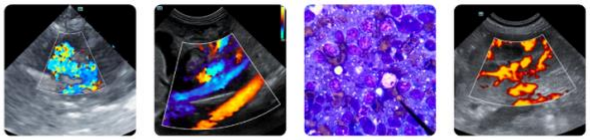


PATIENT

Cookie Stevenson

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

13 Years

WEIGHT

21.9 pounds

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Amanda Olsen VMD

HOSPITAL NAME

Limestone Veterinary Hopsital

REFERRING VET

Dr. Amanda Olsen VMD

INVOICE

12430

DATE

11/21/25

PRESENTING CLINICAL SIGNS

13 MN obese DSH with a history of constipation but has been well controlled on metoclopramide, cisapride, and miralax without a flare up in constipation in past 2 years. She presented on 11/17 after leaking diarrhea and x-rays revealed a large amount of stool. Patient received several enemas, sent out bloodwork, and added in lactulose. She passed a large amount of soft stool at home. Patient presented again 11/20 after not defecating after initial enema, but was not straining or even trying to defecate. Patient had a significant amount of soft to semi formed stool and was given another enema to facilitate visualization during AUS. Patient continues to eat well.

Abnormal PE/Chem/CBC/UA Results: CBC/Chem/T4/UA on 11/17: PSL 46, WBC 16.4, Neut 12956, Mono 656 ASSESSMENT: Neutrophilia, monocytosis, consistent with inflammation but no obvious underlying cause to constipation noted.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is anechoic. Normal appearance of the proximal urethra and vesicoureteral junction. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 4.84×3.13 cm, and the thickness of the cortex is 0.50 cm in the sagittal plane. The cortex is slightly hyperechoic. Numerous cysts are observed throughout the kidney, the largest measuring 1.22 × 1.75 cm. There is no evidence of pyelectasia, nephroliths, or hydronephrosis.

The right kidney is normal in shape and size: 5.03×3.05 cm, and the thickness of the cortex is 0.53 cm in the sagittal plane. The cortex is slightly hyperechoic. Numerous cysts are observed throughout the kidney, the largest measuring 1 cm. There is no evidence of pyelectasia, nephroliths, or hydronephrosis.

Adrenal Glands

Not visualized.

Spleen

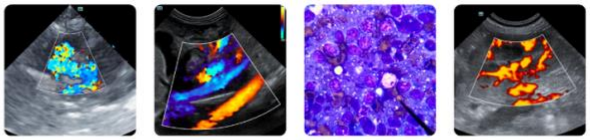
Splenic thickness is 0.86 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma presents numerous very small cysts, the largest measuring 2.9 and 5 mm. A single, much larger cyst is observed more dorsally (approximately 5×3 cm).

The gallbladder lumen is normally distended. The wall is thin and the contents are primarily anechoic with a small amount of biliary sludge. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal



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The stomach is empty and folded, with mural thickness (2.25 mm) and preserved wall layering.
Duodenum: 1.60 mm.
Jejunum: 2.18 mm.
Ileum: 1.60 mm.
Wall layering is normal.
The ileocecal junction measures 1.83 mm. No signs of inflammation, ileus, or foreign material are identified.

Colon: ascending: empty. Transverse 0.60 mm, with semi-formed feces. Descending segment 0.99 mm, with formed feces but not impacted.

Pancreas

5.91 mm diameter. The right limb, body, and left limb appear normal. The parenchyma of the pancreas is isoechoic to the adjacent omental fat. The diameter of the pancreatic duct is 0.38 mm. No signs of active inflammation or neoplastic disease are evident.

Free Abdomen

No abdominal effusion or peritonitis is observed. Cranial mesenteric lymph nodes measure 0.52 and 0.66 mm in diameter, with normal shape and echogenicity. Ileocecal lymph nodes are not visualized, but the surrounding regions appear unremarkable. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Numerous, bilateral renal cortical cysts. Mildly hyperechoic renal cortices.
- Multiple tiny hepatic cysts and one large hepatic cyst (~5 × 3 cm).

SECONDARY FINDINGS

- Ileocecal lymph nodes slightly enlarged. Normal shape and echogenicity.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most significant findings on this abdominal ultrasound are the numerous renal cortical cysts in both kidneys and multiple small hepatic cysts accompanied by a single large hepatic cyst. The pattern strongly suggests a form of polycystic kidney and liver disease, which is uncommon but well-documented in older Domestic Shorthair cats. This is often an incidental and slowly progressive condition, and most affected cats remain asymptomatic for long periods unless cysts become very large or if concurrent CKD develops.

Both renal cortices are also mildly hyperechoic, which may reflect early chronic kidney disease or age-related degenerative changes.

The liver contains innumerable microcysts and one large dorsal cyst (~5 × 3 cm). The presence of multiple tiny cysts surrounding a single dominant cyst is classic for polycystic liver disease, which often accompanies renal cystic disease in cats.

The gastrointestinal tract shows normal wall thickness, normal layering, and no evidence of ileus or constipation. The ileocecal lymph nodes are mildly enlarged and hypoechoic but retain an elongated shape, which is consistent with reactive lymphadenopathy secondary to chronic GI motility issues or mild enteritis.

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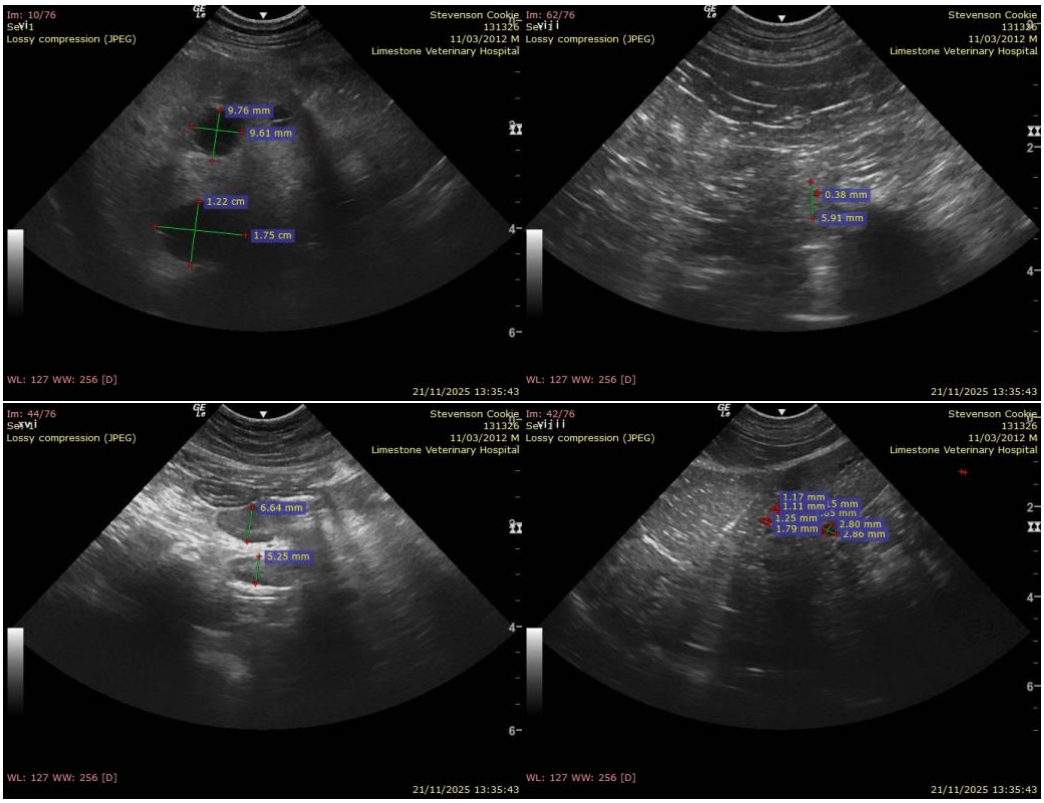
Recommendations

Kidney and liver monitoring

- Recheck renal values (BUN, creatinine, SDMA) every 3–6 months.
- Consider urinalysis and UPC to evaluate renal protein loss.

Monitor hepatic cyst

- If the large cyst increases in size or causes discomfort, consider:
    - Ultrasound-guided cyst drainage
    - Or simply observe if asymptomatic (most common).
- Encourage hydration to support motility and kidney function.
- Consider a high-fiber diet or fiber supplementation if tolerated.



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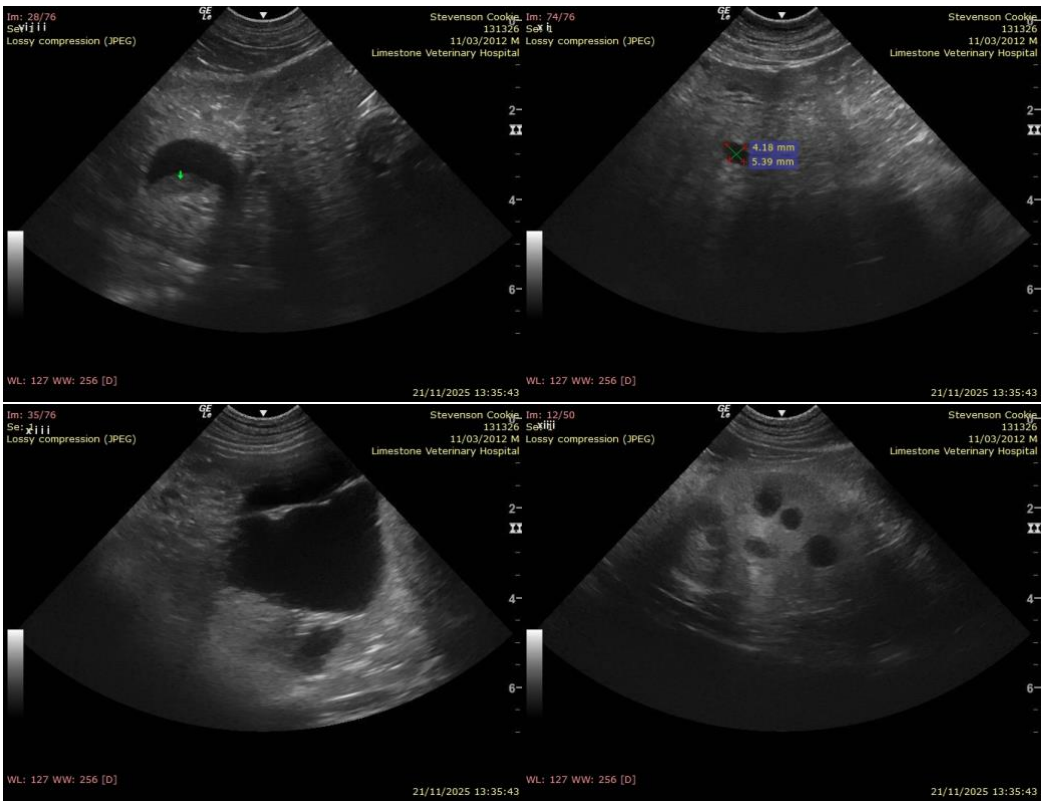

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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