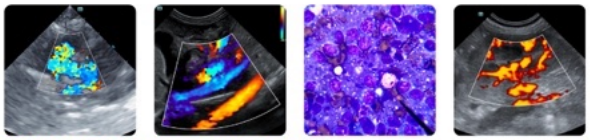


PATIENT

Gingersnap Anderson

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

13 years

WEIGHT

6.5 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Amy Jagger DVM

HOSPITAL NAME

VCA Parkway AH

REFERRING VET

Dr. Jagger

INVOICE

69441

DATE

12/18/25

PRESENTING CLINICAL SIGNS

History: Humane society adoption, ate initially but then vomited the food back up and hasn't eaten again for 3 days. Treated with cerenia and mirtazapine 2 days ago. Labs show hyperthyroidism and elevated bilirubin (serum icteric but sclera not icteric yet).
Abnormal PE/Chem/CBC/UA Results: T4 11.1 ALT 125 (alk phos still very normal at 42) T Bili 2.7 BUN 38, but Creat only 0.5, Urine SG 1.044 2+ bilirubinuria

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 anechoic. The bladder neck and proximal urethra appear normal. No uroliths or ultrasonographic evidence of inflammatory or neoplastic disease are identified.

The left kidney appears mildly globose, measuring 3.61×2.53 cm, with a cortical thickness of 0.36 cm in the sagittal plane. The renal cortex demonstrates normal echogenicity. The corticomedullary ratio is normal, and corticomedullary definition is preserved. Small echogenic foci consistent with incipient nephroliths measuring approximately 3.20 mm and 1.55 mm are identified. There is no evidence of pyelectasia or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

The right kidney is slightly smaller and irregular in contour, measuring 3.14×2.01 cm. The renal cortex is increased in echogenicity, with markedly reduced corticomedullary definition. Nephrolithiasis is present, with echogenic calculi measuring approximately 4.48 mm and 2.96 mm. There is no evidence of pyelectasia or hydronephrosis.

Adrenal Glands

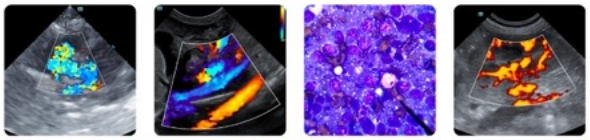
Both adrenal glands appear diffusely hypoechoic, with small punctate mineralized foci. The left adrenal gland measures approximately 0.54 cm at the cranial pole and 0.49 cm at the caudal pole. The right adrenal gland measures approximately 0.51 cm at the cranial pole and 0.53 cm at the caudal pole.

Spleen

Splenic thickness measures approximately 0.76 cm. The splenic 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 margins and a regular contour. The hepatic parenchyma is uniform and isoechoic relative to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.



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The gallbladder lumen is moderately distended. The gallbladder wall is thin. The contents are primarily anechoic with a small amount of biliary sludge. The common bile duct measures approximately 5.05 mm proximally, tapering distally to 2.93 mm and 1.63 mm.

Gastrointestinal

The stomach is empty and folded, with preserved wall layering and mural thickness ranging from approximately 1.98 to 2.23 mm. The pylorus measures approximately 3.40 mm and contains a small amount of luminal fluid.

The duodenum measures approximately 1.61 mm. The jejunum measures approximately 2.16 mm, with the following wall layer measurements: mucosa ~1.41 mm, submucosa ~0.44 mm, and muscularis propria ~0.22 mm. The ileum measures approximately 1.71 mm, with preserved wall layering (mucosa ~0.49 mm, submucosa ~0.64 mm, muscularis propria ~0.31 mm). The ileocecal junction measures approximately 2.63 mm, with a muscularis thickness of approximately 0.87 mm. Several segments of small intestine appear mildly dilated and discretely corrugated, suggestive of transient spasm or functional ileus. No mechanical obstruction or intraluminal foreign material is identified.

The colon contains formed fecal material within the descending segment.

Pancreas

The pancreas measures approximately 8.31 mm in thickness. The right limb, body, and left limb appear normal. The pancreatic parenchyma is isoechoic relative to the adjacent omental fat. The pancreatic duct measures approximately 2.59 mm. No ultrasonographic evidence of active pancreatitis or pancreatic neoplasia is identified.

Peritoneal Cavity

No abdominal effusion or signs of peritonitis are observed.

Cranial mesenteric lymph nodes measure approximately 4.27–4.51 mm, are elongated, and mildly hypoechoic, consistent with reactive lymphadenopathy.

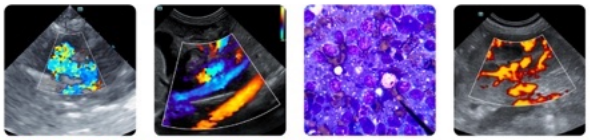
Ileocecal lymph nodes measure approximately 2.12–2.21 mm and demonstrate normal echogenicity.

The iliac trifurcation is unremarkable.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Mild globose appearance of the left kidney. Right kidney: reduced size, irregular contour, increased cortical echogenicity, and poor corticomedullary definition. Bilateral nephrolithiasis.
- Bilateral enlargement of the adrenal glands, hypoechoic with punctate mineralization.



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- Mild dilation and corrugation of small intestinal segments, compatible with functional ileus or spasm.

SECONDARY FINDINGS

- Small amount of biliary sludge with proximal common bile duct dilation.
- Mild enlargement and hypoechogenicity of cranial mesenteric lymph nodes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Renal findings are asymmetric and clinically significant. The right kidney demonstrates features compatible with chronic renal pathology, including reduced size, irregular contour, increased cortical echogenicity, and markedly decreased corticomedullary definition. The left kidney appears mildly globose but otherwise structurally preserved, which may reflect compensatory change. Bilateral nephrolithiasis is present and suggests an ongoing or progressive renal process. Although current serum creatinine remains within normal limits, this does not exclude clinically relevant chronic kidney disease in cats, particularly in the context of hyperthyroidism and reduced muscle mass. The mild elevation in BUN may reflect a combination of pre-renal factors and underlying renal dysfunction. Overall, the ultrasonographic renal changes are concerning chronic nephropathy with active mineralization and warrant close clinical and laboratory monitoring.

The markedly elevated total T4 is consistent with uncontrolled hyperthyroidism, which likely contributes to the patient's acute anorexia, vomiting, and metabolic stress. In this context, the mild hyperbilirubinemia with normal alkaline phosphatase and only mild ALT elevation is most consistent with functional cholestasis, as obstructive biliary disease is ruled out by the ultrasound examination. Mild biliary sludge and proximal common bile duct dilation further support reduced bile flow, potentially secondary to anorexia, dehydration, and systemic illness.

Both adrenal glands appear diffusely hypoechoic with punctate mineralization. While these findings are nonspecific, they may reflect functional or stress-related adrenal hyperplasia, likely secondary to systemic illness and hyperthyroidism. Primary hyperaldosteronism is considered unlikely at this time given the absence of hypokalemia, hypertension, and discrete adrenal enlargement.

Mild small intestinal dilation and corrugation are most compatible with functional ileus or gastrointestinal spasm, likely secondary to systemic illness, nausea, and metabolic derangements. Reactive enlargement of cranial mesenteric lymph nodes supports an inflammatory gastrointestinal response.

Recommendations

- Symptomatic gastrointestinal support and prompt nutritional support is recommended in order to reduce the risk of hepatic lipidosis and functional cholestasis.
- Initiation of therapy for hyperthyroidism is advised as a priority, as thyroid hormone excess is likely contributing to metabolic stress, gastrointestinal signs, and may be masking underlying renal disease. Renal parameters should be reassessed following thyroid stabilization.
- Close monitoring of renal function is recommended given the ultrasonographic evidence of chronic nephropathy and bilateral nephrolithiasis, despite currently mild biochemical changes.

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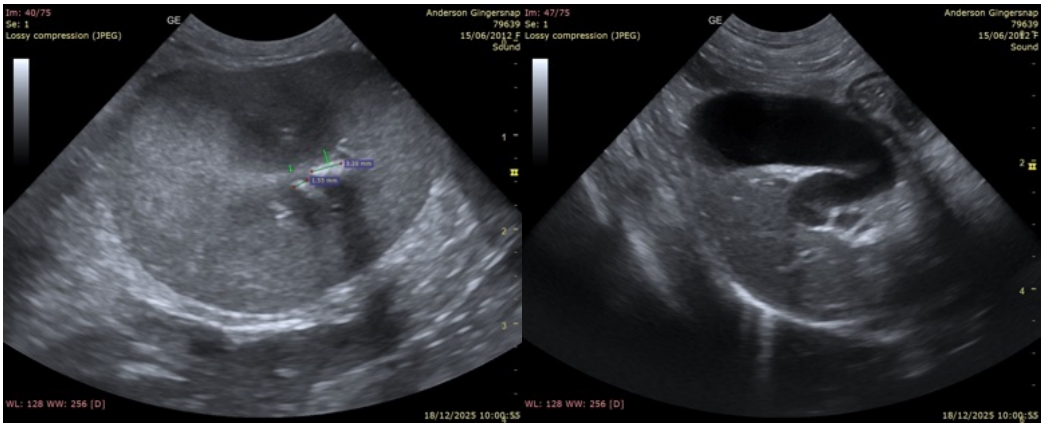
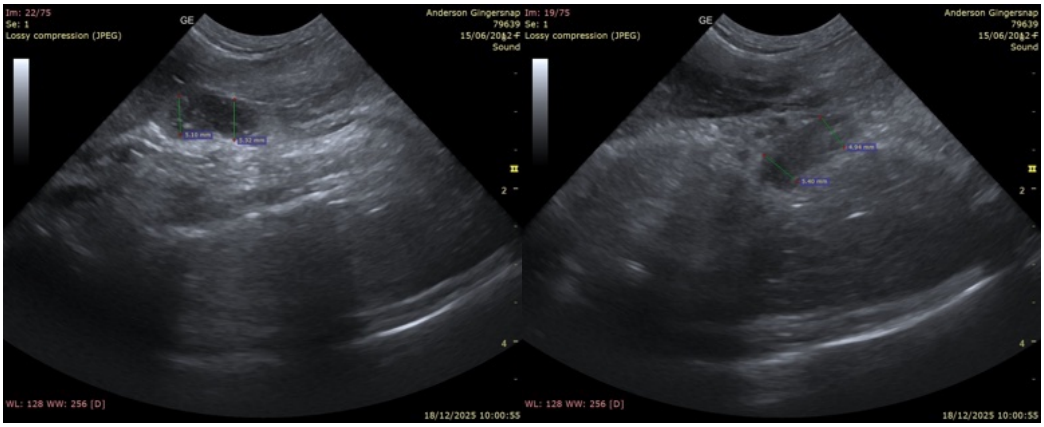
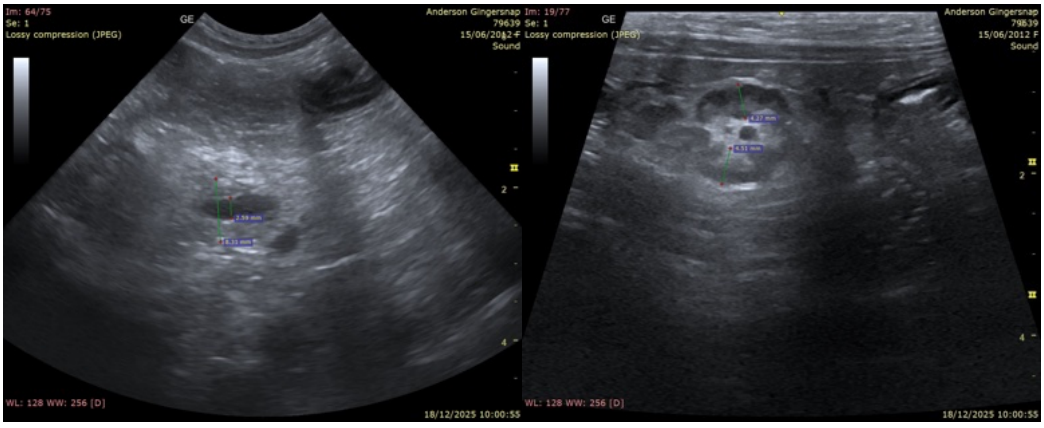
Follow-up evaluation should include renal biochemistry, SDMA, urinalysis with UPC, and blood pressure measurement.







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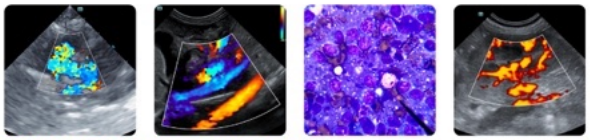

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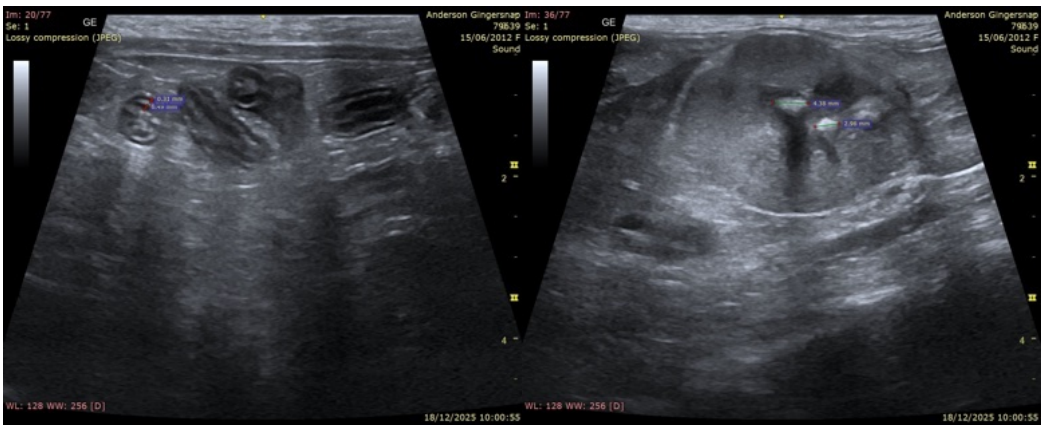

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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