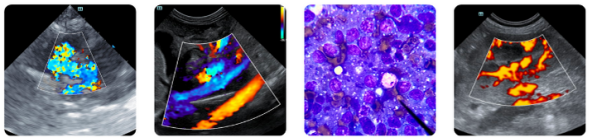

PATIENT

Toffee Nifong-Schnell

SPECIES

Feline

BREED

Domestic Medium Hair

SEX

Spayed Female

AGE

12.6

WEIGHT

10.07

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Renee Ziegler Post

HOSPITAL NAME

For Cats Only Veterinary Clinic

REFERRING VET

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PRESENTING CLINICAL SIGNS

Elevation in the ALT (319).

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The bladder wall is thin and smooth. The urine is turbid, with abundant suspended echogenic material. The bladder neck and proximal urethra appear normal. No uroliths are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic disease.

The left kidney is normal in size, measuring 3.36×1.92 cm, but is mildly irregular in contour. Cortical thickness measures 0.35 cm in the sagittal plane. The renal cortex is isoechoic relative to the liver parenchyma. At the cranial pole, there is a focal hyperechoic lesion causing a distinct cortical indentation/notch. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler evaluation demonstrates a normal vascular pattern.

The right kidney is normal in shape and size, measuring 3.76×2.23 cm, with a cortical thickness of 0.37 cm in the sagittal plane. The renal cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler evaluation demonstrates a normal vascular pattern.

Adrenal Glands

The left adrenal gland measures 0.23 cm at the cranial pole and 0.27 cm at the caudal pole. The right adrenal gland is not visualized.

Spleen

Splenic thickness measures 1.02 cm. The splenic parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

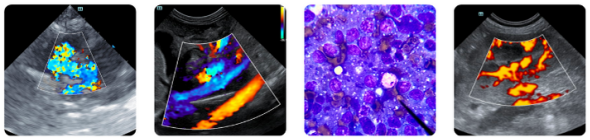
The liver is subjectively normal in size, with sharp margins and a regular contour. The hepatic parenchyma is uniform and isoechoic relative to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The gallbladder wall is thin, and the contents are primarily anechoic. No dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty and mildly folded, with preserved wall layering; wall thickness measurements are not recorded. The pylorus is not measured.

The duodenum measures 1.38 mm. A focal segment of the duodenum demonstrates mild localized luminal dilation without proximal intestinal dilation, obstructive pattern, wall thickening, or loss of wall layering. This finding is considered nonspecific and may represent transient spasm or focal motility



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change.
The jejunum measures 1.82 mm, with the following wall layer measurements: mucosa 1.10 mm, submucosa 0.39 mm, and muscularis propria 0.35 mm.
The ileum measures 1.44–1.61 mm, with mucosa 0.77 mm, submucosa 0.53 mm, and muscularis propria 0.33 mm; wall layering is preserved.

The ileocecal junction measures 2.50 mm, with a muscularis thickness of 0.74 mm. No evidence of gastrointestinal obstruction, ileus, or foreign material is identified.

The colonic wall measures 0.58 mm, with formed fecal material present in the descending colon.

Pancreas

The pancreas is not directly visualized. The pancreatic regions that were assessed do not demonstrate ultrasonographic evidence of inflammation.

Free Abdomen

No abdominal effusion or evidence of peritonitis is observed. The ileocecal lymph nodes measure approximately 3.90–4.11 mm in thickness and have normal shape and echogenicity. The cranial mesenteric lymph node measures 1.86×0.55 mm, with normal shape and a preserved architecture characterized by a mildly hypoechoic cortex (reactive appearance). The iliac trifurcation appears normal.

PRIMARY FINDINGS

- Focal hyperechoic cortical lesion with indentation at the cranial pole of the left kidney, most consistent with chronic scarring/fibrosis.

SECONDARY FINDINGS

- Turbid urinary bladder contents.
- Mild, focal, non-obstructive duodenal luminal dilation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Abdominal ultrasonography does not reveal primary hepatobiliary structural disease. The liver is normal in size and echotexture, with no biliary dilation or hepatic lymphadenopathy. As such, the ALT elevation cannot be explained by ultrasonographic hepatic abnormalities, and functional or microscopic hepatocellular disease (inflammatory, metabolic, or toxic processes) remains possible and cannot be excluded by imaging.

Left renal appearance is most consistent with chronic scarring or fibrosis, such as from prior infarction, focal chronic inflammation, or resolved insult, rather than an active renal mass. The absence of pelvic dilation, vascular distortion, or mass effect supports a chronic, inactive process.

The urinary bladder contains turbid urine with suspended echogenic material in the presence of a smooth, thin wall, consistent with benign urinary sediment (mucus, cellular debris, or microscopic crystals), rather than cystitis or neoplasia.

The gastrointestinal tract demonstrates normal wall thickness and preserved layering throughout. A small focal area of duodenal luminal dilation without obstructive pattern is identified and is considered

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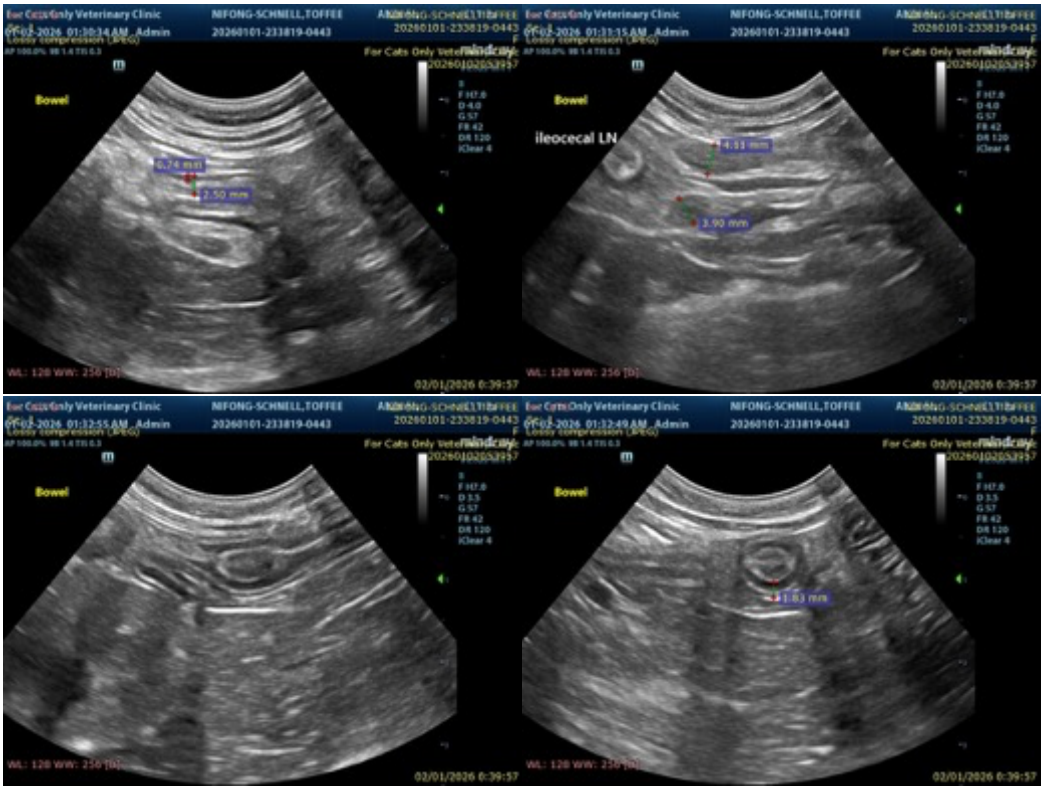
nonspecific, most consistent with transient motility change rather than foreign material or structural disease.

Ileocecal lymph nodes are within normal size limits and maintain normal shape and echogenicity. Mild thickening with cortical hypoechogenicity of the cranial mesenteric lymph node is interpreted as reactive and not suggestive of infiltrative or neoplastic disease.

Recommendations

- Correlate ALT with full liver chemistry (ALP, bilirubin, cholesterol, bile acids if indicated).
- Correlate renal ultrasound findings with serum creatinine, SDMA, and urinalysis (including urine specific gravity and UPC if not already performed).



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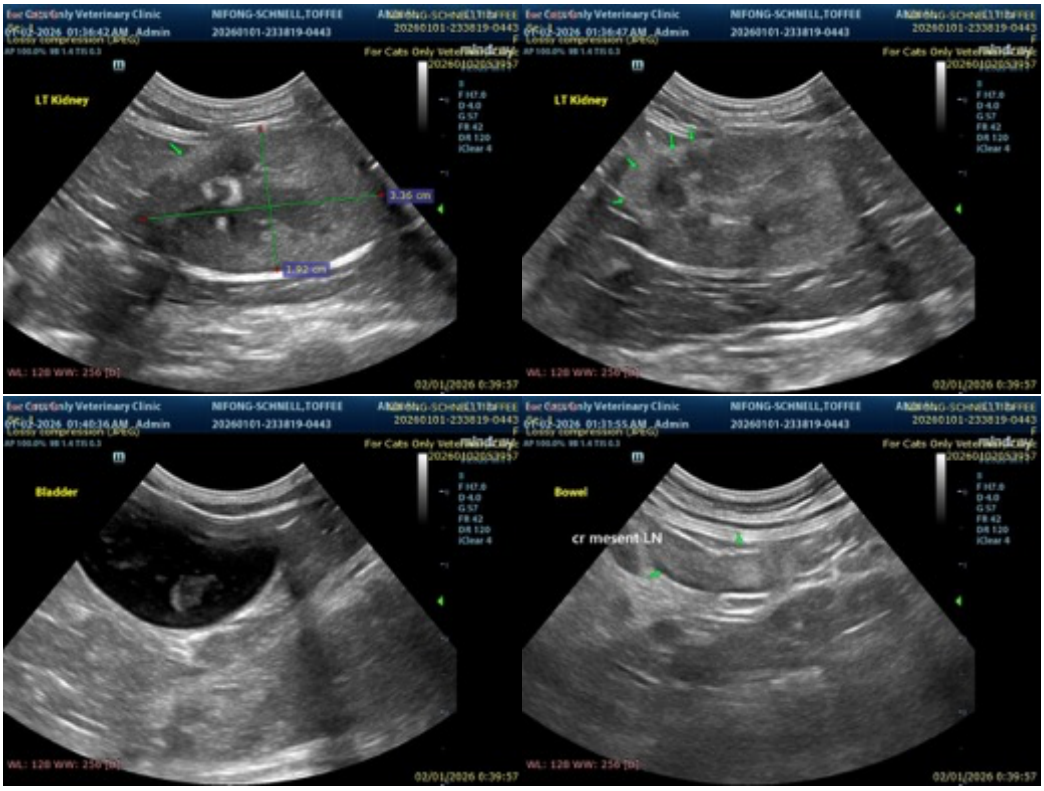

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com