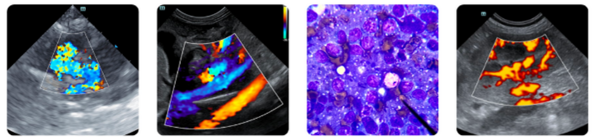


SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT
Dante De La Cerda

SPECIES
Feline

BREED
DSH

SEX
MN

AGE
15 years

WEIGHT
10.02 lbs

INTERPRETED BY
Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY
Dr. Jazmin Munoz

HOSPITAL NAME
Oakridge Veterinary Clinic

REFERRING VET
Dr. Jazmin Munoz

INVOICE
10765

DATE
11/18/2025

PRESENTING CLINICAL SIGNS

Intermitted vomiting (about once a month) with current bout of inappetence.

Abnormal PE/Chem/CBC/UA Results: BW revealed Mild eosinopenia 0.128, mild hyperproteinaemia 8.5 characterized by hyperglobulinaemia 6.6, and AST 69. Creat 1.5 probnp 177 (has HCM) USG 1.027, 1+ urine protein, rbc 30-50 TT4 1.7 FIV positive.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is very distended, and the bladder wall appears thin and smooth. The urine is slightly turbid, without visible sediment, likely due to urine concentration or mild cellularity. The proximal urethra and vesicoureteral junction appear normal. No calculi or evidence of inflammatory or neoplastic disease are identified.

The left kidney is normal in shape and size (3.74×1.92 cm), with a cortical thickness of 0.27 cm in the sagittal plane. The cortex is slightly hyperechoic relative to the liver parenchyma. Corticomedullary ratio and definition are preserved. A cystic/complex cystic nodule with mildly turbid or partially sedimented contents is present at the cranial pole, measuring 1.9×1.26 cm. No pyelectasia, nephroliths, or hydronephrosis are observed. Doppler shows normal perfusion.

The right kidney is normal in shape and size (4.14×2.05 cm), with a cortical thickness of 0.44 cm in the sagittal plane. The cortex is slightly hyperechoic compared to the liver. Corticomedullary ratio and definition are preserved. No pyelectasia, nephroliths, or hydronephrosis are seen. Doppler pattern is normal.

Adrenal Glands

The left adrenal gland was partially visualized (0.27 cm), the right adrenal gland was not clearly visualized. No abnormalities were detected in the portions imaged.

Spleen

Splenic thickness is 0.71 cm. The parenchyma has normal echogenicity and fine homogeneous echotexture without focal lesions. The capsule and vasculature appear normal.

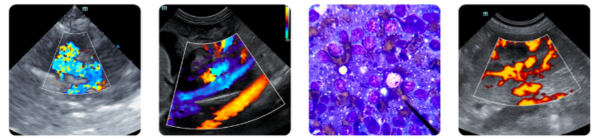
Liver

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

The gallbladder is normally distended. The wall is mildly thickened (1.22 mm), and the lumen contains a small amount of biliary sludge. No dilation of the cystic duct or common bile duct is present.

Gastrointestinal

The stomach is empty and folded, with a small amount of fluid in the lumen. Wall thickness is 2.22 mm, with preserved layering.
Pylorus: 2.99 mm
Duodenum: 1.79 mm



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Jejunum: 2.23 mm
Ileum: 2.10 mm
The ileocecal junction measures 2.19 mm with muscularis 0.39 mm.

Wall layering is preserved throughout. No signs of inflammation, ileus, or foreign material are detected.

Colonic wall: 0.97 mm, containing formed feces.

Pancreas

The pancreatic body and limbs measure 7.40–8.35 mm. The parenchyma is isoechoic to adjacent omental fat. The pancreatic duct measures 1.51 mm and is within normal limits. No signs of inflammation or neoplasia are observed.

Free Abdomen

No abdominal effusion or peritonitis is present. Cranial mesenteric lymph nodes measure 3.18 mm in thickness and appear normal in shape and echogenicity. Ileocecal lymph nodes were not visualized, but surrounding regions appear unremarkable. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Left renal complex cyst, most likely a complicated/hemorrhagic or proteinaceous cyst, currently with benign imaging features.
- Mild bilateral cortical hyperechogenicity.

SECONDARY FINDINGS

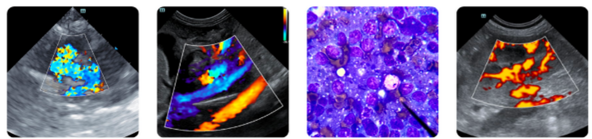
- Mild gallbladder wall thickening with biliary sludge.
- Slightly turbid urine in a markedly distended bladder.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The renal lesion identified in the cranial pole of the left kidney most likely represents a complicated (proteinaceous, hemorrhagic, or mildly inflammatory) renal cyst, given its well-defined borders, lack of solid mural components, normal surrounding parenchyma, and the absence of architectural distortion or mass effect. While a cystic neoplasm cannot be entirely ruled out, its imaging characteristics are not typical of renal tumors, which more commonly present as solid or mixed solid–cystic masses with distortion of renal contours or evidence of infiltrative behavior. At this time, the lesion's appearance is most consistent with a benign complex cyst.

The other renal findings suggest early chronic renal changes, though not advanced CKD. Creatinine is within the high-normal range for an older cat with muscle loss, and USG indicates adequate concentrating ability (making significant CKD less likely).

Mild gallbladder wall thickening and biliary sludge are common age-related findings but can also represent early cholecystitis.



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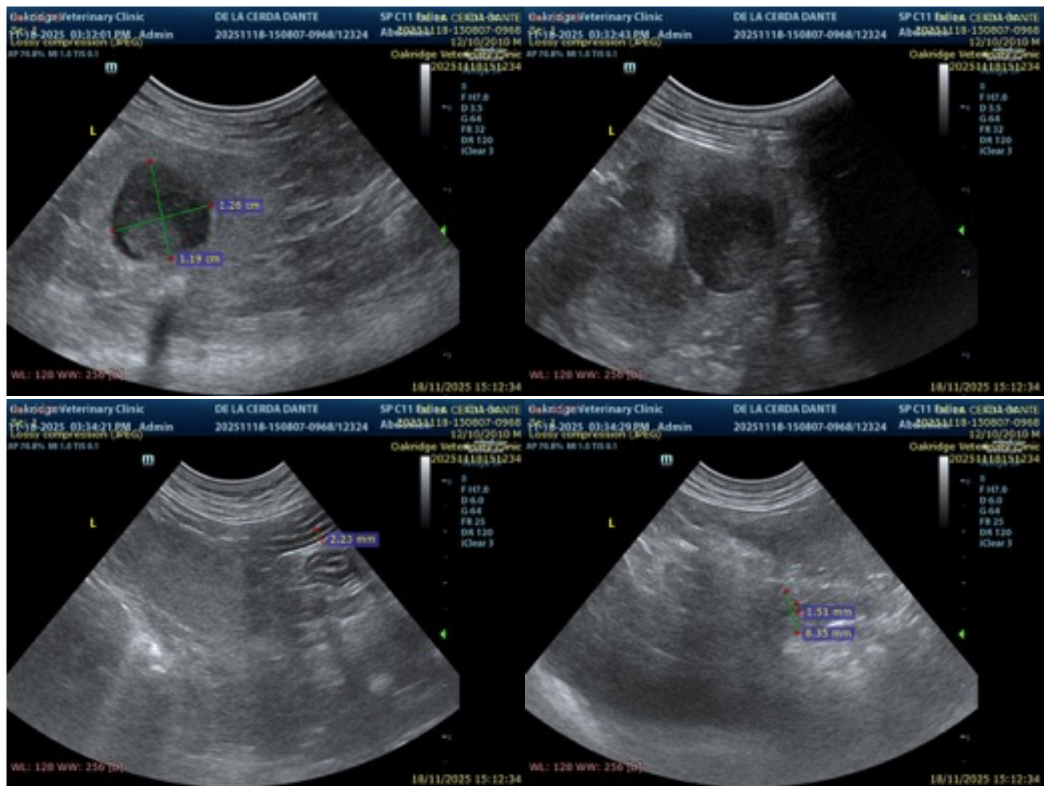
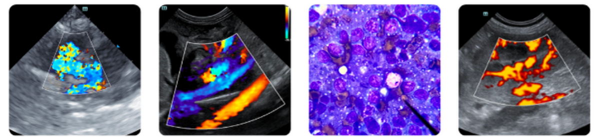
The hyperglobulinemia is likely related to chronic antigenic stimulation from FIV, though early chronic enteropathy with no ultrasonographic changes, dental disease, or occult inflammation cannot be ruled out.

Recommendations

- Follow-up ultrasonography is recommended to ensure stability, and fine-needle aspiration of the cystic content may be considered if the lesion enlarges, changes in internal structure, or if clinical signs suggest infection or neoplastic progression.
- Monitor UPC.
- Consider SPEP (serum protein electrophoresis) if hyperglobulinemia worsens (to rule out chronic inflammatory vs. gammopathy).
- Monitor AST, ALT, ALP in 3 months.
- If vomiting persists, consider:
    - Cobalamin level, diet trial, antiemetic trial (maropitant), and GI panel depending on clinical evolution.





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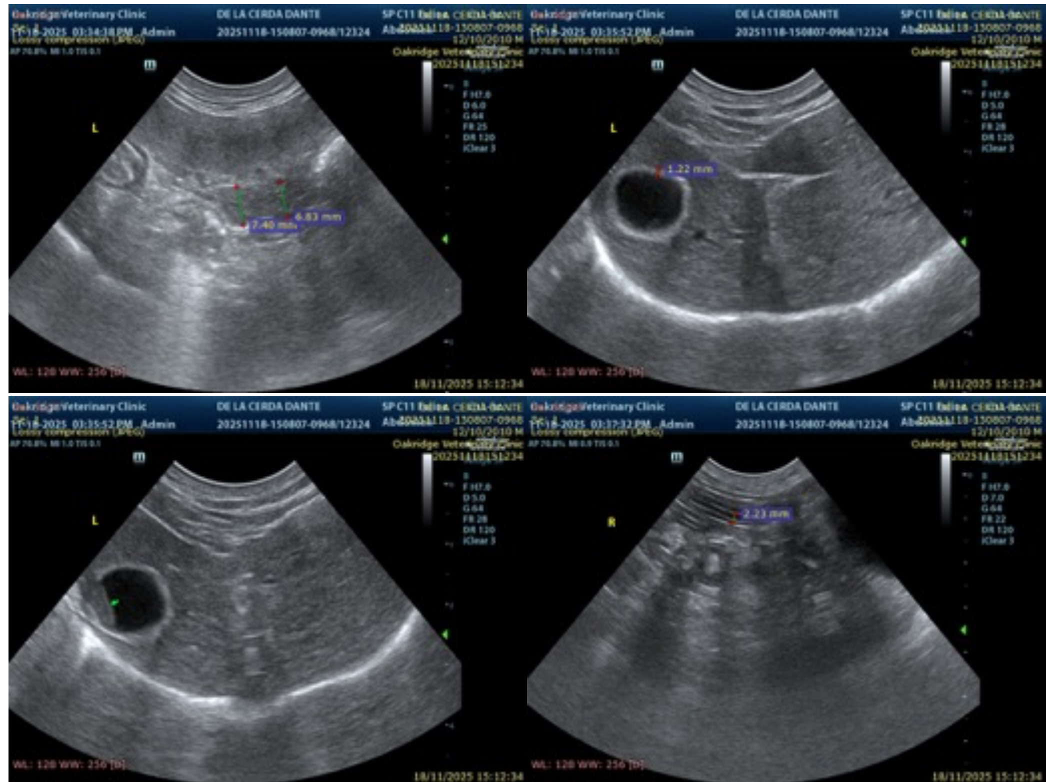

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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