



## PATIENT

Kitty Lou Biondo

## SPECIES

Feline

## BREED

DSH

## SEX

Spayed Female

## AGE

11 years

## WEIGHT

2.49 kg

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Dr. Abby Gerenser

## HOSPITAL NAME

Abby Road VH

## REFERRING VET

Dr. Abby Gerenser

## INVOICE

11416

## DATE

3/4/2026

## PRESENTING CLINICAL SIGNS

- Patient has hx of CKD diagnosed last year
- Managed on renal diet, but patient is very picky with appetite
- Was started on Amlodipine October 2025 for hypertension
- Owner reported vomiting, weight loss, and decreased appetite suspected to be related to Amlodipine administration since starting it in October 2025. Just reported to us that she stopped Amlodipine about 3 weeks ago
- Since then, patient has not regained lost weight and reports significantly less vomiting, appetite is still decreased

Abnormal PE/Chem/CBC/UA Results: Heart murmur, dehydration, muscle wasting Labwork attached (azotemia, hypercalcemia, proteinuria, increased SDMA, inappropriate USG).

## 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 borderline small, and irregular in shape (likely due to previous infarcts) with decreased corticomedullary distinction and numerous non-obstructive nephroliths and small cortical cysts. A larger cortical cyst is visualized at the cranial pole measuring 0.87 cm. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia or hydroureter. Renal vasculature is normal.

The right kidney is borderline small in size, and irregular in shape (likely due to previous infarcts) with decreased corticomedullary distinction. There are numerous small non-obstructive nephroliths and small cortical cysts are visualized. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia or hydroureter. Renal vasculature is normal.

### Adrenal Glands

The region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.41 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 (0.17 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



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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. There are occasional hyperechoic foci, most consistent with small intrahepatic biliary mineralizations.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. 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 (0.25 cm) and ileum have a uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed

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 large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild pancreatitis in the left limb.

### **Free Abdomen**

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is no significant lymphadenopathy. The omentum is slightly prominent near the left limb of the pancreas.

## ULTRASONOGRAPHIC FINDINGS

- Borderline small, irregular kidneys with non-obstructive nephroliths, poor corticomedullary distinction, and cortical cysts. Findings are most consistent with chronic renal disease.
- Pancreatic changes most consistent with mild pancreatitis in the left limb.
- Occasional hyperechoic intrahepatic biliary mineralizations noted associated with the liver. Significance of this is uncertain. This can be seen with chronic inflammatory changes.
- Moderate gallbladder debris. The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.
- Mildly thickened small intestine. The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).



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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

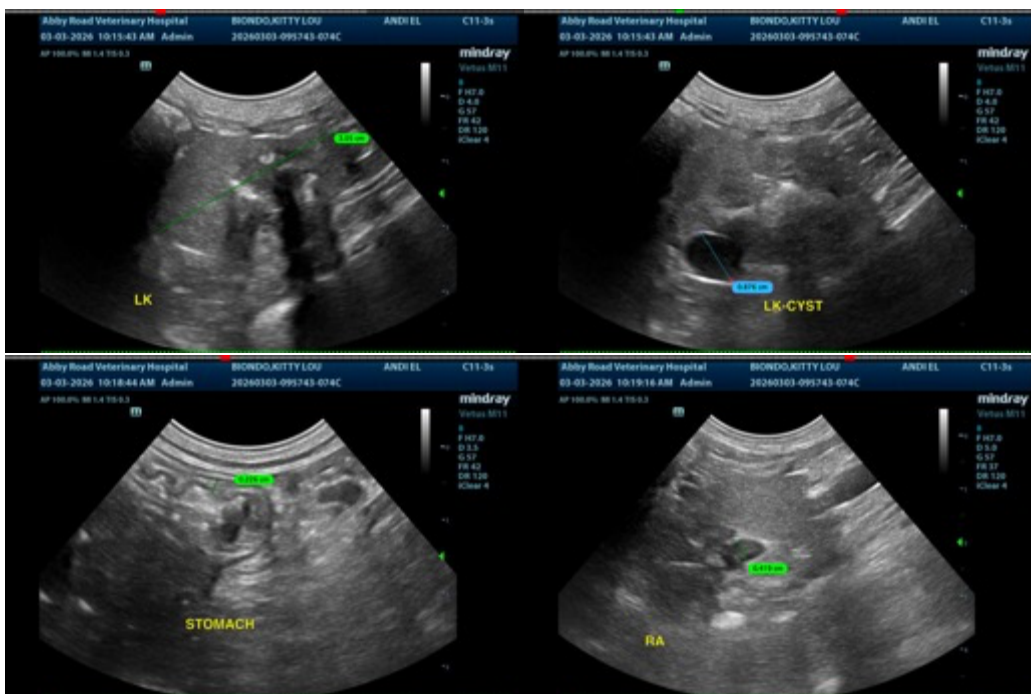
Both kidneys have significant changes consistent with chronic renal disease. I would suspect this is playing a large part in the patient's clinical symptoms. Consider treatment for uremia and possibly alternate medications for hypertension (Depending on the degree of hypertension. Possibly topical amlodipine?)

The left limb of the pancreas appears hypoechoic and somewhat prominent. Correlate with a PLI level and consider empirical treatment for mild pancreatitis if clinically appropriate.

There are mild intrahepatic biliary mineralizations visualized associated with the liver. The significance of this is uncertain, particularly in the absence of liver enzyme elevations.

Some areas of small intestine appear mildly thickened. If there is concern for a concurrent enteropathy you could consider a GI Panel to Texas A&M for a qualitative fPLI/TLI, cobalamin, and folate looking for additional evidence. If this is the case you could consider a combined hydrolyzed/renal diet (I believe royal canin has one), continued monitoring of the small intestine with ultrasound, probiotic therapy, etc.

If symptoms are progressing and a primary gastrointestinal disease is suspected, you could consider repeat imaging in the future looking for the progression of today's lesions.





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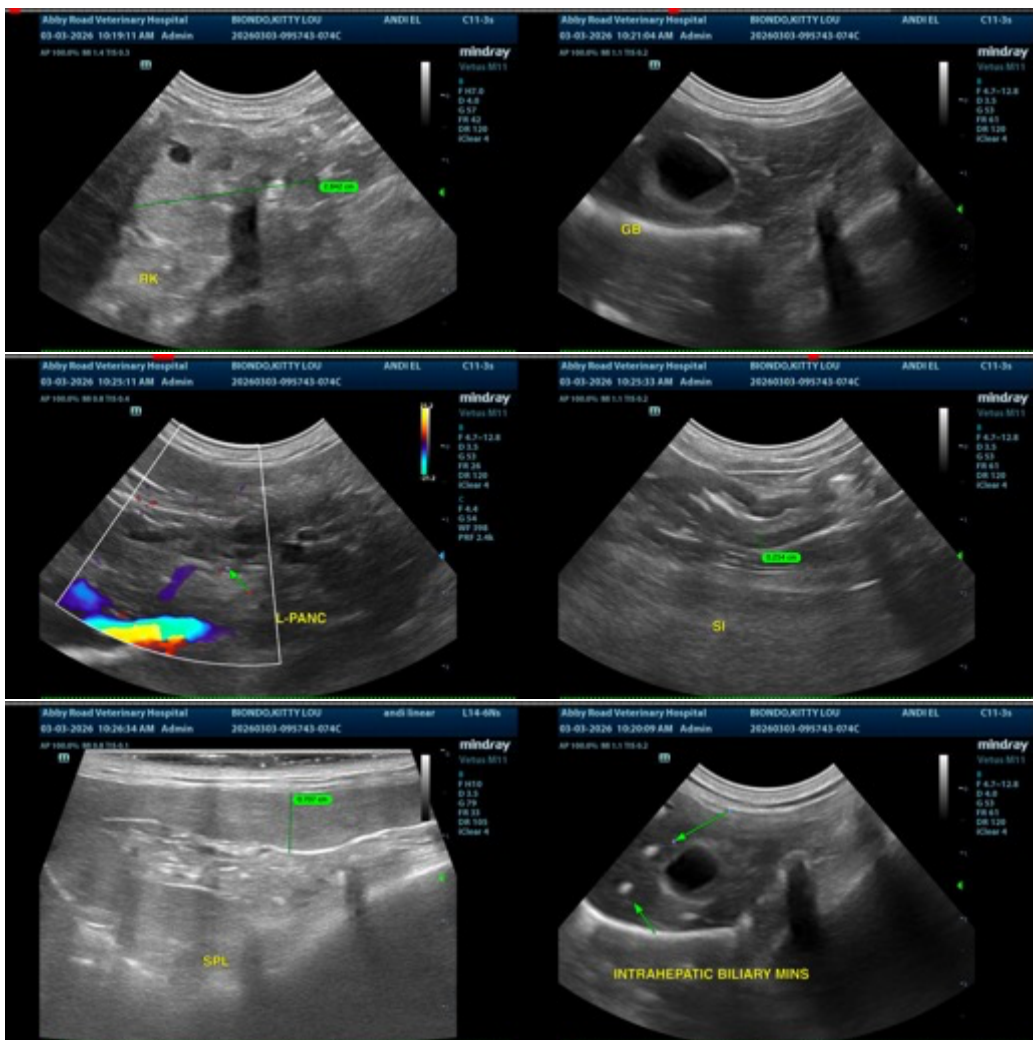
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com