



PATIENT

Blinky Werner

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

9 Years 11 Months

WEIGHT

16.8 lbs

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Shari Reffi, CVT

HOSPITAL NAME

VCA AVH Animal
Hospital

REFERRING VET

Dr. Dymond-Szabo

INVOICE

74334

DATE

4/9/26

PRESENTING CLINICAL SIGNS

Vomiting, anorexia, weight loss. Tense abdomen. Large amt of stool on x-rays. Enema given this am. Defecated large ball of stool.

Current Meds: lactulose x 1 mos but O stopped 1 wk ago and started back up. Miralax daily. Fluticasone 1 puff, K Citrate for bladder stones. Prev. PU sx 7/2/25.

Abnormal PE/Chem/CBC/UA Results: 2/25/26: Ca 11.1; Fructosamine 298. UA: USG 1.040; 2+ protein, 1+ glucose (stress !) BW and cysto performed today pending.

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, or masses. There is a focal dependent hyperechoic shadowing structure with "twinkle" artifact suspected to be a stone measuring 1.22 cm. A pile of dependent mineralized debris cannot be ruled out.

The left kidney has a normal shape and size (4.5 cm) with significant pyelectasia at 0.66 cm and occasional small intrapelvic nephroliths. 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 has a normal shape and size (3.16 cm) with significant pyelectasia at 0.54 cm and occasional small intrapelvic nephroliths. 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 region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

The right adrenal gland is normal in size measuring 0.42 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 (0.77 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.



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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 proximal cystic duct appears mildly dilated and tortuous. The common bile duct is visualized distally as slightly dilated at 0.36 cm.

Gastrointestinal

The stomach contains moderate fluid/ingesta. 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 relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.31 cm. Jejunum wall measures 0.19 cm. 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 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.

ULTRASONOGRAPHIC FINDINGS

- Cystolith/dependent mineralization visualized in the urinary bladder – Correlate with radiographs, urinalysis and culture.
- Decreased corticomedullary distinction in both kidneys with significant pyelectasia and small intrapelvic nephroliths – Findings are most consistent with chronic renal disease and suspected obstructive disease secondary to stones. A definitive obstruction is not evident at this time. Pyelonephritis is also a concern.
- Pancreatic changes consistent with chronic pancreatic remodeling +/- chronic active pancreatitis.
- Mildly prominent/dilated bile duct – Dilation of the common bile duct could be consistent with a functional obstruction (i.e. primary hepatic disease resulting in hepatocellular swelling) or



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with an extrahepatic bile duct obstruction (ie. choledocholith, bile duct tumor, pancreatic disease, other).

- Fluid/ingesta distended stomach – Correlate with feeding history. If the patient was adequately fasted, consider the possibility of delayed gastric emptying or a partial outflow tract obstruction (none visualized).

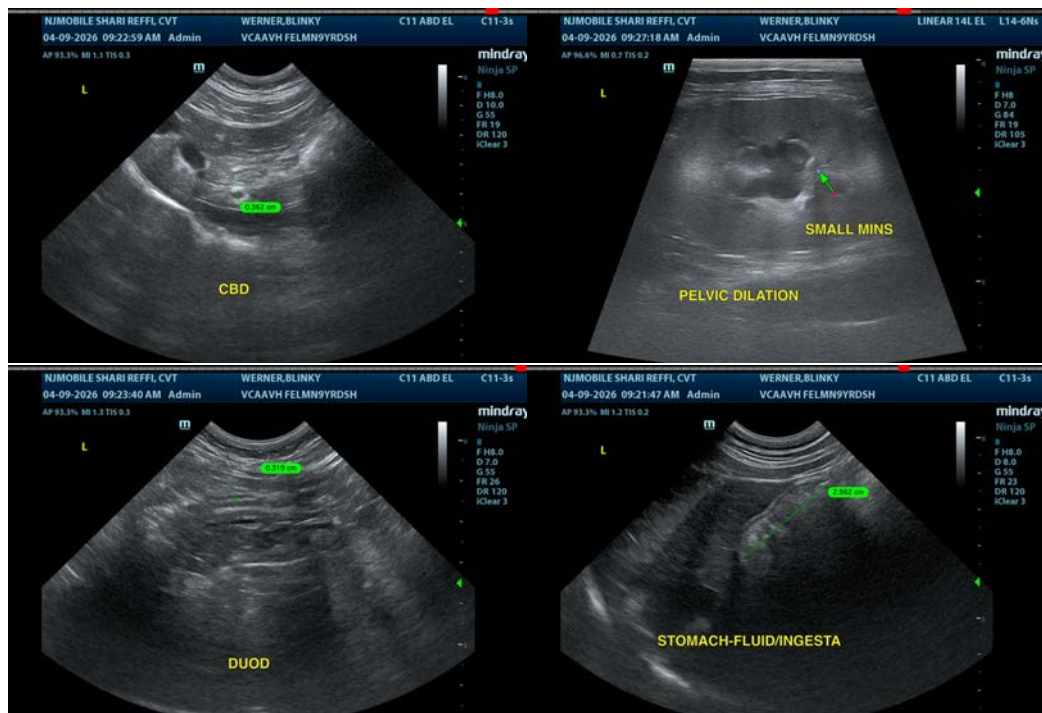
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Both kidneys have decreased corticomedullary distinction and significant pyelectasia with occasional small non-obstructive nephroliths/mineralization visualized within the renal pelvis. A definitive obstruction is not visualized at this time, but a small distal ureterolith cannot be ruled out. Findings are concerning for intermittent obstruction, pyelonephritis, and chronic renal disease. A contrast study could be considered, particularly if there is progressive renal dilation occurring.

Both limbs of the pancreas are prominent and mottled, most consistent with chronic pancreatic remodeling, but chronic active pancreatitis could also be present. Correlate with a PLI level and consider empirical treatment for pancreatitis.

The significance of the mild bile duct dilation is uncertain. Recommend monitoring of liver values and continued monitoring of the gallbladder, looking for evidence of cholecystitis, partial obstruction, etc.

Consider diuresis and pain medication as well as a urine culture to workup for underlying renal disease. This would also cover the bases for pancreatitis. If the patient continues to be anorexic, advanced imaging may be warranted.





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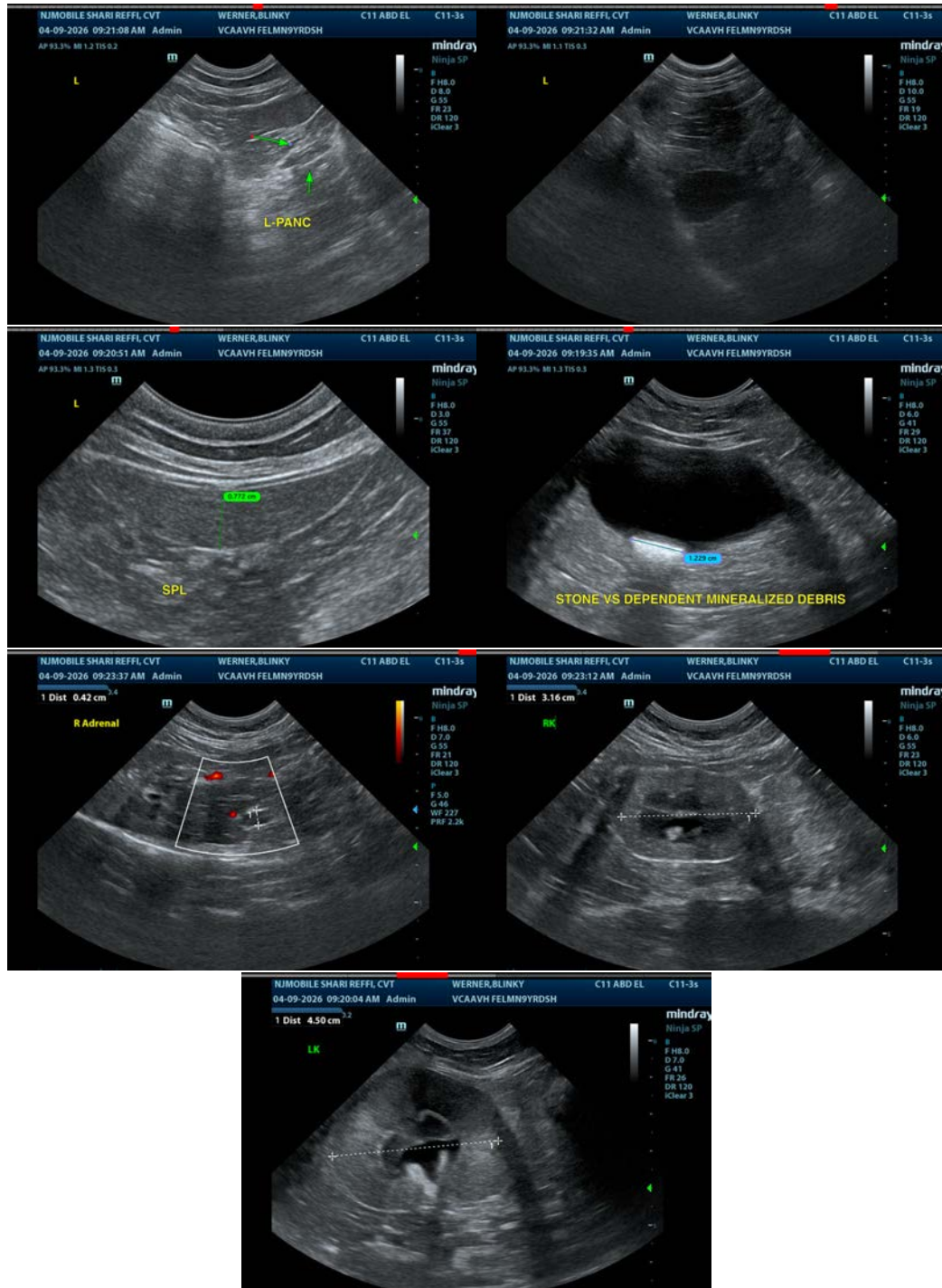
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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