



PATIENT

Missy Wilbur

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

15 years

WEIGHT

5 lbs

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Loetitia Saint-Jacques,
LVT

HOSPITAL NAME

MountainView Animal
Hospital

REFERRING VET

Dr. Razia Sultana

INVOICE

12028

DATE

5/28/2026

PRESENTING CLINICAL SIGNS

Heart murmur and inguinal hernia. No sedation-Relevant Medical History and Physical Exam Findings: Recent inappropriate elimination: urination and defecation on carpet over past few months. Previous report of "large heart."

Abnormal PE/Chem/CBC/UA Results: Recent Diagnostics: Relevant Laboratory Results / Abnormalities: RBC 4.45 M/ μ L 6.5 11.53 Hematocrit 22.6 % 31 51 Hemoglobin 8.3 g/dL 10.6 16.7 MCV 51 fL 38 53 MCH 18.7 pg 12.3 17.3 MCHC 36.7 g/dL 29.1 35.7 RDW 15.9 % 10 26 Test Results Unit Lowest Value Highest Value Qualifier Glucose 79 mg/dL 72 175 IDEXX SDMA 16 μ g/dL 14 SDMA is increased and creatinine is within the reference interval: likely impaired GFR and kidney function. Recommended next step: evaluate complete urinalysis. For information on recommended actions visit: www.idexx.com/sdmaalgorithm. Show Less Creatinine 1.5 mg/dL 0.9 2.3 BUN 61 mg/dL 16 37.

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 has a normal shape and size (2.87 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. Pyelectasia noted measuring 0.24 cm. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (2.75 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. Occasional cortical cysts and mild pyelectasia measuring 0.14 cm are noted. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.36 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 0.43 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 (0.74 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. 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 prominent but not overtly thickened measuring 0.13 cm. There is a moderate amount of non-organized echogenic debris. The bile duct is dilated and significantly tortuous with a thickened wall measuring at 0.57 cm in diameter. Proximally, at the level of the duodenal papillae it measures 0.42 cm with intraluminal mucoid appearing debris. Soft tissue cannot be ruled out.

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Gastrointestinal

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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.

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The visualized areas of duodenum (0.35 cm), jejunum (0.26 cm) and ileum have a uniform diameter with minimal fluid distension. Wall thickness is increased. Bowel loops follow a typical curvilinear path. Motility appears decreased. The small intestine appears diffusely thickened with some areas exhibiting a prominent muscularis layer. There is also an inguinal hernia which intermittently has bowel passing through the herniation. The duodenal papillae and is prominent measuring at 0.5 cm.

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The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. The descending colon appears significantly distended with formed fecal material. There is no observed focal or generalized colon wall thickening or loss of layering.

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Pancreas

The pancreas is large, hypoechoic and mottled with a prominent pancreatic duct. There are numerous hypoechoic nodules throughout the pancreas and occasional cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

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Free Abdomen

Evaluation of the peritoneal cavity revealed mild to moderate free abdominal fluid. There are occasional prominent mesenteric lymph nodes. Lymph nodes at the mesenteric root measure 0.52 cm and 0.46 cm. The PD lymph node measures 0.65 cm x 0.42 cm. The omentum is diffusely hyperechoic.

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Other

A large inguinal hernia is visualized measuring approximately 1.42 cm in diameter. Omentum, fat, and bowel can be seen actively passing through the hernia and in some images is placed back within the abdomen.

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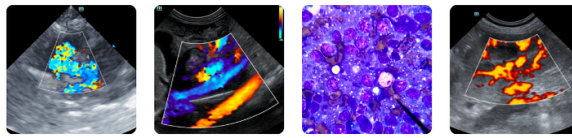
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ULTRASONOGRAPHIC FINDINGS

- Decreased corticomedullary distinction in both kidneys with bilateral pyelectasia. Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. Pylectasia of the kidney could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.

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- Large, hypoechoic, prominent pancreas with a prominent pancreatic duct and numerous hypoechoic nodules and cystic lesions. Findings are suggestive of chronic pancreatic remodeling with lymphoid nodules and cysts. Concurrent chronic active pancreatitis is suspected.
- Large gallbladder debris with a severely dilated and thickened bile duct with intraluminal debris. Findings could be consistent with cholecystitis/chronic biliary disease, a mucoduct, an intraluminal soft tissue mass effect cannot be ruled out.
- Diffusely thickened small intestine with a prominent muscularis layer, subjective hypomotility. The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia.
- Mild/moderate mesenteric lymphadenopathy. Findings are suggestive of reactive lymph nodes. Although an early neoplastic change cannot be ruled out.
- Inguinal hernia with bowel, omentum, and fat passing into and out of the herniated space.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine appears diffusely thickened with a prominent muscularis layer. Subjectively motility appears reduced, although there is no evidence of significant fluid distension. Additionally, the pancreas is large, mottled, and hypoechoic with cysts and hypoechoic nodules. The changes are concerning for chronic active pancreatitis, chronic pancreatic remodeling, and lymphoid hyperplasia. A fine needle aspirate of the pancreas could be considered.

The gallbladder has moderate to large debris and the bile duct is severely thickened and dilated. Recommend empirical treatment for cholangiohepatitis with chronic ursodiol, denamarin, and antibiotics. Recommend continued monitoring of the gallbladder.

It is interesting that liver values are normal. The combination of changes to the bile duct, bowel, and pancreas could be concerning for possible triaditis. Recommend initial empirical therapy for IBD with a hydrolyzed protein prescription diet, probiotic therapy, and consider a GI Panel to Texas A&M for a qualitative fPLI/TLI, cobalamin and folate. If the patient improves with treatment for pancreatitis, cholangiohepatitis, and IBD then treatment should be continued. If there's minimal improvement then ultimately biopsies of the GI tract, liver, etc. may be warranted. Additionally, you could consider repeat imaging looking for the progression of these changes and/or a contrast CT scan to further assess.

There are changes consistent with chronic renal disease. Correlate with a urinalysis, blood pressure, and urine culture. If an acute on chronic episode is suspected, consider diuresis.

There's a large inguinal hernia with bowel and abdominal contents passing into and out of the herniated space. If this is a chronic finding continued monitoring could be considered. If there has been trauma or other surgical evaluation may be warranted. Close monitoring for bowel strangulation is recommended.

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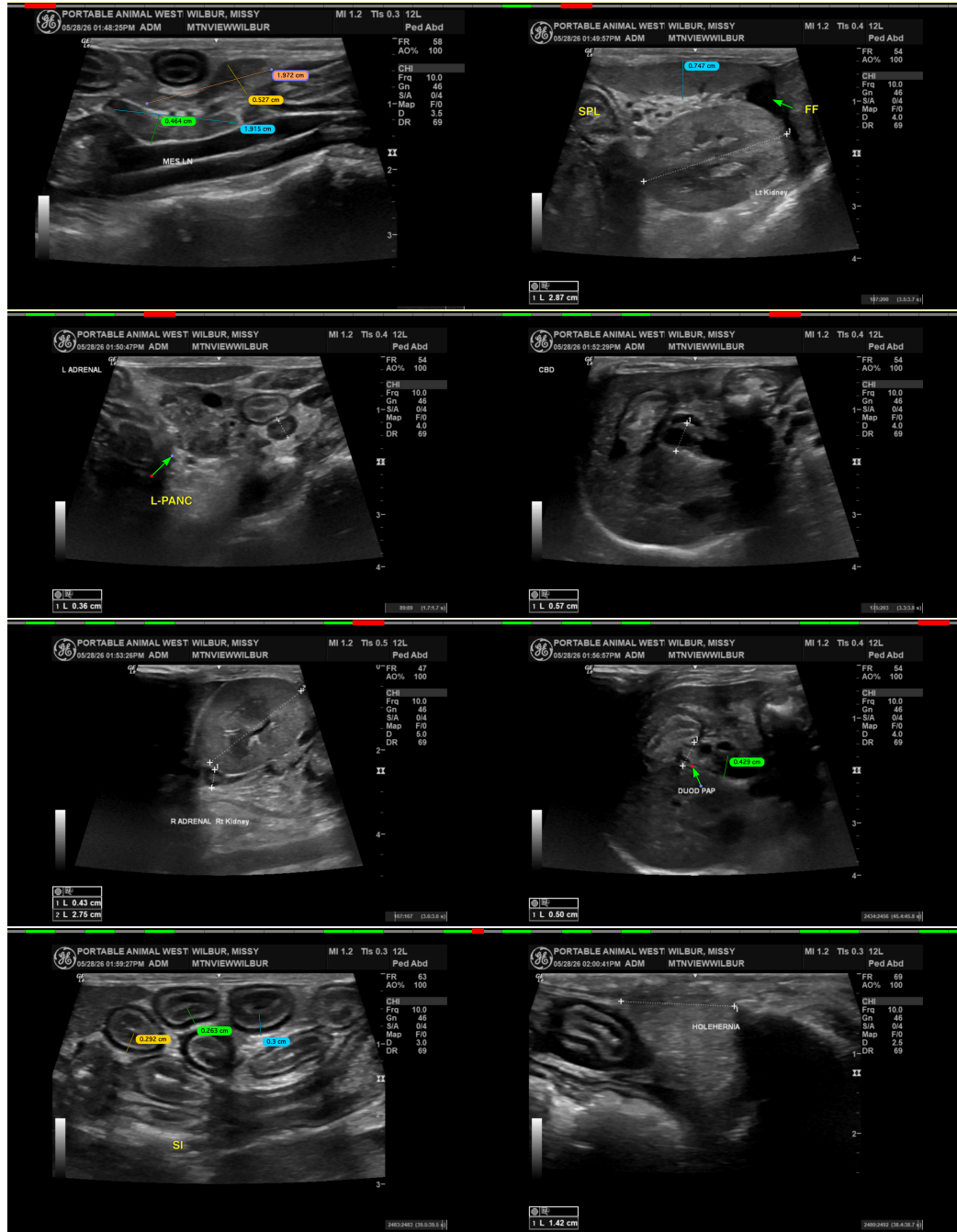
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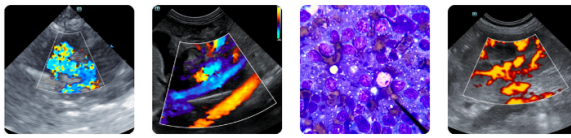
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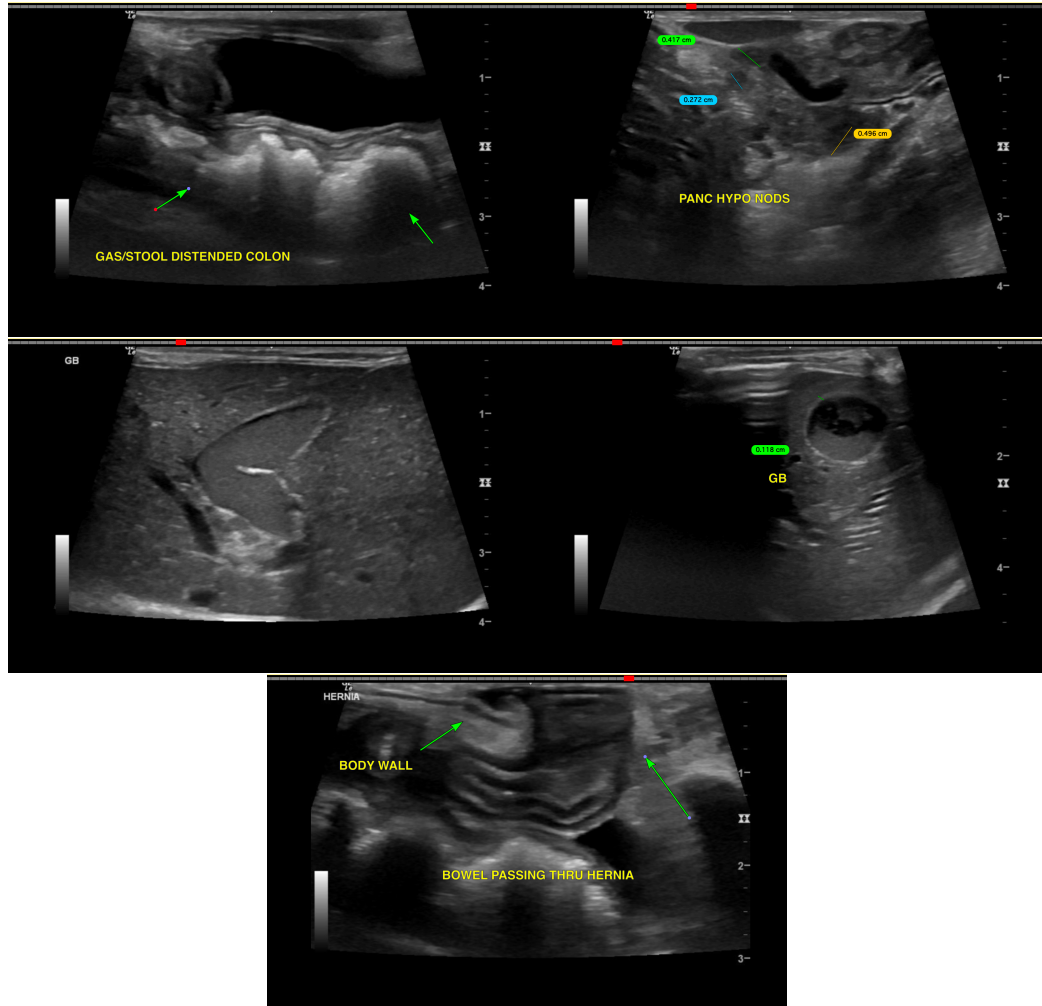
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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