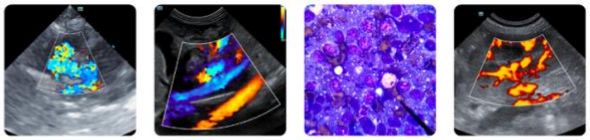


PATIENT

Gabriel Coleman

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

15 Years

WEIGHT

13.56 pounds

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Kelly Vida

HOSPITAL NAME

Sherrills Ford Animal Hospital

REFERRING VET

Dr. Kelly Vida

INVOICE

13478

DATE

01/30/26

PRESENTING CLINICAL SIGNS

- Acute onset of vocalizing and lethargy
- History CKD IRIS Stage 2
- On renal diet with improvement in azotemia
- Weight loss appreciated

Abnormal PE/Chem/CBC/UA Results: Mild anemia on lab work (Hct 28%) Abdominal pain (+/- back pain?) suspected and mild nausea Vocalizing when picked up

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The bladder wall is thin and smooth. Urine is predominantly anechoic with scant mineral sediment without distal acoustic shadowing. The bladder neck and proximal urethra appear normal. No uroliths or ultrasonographic evidence of inflammatory or neoplastic disease are identified.

The left kidney measures 3.13×2.45 cm, with a cortical thickness of 0.29 cm in the sagittal plane. The renal cortex is diffusely hyperechoic relative to the liver parenchyma. A well-defined, triangular hyperechoic cortical lesion is present, along with two additional, less distinct hyperechoic cortical areas of uncertain significance. The corticomedullary ratio is within normal limits, and corticomedullary distinction is preserved. A medullary band is present. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

The right kidney measures 4.36×2.72 cm, with a cortical thickness of 0.46 cm in the sagittal plane. Renal shape is normal. The cortex is diffusely hyperechoic relative to the liver parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. A medullary band is present. No pyelectasia or hydronephrosis is identified. A nephrolith measuring 3.80 mm is present, with additional small mineral foci consistent with developing nephroliths. There is a mild increase in echogenicity of the perirenal fat.

Adrenal Glands

The left adrenal gland measures 0.23 cm at the cranial pole and 0.25 cm at the caudal pole and appears within normal limits. The right adrenal gland is not visualized.

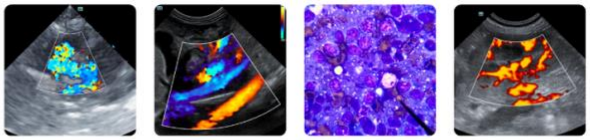
Spleen

Splenic thickness is 0.85 cm. The parenchyma has normal echogenicity and a fine, homogeneous echotexture. No focal lesions are identified. The splenic capsule is smooth and regular.

Liver

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

The gallbladder is normally distended. The gallbladder morphology is consistent with a septated (bilobed) appearance. The gallbladder wall is thin. The lumen contains a moderate amount of biliary sludge. The common bile duct measures 3.05 mm proximally and 1.16 mm distally.



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Gastrointestinal

The stomach is partially empty and contains residual ingesta and fluid. Gastric wall thickness is 1.48 mm, with preserved wall layering. The pyloric wall measures 3.54 mm.

The duodenum measures 1.85 mm in thickness and contains a small amount of luminal fluid. The jejunum measures 1.98–2.02 mm in thickness, with preserved wall layering. No ultrasonographic evidence of gastrointestinal inflammation, ileus, or foreign material is identified.

The colon wall measures 0.56 mm and contains formed fecal material within the descending colon.

Pancreas

The evaluated pancreatic areas do not show evidence of overt inflammation.

Free Abdomen

A very small volume of abdominal effusion in the retroperitoneal fat, is observed. Cranial mesenteric and ileocecal lymph nodes are not visualized; the surrounding regions appear unremarkable. The iliac trifurcation appears normal.

PRIMARY FINDINGS

- Renal cortical hyperechogenicity with cortical thinning. Focal triangular hyperechoic cortical lesion and additional ill-defined hyperechoic cortical areas in the left kidney.
- Right renal nephrolith (3.80 mm) with additional developing mineral foci. Mildly increased echogenicity of right perirenal fat.
- Mineral intravesical sediment without distal acoustic shadowing

SECONDARY FINDINGS

- Septated (bilobed) gallbladder morphology with moderate biliary sludge.
- Small volume abdominal effusion.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The ultrasonographic findings are most consistent with chronic bilateral renal disease. These findings align with the patient's known history of IRIS Stage 2 chronic kidney disease. The triangular hyperechoic cortical lesion within the left kidney, represents chronic cortical scarring or prior infarction. The presence of a right renal nephrolith with additional developing mineral foci, accompanied by mildly increased perirenal fat echogenicity and small volume of abdominal effusion, raises suspicion for localized chronic irritation or inflammatory change, although there is no evidence of obstruction, hydronephrosis, or pyelectasia at this time. These findings may be clinically relevant in the context of vocalization, suspected abdominal or lumbar discomfort.

The presence of conspicuous mineral intravesical sediment, in conjunction with right renal nephrolithiasis and developing mineral foci, indicates an active urinary mineral precipitation process.

The gallbladder demonstrates a septated (bilobed) morphology with moderate biliary sludge and a common bile duct diameter that remains within acceptable limits for a geriatric cat. This may reflect biliary stasis, which can be incidental or associated with chronic systemic disease, anorexia, or nausea. There is no ultrasonographic evidence of extrahepatic biliary obstruction.

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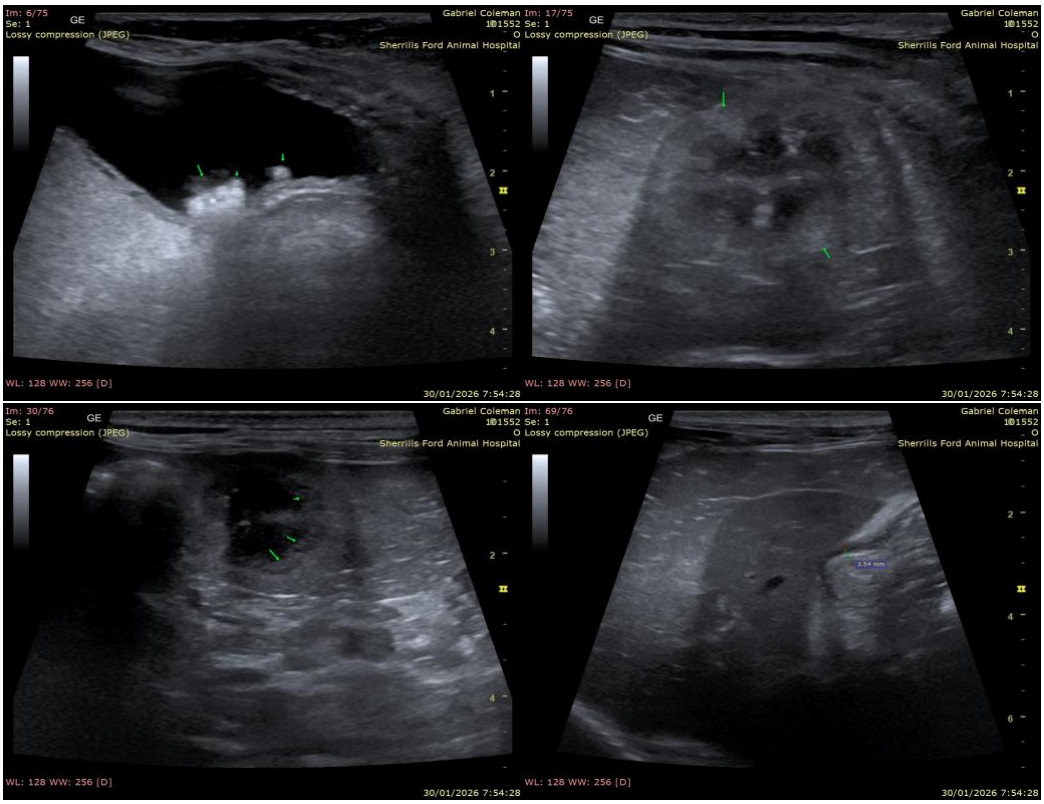
The gastrointestinal tract shows preserved wall thicknesses and layering throughout the segments evaluated, with no focal or diffuse changes suggestive of active inflammatory bowel disease or neoplasia.

Recommendations

- Complete urinalysis, including urine specific gravity, sediment examination, and urine pH, is recommended to further characterize the intravesical mineral sediment and to assess for crystalluria in the context of concurrent renal nephrolithiasis and chronic kidney disease.
- Correlate renal findings with current renal values, urine specific gravity, blood pressure, and clinical signs to assess progression or complication of chronic kidney disease.
- Consider analgesic management tailored to renal patients if renal or lumbar discomfort is suspected clinically.
- Monitor the right renal nephrolith and developing mineral foci for progression or signs of obstruction; serial imaging may be considered based on clinical evolution.



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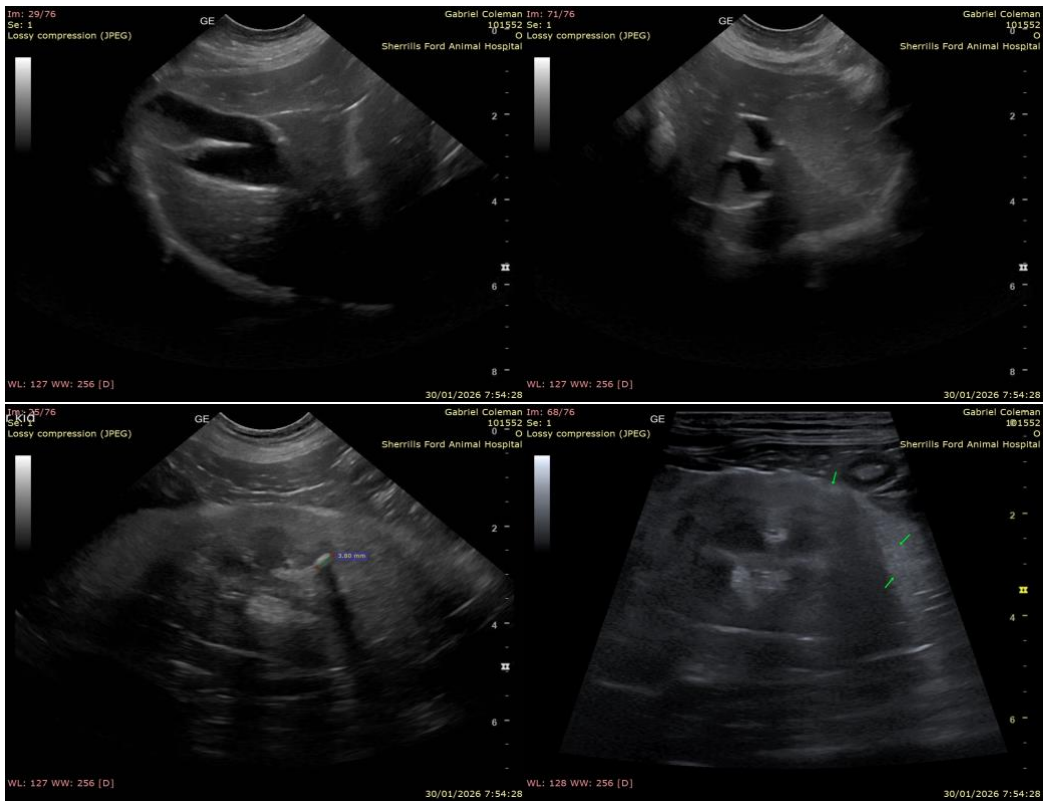

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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