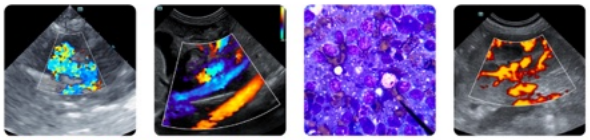


PATIENT

Brody Randlett

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

14 years

WEIGHT

11.4 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Dr. Warner

HOSPITAL NAME

VTNH Vet Clinic

REFERRING VET

Dr. Randlett

INVOICE

69609

DATE

12/12/25

PRESENTING CLINICAL SIGNS

History: Brody presented today for evaluation of the GI tract following unexplained weight loss despite a good appetite. No other GI signs noted. Radiographs revealed normal GIT with possible splenic mass. Intestines appeared mildly clumped on radiographs.
12/10 Chem10 all WNL, T4 1.9 08/22 Full wellness panel WNL aside from T4 2.3

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the bladder wall appears thin and smooth. The urine is turbid, with echogenic material floating within the lumen. The proximal urethra and vesicoureteral junction have a normal appearance. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney measures 4.08 × 2.98 cm, with a cortical thickness of 0.58 cm in the sagittal plane. The right kidney measures 4.26 × 2.78 cm, with a cortical thickness of 0.50 cm in the sagittal plane. In both kidneys, the renal cortex shows increased thickness and echogenicity, resulting in increased corticomedullary distinction. A medullary rim sign is present. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Color Doppler demonstrates a normal perfusion pattern.

Adrenal Glands

The left adrenal gland measures 0.23 cm at the cranial pole and 0.25 cm at the caudal pole. The right adrenal gland is not visualized. Images labeled as the right adrenal gland may not reliably represent the right adrenal gland.

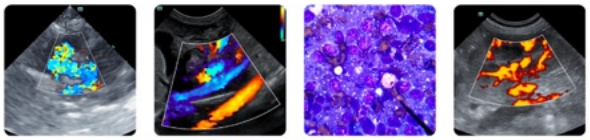
Spleen

Splenic thickness is 0.89 cm. The parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture, with a well-defined hyperechoic homogeneous nodule measuring 1.01×0.70 cm. The splenic capsule is smooth and regular.

Liver

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

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



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Gastrointestinal

The stomach is distended and contains a small amount of digested ingesta, with a mural thickness of 1.96 mm and preserved wall layering. The pylorus measures 2.38 mm. The duodenum measures 1.58 mm.

The jejunum measures 2.47 mm in total wall thickness, with the following layer measurements: mucosa 1.27 mm, submucosa 1.01 mm, and muscularis propria 0.31 mm. The ileum measures 1.50 mm in total wall thickness, with the following layer measurements: mucosa 0.92 mm, submucosa 0.73 mm, and muscularis propria 0.47 mm. Wall layering is preserved. The ileocecal junction is not clearly visualized. No signs of obstruction, ileus, or foreign material are identified.

The colon wall thickness measures 0.99 mm, with formed feces present in the descending segment.

Pancreas

The right pancreatic lobe and pancreatic body are obscured by acoustic shadowing from gastric contents. The left pancreatic lobe is visualized, and the pancreatic parenchyma is hypoechoic relative to the adjacent omental fat. The pancreatic duct diameter measures 1.13 mm. No evidence of active inflammation of the peripancreatic fat is observed.

Peritoneal Cavity

No abdominal effusion or evidence of peritonitis is observed. Cranial mesenteric and ileocecal lymph nodes are not visualized; however, the surrounding regions appear unremarkable. The iliac trifurcation appears normal.

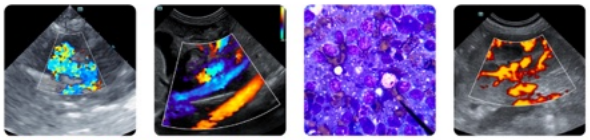
ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Bilateral increased renal cortical echogenicity with enhanced corticomedullary distinction. Medullary rim sign.
- Mild hypoechogenicity of the left pancreatic lobe relative to omental fat. Mild dilation of the pancreatic duct.

SECONDARY FINDINGS

- Turbid urinary bladder contents with suspended echogenic material.
- Focal, well-defined hyperechoic splenic nodule.
- Small amount of biliary sludge within the gallbladder.
- Persistent gastric ingesta despite reported fasting since the evening of the previous day.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The bilateral increase in renal cortical echogenicity with preserved size and architecture is most consistent with chronic renal parenchymal disease. Early chronic kidney disease, IRIS stage I–II is suspected.

The solitary, well-defined hyperechoic splenic nodule is most consistent with a benign splenic lesion, with primary differentials including: Splenic nodular hyperplasia, splenic myelolipoma, or Bates body (siderotic nodule). Given its echogenicity, homogeneity, and lack of splenomegaly or capsular disruption, malignant splenic disease is considered unlikely.

Mild pancreatic parenchymal hypoechogenicity with minimal ductal dilation, in the absence of peripancreatic inflammation, is most consistent with: Age-related pancreatic changes, or chronic or subclinical pancreatitis.

Incidental biliary sludge without ductal dilation is most consistent with functional cholestasis or age-related biliary changes, without evidence of obstructive or inflammatory hepatobiliary disease.

The lack of mural thickening, preserved layering, and normal muscularis-to-wall ratios throughout the visualized small intestine does not support inflammatory or infiltrative, gastrointestinal disease as a cause of the reported weight loss. Primary intestinal disease is therefore considered unlikely based on current imaging.

Echogenic urinary sediment in the absence of mural pathology or urolithiasis is most consistent with crystalluria or inflammatory debris, of uncertain clinical relevance.

Recommendations

- Renal monitoring, including serial serum creatinine, SDMA, urine specific gravity, UPC and blood pressure assessment.
- Urinalysis with sediment examination (if not already performed) to further characterize the echogenic urinary material.
- Clinical and ultrasonographic follow-up of the splenic nodule to assess stability over time.
- Pancreatic enzyme testing (fPLI).
- Continued T4 monitoring.
- Dietary review and caloric intake assessment. If weight loss persists despite preserved appetite and in the absence of definitive gastrointestinal disease on imaging, a comprehensive feline gastrointestinal panel may be considered to further assess for functional or biochemical causes not detectable sonographically.

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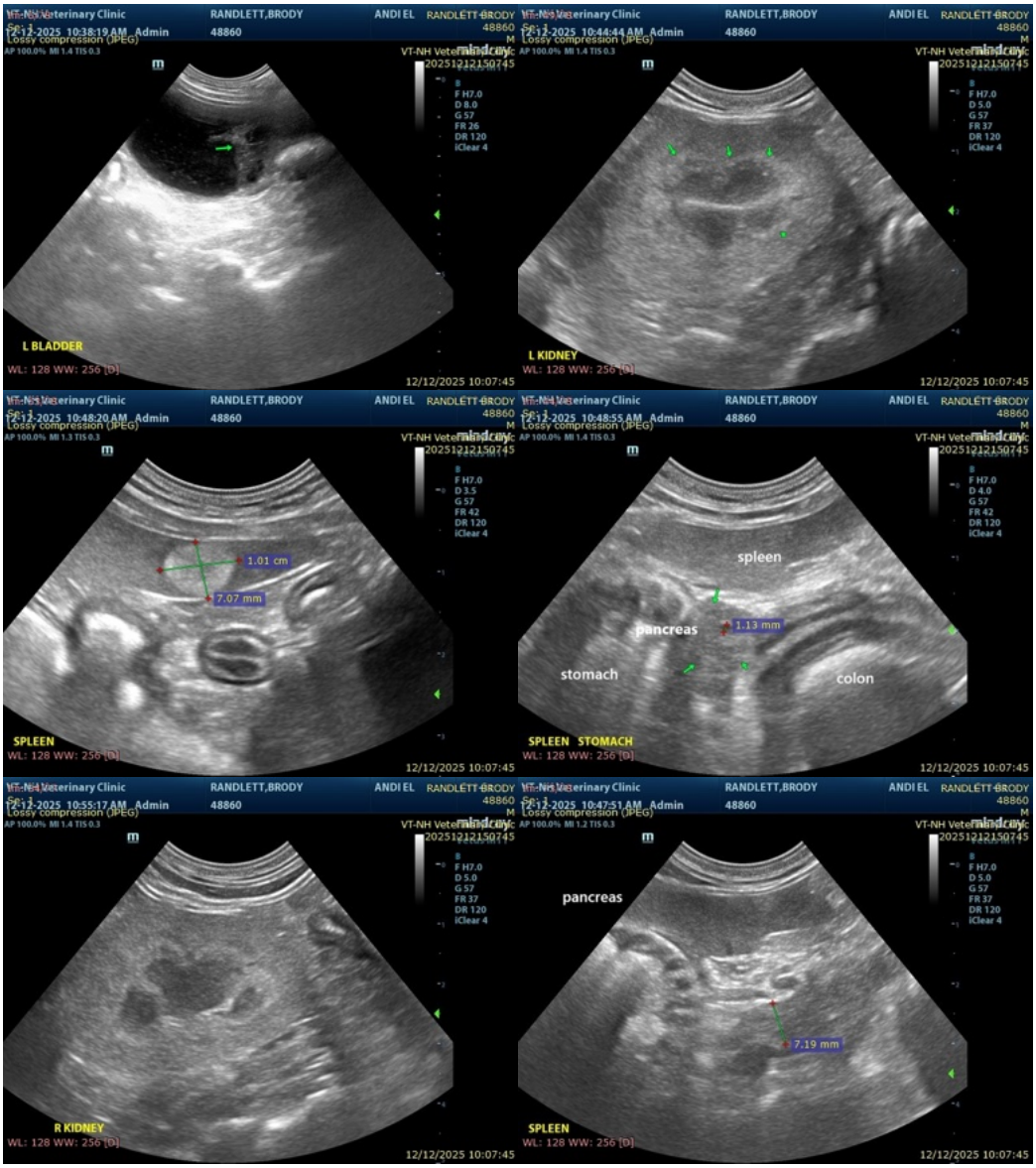

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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