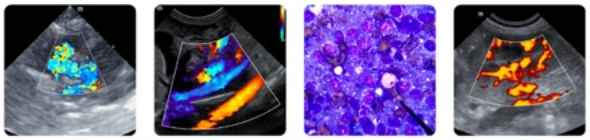




**PATIENT**

Walt Surh

**SPECIES**

Feline

**BREED**

Domestic Shorthair

**SEX**

Neutered male

**AGE**

10 years

**WEIGHT**

5.7 kg

**INTERPRETED BY**

Dr. Alicia Angosto Guerrero

**IMAGING PERFORMED BY**

Matthew Olcha

**HOSPITAL NAME**

Eat Meadow VC

**REFERRING VET**

Dr. Olcha

**INVOICE**

69576

**DATE**

12/11/25

## PRESENTING CLINICAL SIGNS

History: Presents for reduced appetite, found to have hypercalcemia, elevated liver enzymes and TBil, mild azotemia. P has a Hx of constipation and bladder stones (see last Sonopath ultrasound). Is on Purina urinary Rx diet and Cisapride 2.5mg BID.
Abnormal PE/Chem/CBC/UA Results: PE NSF Chest x-rays NSF Abnormal labs attached

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The bladder lumen is severely underfilled, and the bladder wall thickness cannot be accurately assessed due to poor distension. The urine is anechoic. The bladder neck and proximal urethra have a normal appearance. No calculi or evidence of any sediment are identified.

The left kidney is normal in shape and size (3.51 x 2.47 cm), with a cortical thickness of 0.31 cm in the sagittal plane. Image quality is limited due to low brightness, but the renal cortex appears mildly increased in echogenicity, resulting in increased corticomedullary distinction. No pyelectasia, nephroliths, or hydronephrosis are observed.

The right kidney is normal in shape and size (4.14 x 2.44 cm), with a cortical thickness of 0.35 cm in the sagittal plane. The renal cortex is mildly increased in echogenicity with enhanced corticomedullary distinction. No pyelectasia, nephroliths, or hydronephrosis are observed.

### *Adrenal Glands*

The adrenal glands were not visualized.

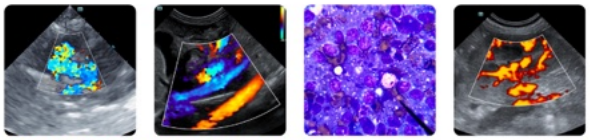
### *Spleen*

Splenic thickness is 0.77 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 parenchyma appears uniform and isoechoic relative to falciform fat, with normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is moderately distended. The wall is thin, and the contents are primarily anechoic with a small amount of biliary sludge. The cystic duct and common bile duct are not dilated (CBD diameter: 2.15–3.15 mm).





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### *Gastrointestinal*

The stomach is empty and folded, with mural thickness of 2.08 mm and preserved wall layering. The pylorus measures 3.02 mm.

Duodenum: 1.28 mm. Jejunum: 1.65 mm. Ileum: 1.53 mm. All segments show normal wall layering. The ileocecal junction is not visualized. No signs of obstruction, ileus, or foreign material are identified.

Colon wall thickness: 1.01–1.17 mm, with formed feces in the descending colon.

### *Pancreas*

The pancreas is not clearly visualized; however, the peripancreatic regions show no ultrasonographic evidence of inflammation.

### *Peritoneal Cavity*

No abdominal effusion or signs of peritonitis are observed. Cranial mesenteric and ileocecal lymph nodes are not visualized, though surrounding regions appear unremarkable. The iliac trifurcation is normal.

## ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Increased cortical echogenicity in both kidneys, with preserved size and architecture.
- Severely underfilled urinary bladder, preventing accurate wall thickness assessment.

SECONDARY FINDINGS

- Gallbladder moderately distended with a small amount of biliary sludge.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver appears normal despite the biochemical evidence of hepatocellular injury, suggesting that the hepatic enzyme elevations may be secondary rather than due to a primary structural hepatopathy. Hypercalcemia, anorexia, dehydration, or concurrent systemic illness can all lead to hepatocellular injury without producing ultrasonographic changes.

Pancreatitis or adrenal disease cannot be entirely excluded, but there is no supportive ultrasonographic evidence at this time. The gallbladder contains only a small amount of sludge, which is commonly incidental in cats.

No abdominal lymphadenopathy, masses, or effusion are identified, reducing the suspicion for abdominal neoplasia such as lymphoma or carcinoma as the source of the hypercalcemia. However,

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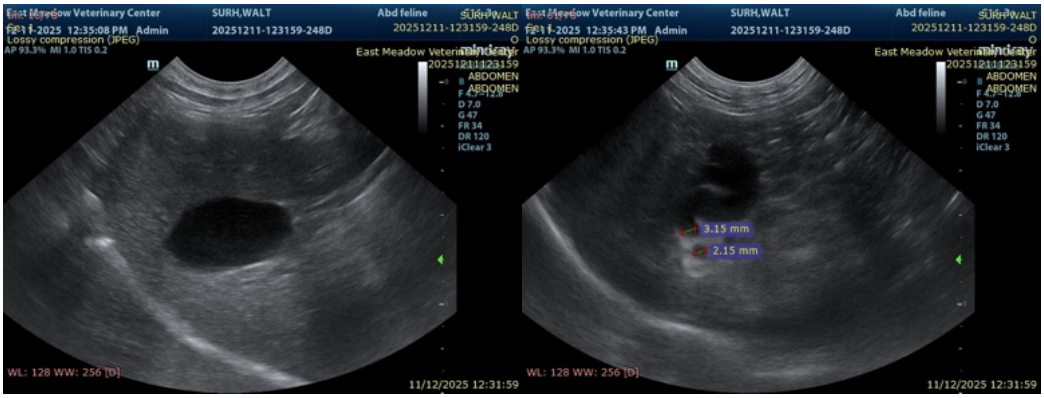
neoplastic causes cannot be completely ruled out, as some malignancies—particularly early lymphoma or anal sac adenocarcinoma (rare in cats)—may not produce detectable lesions on ultrasound.

Overall, the abdominal ultrasound does not identify a cause for the hypercalcemia or hepatic enzyme elevations. The most significant finding is increased renal cortical echogenicity, which may represent early chronic kidney disease, renal insult from sustained hypercalcemia, or a concurrent metabolic process.

Recommendations

- Complete hypercalcemia workup:
- Ionized calcium (iCa) – essential
- PTH and PTHrP panel – to differentiate:
    - Primary hyperparathyroidism
    - Hypercalcemia of malignancy
    - Idiopathic hypercalcemia
- Recheck renal values and SDMA after partial correction of hypercalcemia.
- Urinalysis with USG and UPC ratio.
- Optional: GI panel (TLI, cobalamin, folate, fPLI) given anorexia and risk of pancreatitis or GI involvement.
- Medical management of hypercalcemia if persistent or symptomatic.



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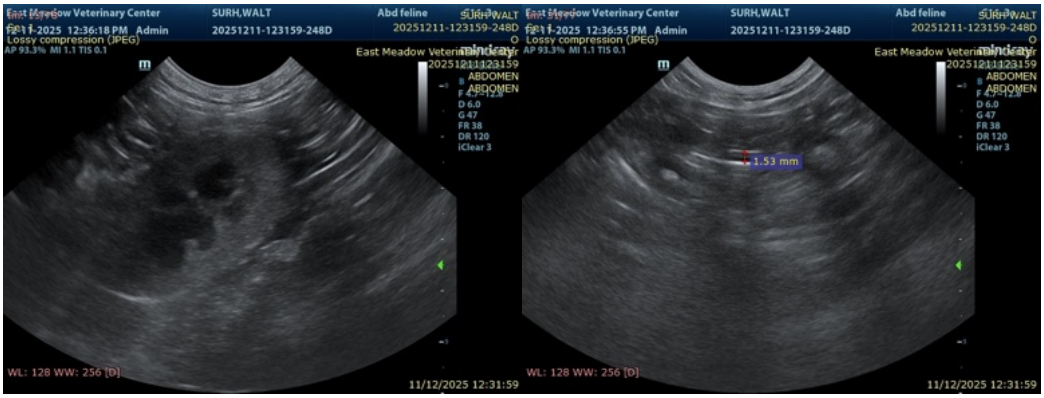


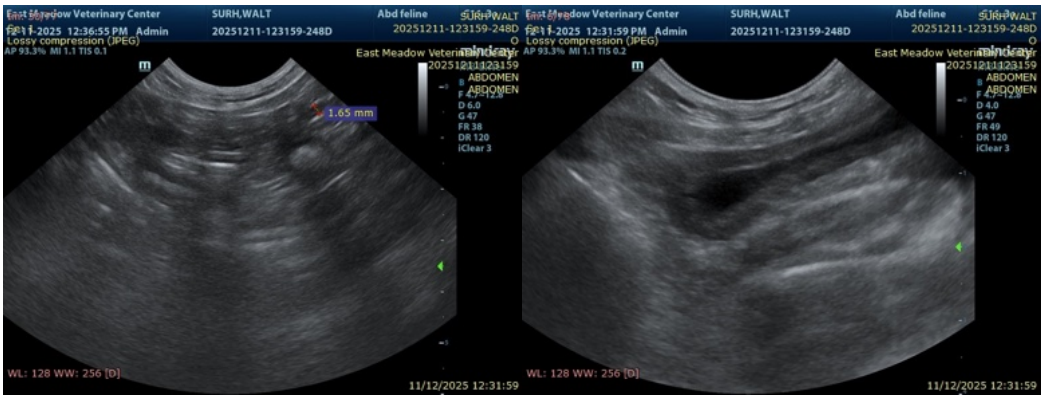


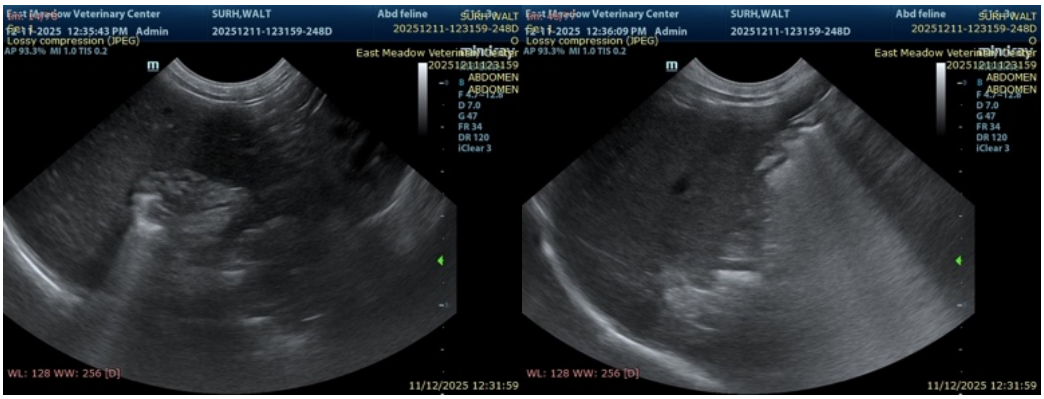


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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

info@SonoPath.com