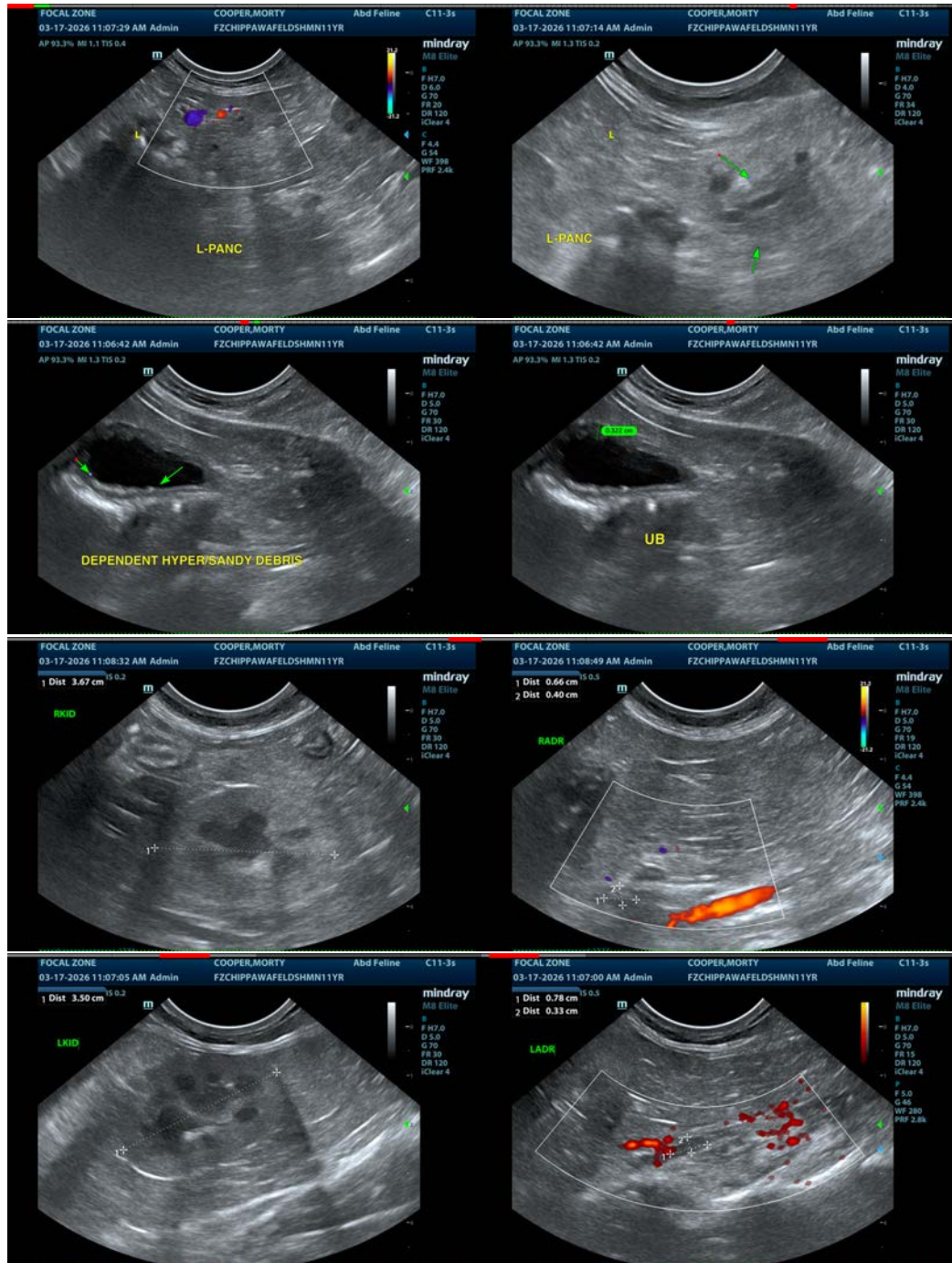
Dr. Kilkenny

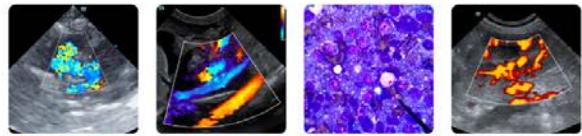
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com