



## PATIENT

Neo Abram

## SPECIES

Feline

## BREED

Domestic Shorthair

## SEX

Neutered male

## AGE

15 years

## WEIGHT

13.7 lbs

## INTERPRETED BY

Dr. Alicia Angosto  
Guerrero

## IMAGING PERFORMED BY

Quinn Robinson RVT

## HOSPITAL NAME

Hess Ridge AH

## REFERRING VET

Dr. Vaccari

## INVOICE

70183

## DATE

1/15/26

## PRESENTING CLINICAL SIGNS

History: -Senior bloodwork done 1/5/26 showed azotemia and hypercalcemia. -O elects abdominal ultrasound over malignancy profile. -Also mildly elevated ALT. Patient was initially seen for a lameness but O does note PU/PD and gradual weight loss.

Abnormal PE/Chem/CBC/UA Results: CBC: Eos 172 (209-1,214), Plts 563k (100-440k) Chem27: SDMA 15 (0-14), Creat 3.5 (0.9-2.3), BUN 41 (16-37), Ca 14 (8.2-11.2), ALT 166 (27-158) UA: USG 1.016, pH 5.5 (6-7.5), no protein UPC: Not indicated T4: 1.9

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder is normally distended. The urinary bladder wall appears thin, smooth, and regular. The bladder lumen contains predominantly anechoic urine with a small amount of dependent sediment/mineralized material. The bladder neck and proximal urethra are unremarkable. There is no sonographic evidence of urolithiasis or inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 3.23×2.11 cm, with a cortical thickness of 0.31 cm in the sagittal plane. The renal cortex is isoechoic relative to the liver parenchyma. Corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler evaluation demonstrates normal renal perfusion.

The right kidney is normal in shape and size, measuring 3.41×2.58 cm, with a cortical thickness of 0.34 cm in the sagittal plane. The renal cortex is isoechoic relative to the liver parenchyma. Corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler evaluation demonstrates normal renal perfusion.

### Adrenal Glands

Both adrenal glands demonstrate normal shape and echogenicity. The left adrenal gland measures approximately 0.20 cm at the cranial pole and 0.23 cm at the caudal pole. The right adrenal gland measures approximately 0.34 cm at the cranial pole and 0.26 cm at the caudal pole.

### Spleen

The spleen measures approximately 1.08–1.50 cm in thickness. The splenic parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture without focal lesions. The splenic capsule is smooth and regular.

### Liver

The liver is subjectively normal in size, with sharp margins and a smooth contour. The hepatic parenchyma is uniform and isoechoic relative to the falciform fat, with normal echotexture. No hepatic lymphadenopathy is identified.



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The gallbladder is normally distended. The gallbladder wall is thin, and the lumen contains predominantly anechoic bile. There is no sonographic evidence of dilation of the cystic duct or common bile duct.

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### *Gastrointestinal*

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The stomach is empty and folded, with a mural thickness of approximately 1.87 mm and preserved wall layering. The duodenum measures approximately 2.23 mm.

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The jejunum measures approximately 2.01–2.59 mm, with preserved wall layering:

- Mucosa: 1.33 mm, Submucosa: 0.47 mm, Muscularis propria: 0.22 mm

The ileum measures approximately 1.54 mm, with preserved wall layering:

- Mucosa: 0.46 mm, Submucosa: 0.56 mm, Muscularis propria: 0.28 mm

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The ileocecal junction is not visualized.

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No sonographic evidence of gastrointestinal inflammation, ileus, or foreign material is identified.

The colon measures approximately 0.84 mm, with formed fecal material present in the descending colon.

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### *Pancreas*

The pancreas itself is not directly visualized; however, the pancreatic regions evaluated do not demonstrate sonographic evidence of overt inflammation.

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### *Peritoneal Cavity*

No abdominal effusion or sonographic evidence of peritonitis is observed. Cranial mesenteric and ileocecal lymph nodes are not visualized, and the surrounding regions appear unremarkable. The iliac trifurcation is normal.

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## ULTRASONOGRAPHIC FINDINGS

- Mild urinary sediment.

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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The abdominal ultrasound does not identify a focal mass, lymphadenopathy, or organ-specific infiltrative process to account for a malignant cause of hypercalcemia. The kidneys are normal in size and architecture with preserved corticomedullary definition, indicating no sonographic evidence of advanced chronic kidney disease, despite the documented azotemia and low urine specific gravity. This discordance supports functional renal insufficiency rather than end-stage structural disease.



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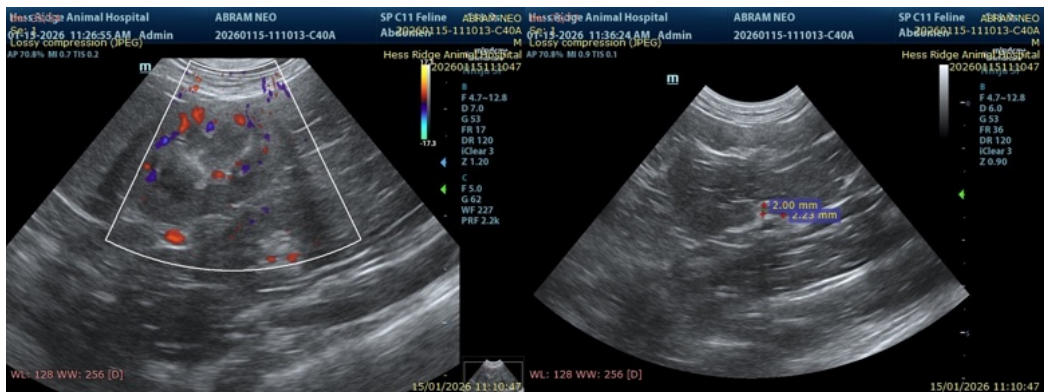
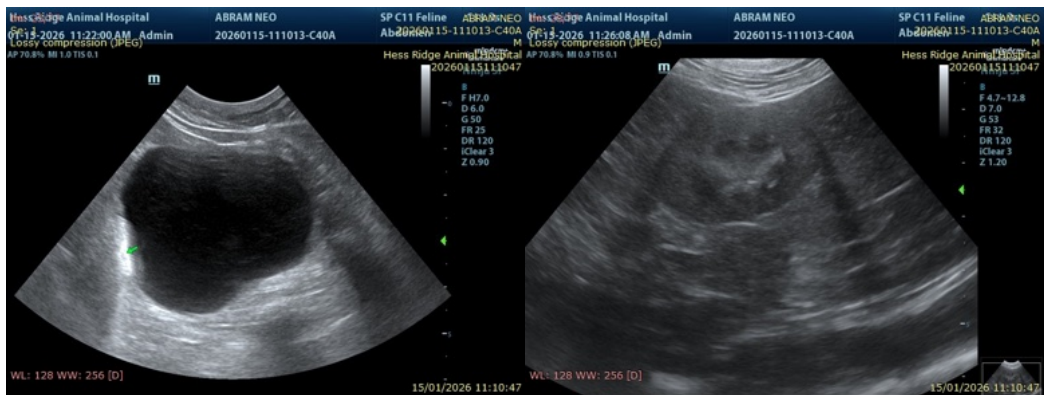
1/15/26

The absence of abdominal masses, lymphadenopathy, or intestinal mural abnormalities argues against an abdominal neoplastic process detectable by ultrasound as the cause of hypercalcemia. The liver and the gallbladder are unremarkable, and there is no evidence of biliary obstruction or hepatic infiltration to explain the mild ALT elevation.

Overall, imaging findings support systemic metabolic disease with secondary renal involvement, rather than primary abdominal malignancy.

**Recommendations**

- Further investigation for non-abdominal causes of hypercalcemia is recommended (ionized calcium confirmation, PTH/PTHrP testing if clinically appropriate).
- Correlation with renal parameters over time is advised, including serial assessment of serum creatinine, SDMA, urine specific gravity, and evaluation for proteinuria (only if indicated).
- Given the presence of conspicuous mineral-appearing urinary sediment, a complete urinalysis with sediment examination is recommended to characterize crystal type, even though this finding is unlikely to account for the patient's hypercalcemia or renal dysfunction.
- Thoracic imaging may be considered if further investigation confirms persistent, non-renal-associated hypercalcemia.





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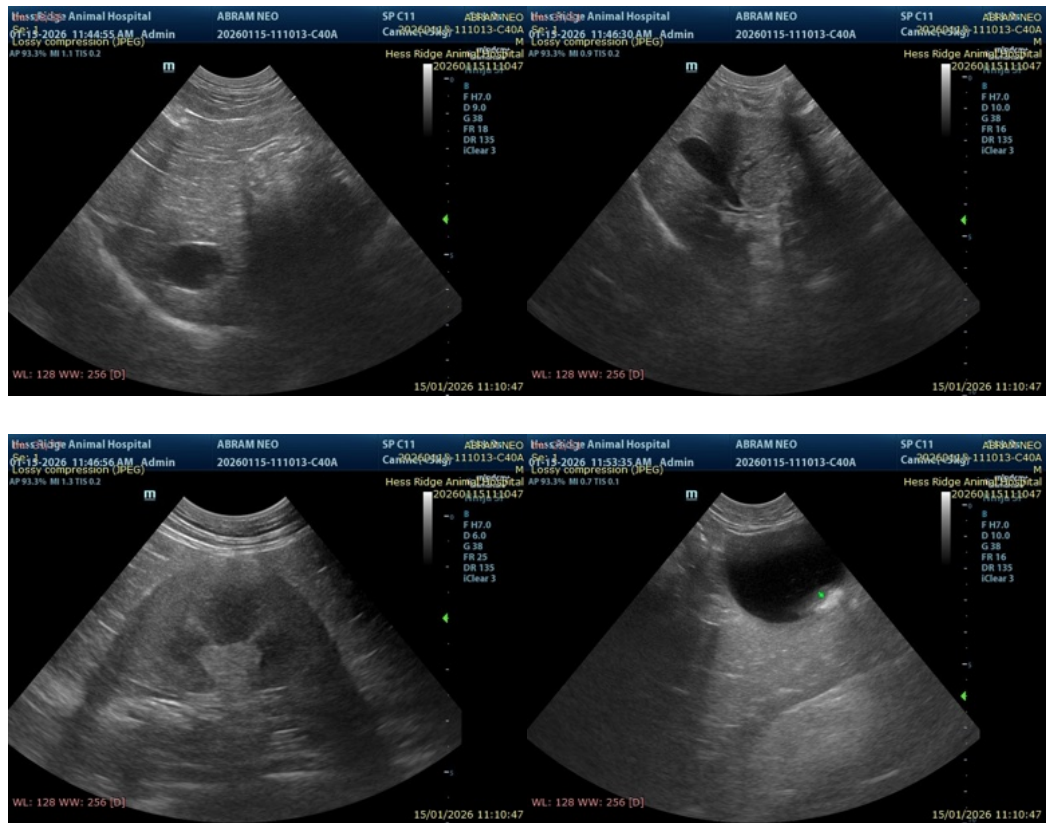
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

MV Esp Ultrasound in Domestic and Wild Animals

[info@SonoPath.com](mailto:info@SonoPath.com)