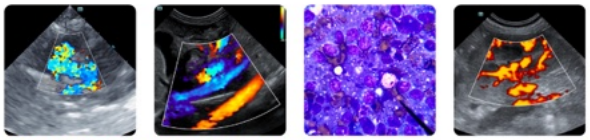


PATIENT

Squeak Clarke

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

16 years

WEIGHT

8.9 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Michele Pfannenstiel

HOSPITAL NAME

Mill Brook AC VBF

REFERRING VET

Dr. Pfannenstiel

INVOICE

70866

DATE

1/22/26

PRESENTING CLINICAL SIGNS

- significant weight loss (~8%), inappetence, increased urination, and increased thirst
- Hematology: mild non-regenerative anemia (Hematocrit 29.2%) and mild thrombocytosis (Platelets 490 K/uL). Chemistry: marked azotemia (BUN 47 mg/dL, Creatinine 3.7 mg/dL, SDMA 21 ug/dL). IDEXX Cystatin B was elevated (377 ng/mL), GGT was mildly elevated (9 U/L). Urinalysis (Cystocentesis): Specific Gravity 1.019, proteinuria (1+), pyuria (WBC 30-50/HPF), and marked bacteriuria (rods >40/HPF). Endocrinology: Total T4 was within normal limits (2.0 ug/dL). Cardiac: Cardiopet proBNP was elevated (107 pmol/L) MAP 132

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is markedly distended. The bladder wall is thin and smooth. The urine is predominantly anechoic with scant suspended echogenic debris. The bladder neck and proximal urethra appear normal. No uroliths are identified, and there is no sonographic evidence of inflammatory or neoplastic bladder wall changes.

The left kidney is normal in shape and size (2.56×1.85 cm). The right kidney is normal in shape and size (2.53×1.99 cm); At the caudal pole of the right kidney, a triangular, markedly hyperechoic focal lesion is identified, compatible with a chronic, fibrotic renal infarct. In both kidneys, the renal cortex is mildly hyperechoic relative to the liver parenchyma, with reduced corticomedullary distinction. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler evaluation suggests globally reduced renal perfusion, consistent with chronic low renal blood flow in an elderly patient with chronic kidney disease. Subjectively decreased perfusion of the left kidney relative to the right is noted, though technical factors may contribute to this apparent asymmetry.

Adrenal Glands

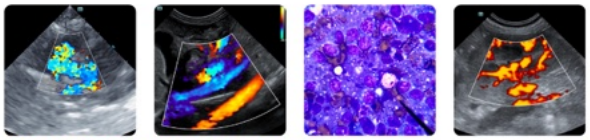
The adrenal glands are not visualized, limiting adrenal assessment.

Spleen

Splenic thickness is 0.66 cm. The splenic parenchyma demonstrates normal echogenicity and fine, homogeneous echotexture without focal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with a mildly irregular contour. The hepatic parenchyma is uniform and isoechoic to falciform fat, with normal echotexture. A multicystic lesion measuring approximately 3.5×2.0 cm is identified in the cranial abdomen, adjacent to the stomach and possibly arising from the left lateral hepatic lobe. Visualization is limited, and the lesion is not fully included within the imaging field. Its origin, extent, and anatomic continuity cannot be definitively determined, as only limited cine loops are available and a targeted evaluation of this structure was not performed.



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The gallbladder is normally distended. The wall is thin. Luminal contents are primarily anechoic. No dilation of the cystic duct or common bile duct is identified.

Gastrointestinal

The stomach contains ingesta. Gastric wall thickness measures approximately 1.24 mm, with preserved wall layering.

The pylorus measures approximately 2.62 mm.

The duodenum measures approximately 1.78 mm.

The ileum measures approximately 1.34 mm, with preserved wall layering.

At the ileocecal junction, there is a marked focal mural thickening measuring up to approximately 1.4 cm in total wall thickness, predominantly involving the muscularis layer. The mucosal and submucosal layers remain distinguishable, and the expansion is predominantly outward rather than intraluminal. Each wall segment is estimated to measure approximately 0.50–0.70 cm, and the lesion extends over an estimated length of approximately 2.30 cm, though its full extent is not completely visualized.

No sonographic evidence of intestinal obstruction, ileus, or foreign material is identified.

The colon measures approximately 0.89 mm in wall thickness and contains minimal luminal content.

Pancreas

The pancreas is not visualized, limiting pancreatic assessment.

Peritoneal Cavity

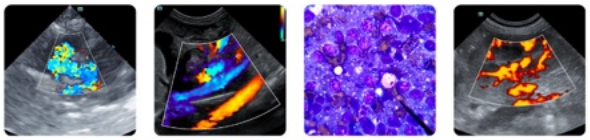
A small volume of abdominal effusion is present, noted in the rectovesical recess and between hepatic lobes.

Several abdominal lymph nodes are mildly enlarged (up to approximately 0.5 cm in diameter), rounded, and hypoechoic.

The iliac trifurcation appears normal.

ULTRASONOGRAPHIC FINDINGS

- Bilateral renal cortical hyperechogenicity with reduced corticomedullary definition.
- Focal triangular hyperechoic lesion at the caudal pole of the right kidney (chronic renal infarct).
- Multicystic cranial abdominal lesion, possibly hepatic in origin, incompletely characterized.
- Severe focal ileocecal wall thickening with muscularis predominance and outward expansion.



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- Abdominal effusion.
- Mildly enlarged, rounded, hypoechoic abdominal lymph nodes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Renal changes, including mild bilateral cortical hyperechogenicity and reduced corticomedullary definition, are consistent with chronic kidney disease in the context of marked azotemia, isosthenuria, and elevated renal biomarkers. The focal triangular hyperechoic lesion at the caudal pole of the right kidney is most compatible with a chronic, fibrotic renal infarct, particularly given its morphology and the absence of features suggestive of active inflammation or obstruction. Doppler findings of globally reduced renal perfusion further support chronic renal insufficiency.

At the urinary bladder, no sonographic evidence of cystitis or obstructive uropathy is identified.

A multicystic cranial abdominal lesion, possibly hepatic in origin, represents a significant but incompletely characterized finding. Due to limited visualization and lack of targeted assessment, its anatomic origin and biological behavior cannot be determined, and further characterization is required before clinical significance can be assigned.

The ileocecal junction demonstrates severe focal mural thickening with muscularis predominance and outward expansion, a pattern that is highly suspicious for a focal intestinal mass lesion. Given the degree of thickening, focality, associated lymph node changes, and the patient's systemic decline, neoplasia is a realistic and important consideration, although ultrasonography alone cannot establish a definitive diagnosis.

The presence of small-volume abdominal effusion and mildly enlarged, rounded, hypoechoic lymph nodes may reflect reactive change or neoplastic involvement and should be interpreted in the context of the ileocecal lesion.

Recommendations

- Given the marked focal ileocecal thickening and lymph node changes, pursue definitive diagnostic sampling (surgical biopsy or image-guided sampling where appropriate) to establish a diagnosis, as imaging alone is insufficient.
- Further characterize the multicystic cranial abdominal lesion.
- Monitor the small-volume abdominal effusion, with cytologic evaluation considered if the volume increases or if clinical signs progress.
- Continue to integrate imaging findings with ongoing laboratory monitoring and clinical response, given the multisystemic nature of the disease.

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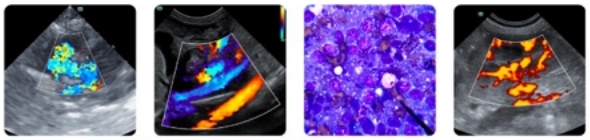

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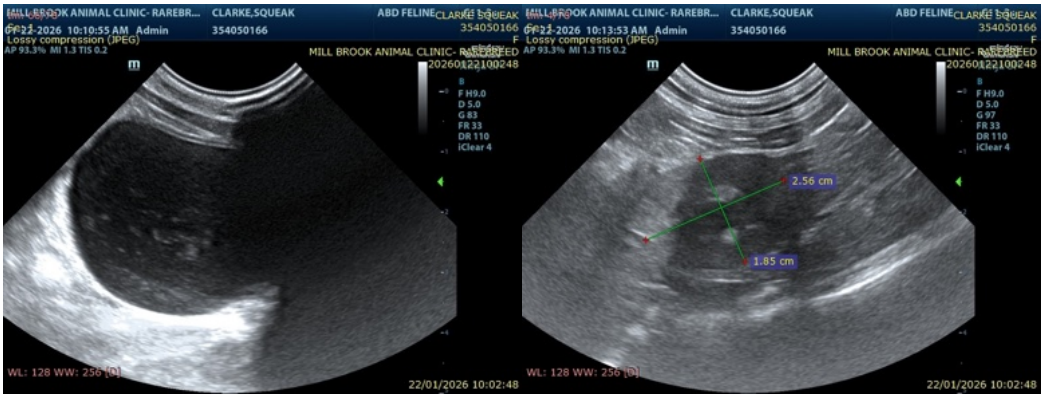

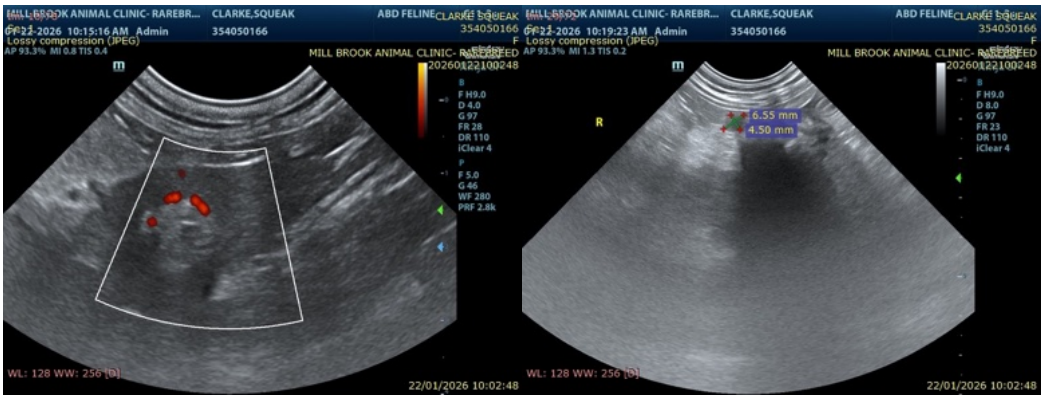

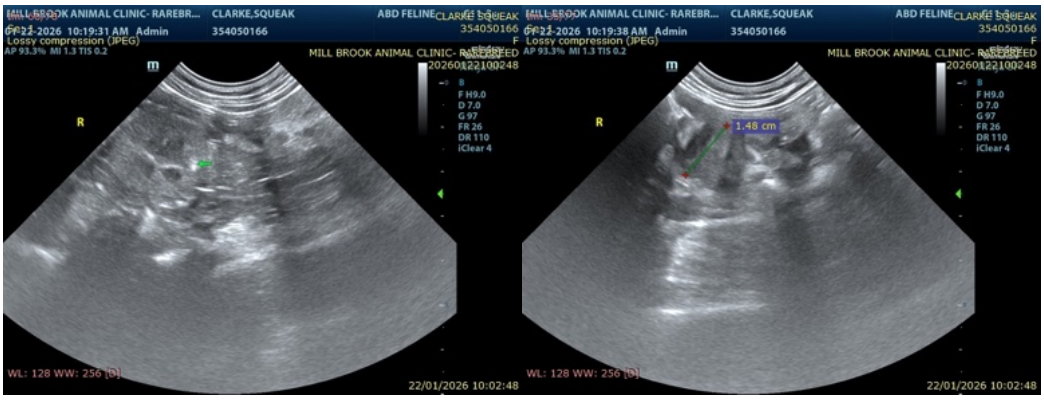

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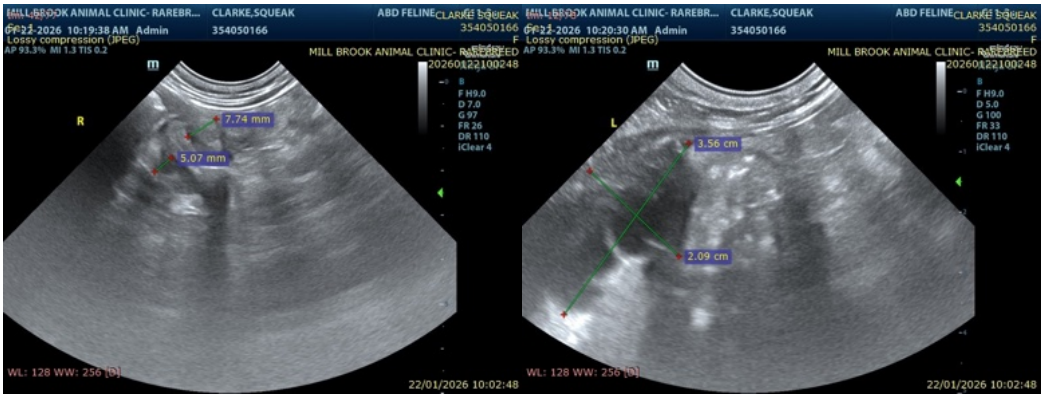

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

MV Esp Ultrasound in Domestic and Wild Animals

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