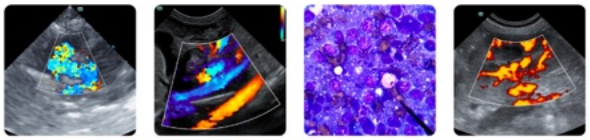


PATIENT

Fred Shimek

SPECIES

Feline

BREED

Domestic Longhair

SEX

Neutered male

AGE

12 years

WEIGHT

12.8 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Grace Jayne CVT

HOSPITAL NAME

Ark Animal Homecare

REFERRING VET

Dr. Penraat

INVOICE

69433

DATE

12/9/25

PRESENTING CLINICAL SIGNS

History: Middle-aged cat Assessment Weight loss 1.5 lbs since April 2025 Anorexia and recent hx of constipation which was resolved with enema HCM stage B1 Recent CBC Chemistry - minimal lymphopenia likely the result of corticosteroid-induced stress, moderately elevated SDMA, creatinine, BUN, phos with concurrent minimally concentrated urine 1022 consistent with renal insufficiency stage 2/3 Urine protein: creatinine ratio 0.9 high and urine cystatin B is high the latter indicative of active injury. Protein electrophoresis is consistent with monoclonal gammopathy AUS today to follow up on recent renal changes, gi signs and monoclonal gammopathy suggestive of neoplasia - less likely infectious conditions such as FIP
Abnormal PE/Chem/CBC/UA Results: FNA of spleen and right kidney pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the urinary bladder wall appears thin and smooth. The urine is anechoic. The proximal urethra and vesicoureteral junction appear normal. No calculi or evidence of inflammatory or neoplastic changes are observed.

The left kidney is normal in shape and size: 4.55x3.03 cm, with a cortical thickness of 0.75 cm in the sagittal plane. The right kidney is normal in shape and size: 4.59x3.43 cm, with a cortical thickness of 0.70 cm in the sagittal plane. Both kidneys show increased cortical echogenicity, resulting in increased corticomedullary distinction. No pyelectasia, nephroliths, or hydronephrosis are observed. Basic color Doppler shows no evident abnormalities (resistive and pulsatility indices were not assessed).

Adrenal Glands

Not clearly visualized for measurement.

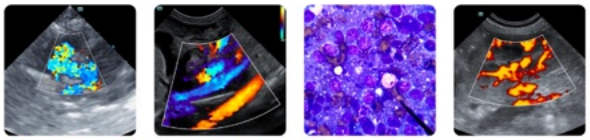
Spleen

Splenic thickness ranges from 0.92–1.63 cm, with mildly rounded margins. The parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture without focal abnormalities.

Liver

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

The gallbladder is normally distended. The wall measures 0.78 mm, and the contents are primarily anechoic with a small amount of biliary sludge. The common bile duct measures 2.06–1.99 mm.



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Gastrointestinal

The stomach is empty and folded, with a mural thickness of 2.16 mm and preserved wall layering.

Pylorus: (measurement not provided). Duodenum: 1.75 mm. Jejunum: 2.51 mm. Ileum: 2.03 mm. Wall layering is normal throughout. The ileocecal junction measures 2.12 mm. No signs of obstruction, ileus, or foreign material are identified.

Colon: 1.09 mm, with formed feces in the descending segment.

Pancreas

The pancreas measures 4.33 mm. The pancreatic parenchyma is isoechoic to the adjacent omental fat, and the pancreatic duct is not dilated. No signs of active peripancreatic inflammation are evident.

Peritoneal Cavity

No abdominal effusion or peritonitis is observed.
Ileocecal lymph nodes measure 3.61 mm; cranial mesenteric lymph nodes were not individually measured, but their surrounding regions appear unremarkable.
The iliac trifurcation is normal.

ULTRASONOGRAPHIC FINDINGS

- Diffuse increased renal cortical echogenicity with preserved renal architecture.
- Splenomegaly.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The renal ultrasonographic findings demonstrate diffusely increased cortical echogenicity with preserved renal size, shape, and corticomedullary architecture. No masses, capsular irregularity, perirenal hypoechoic halo, or distortion of the renal contour are observed. Therefore, this pattern is not suggestive of renal lymphoma. Rather, the findings are most consistent with a diffuse glomerular disease such as:

- Immune-complex glomerulonephritis.
- Glomerular injury secondary to monoclonal immunoglobulin deposition (Monoclonal Gammopathy of Renal Significance) is also strongly suspected in the context of marked proteinuria, elevated SDMA/creatinine/BUN/phosphorus, high urine cystatin B, and a monoclonal gammopathy.
- Renal amyloidosis.

Mild splenomegaly is nonspecific and may reflect reactive change, sedation-related enlargement, or an underlying systemic process. Cytology will help clarify its significance.

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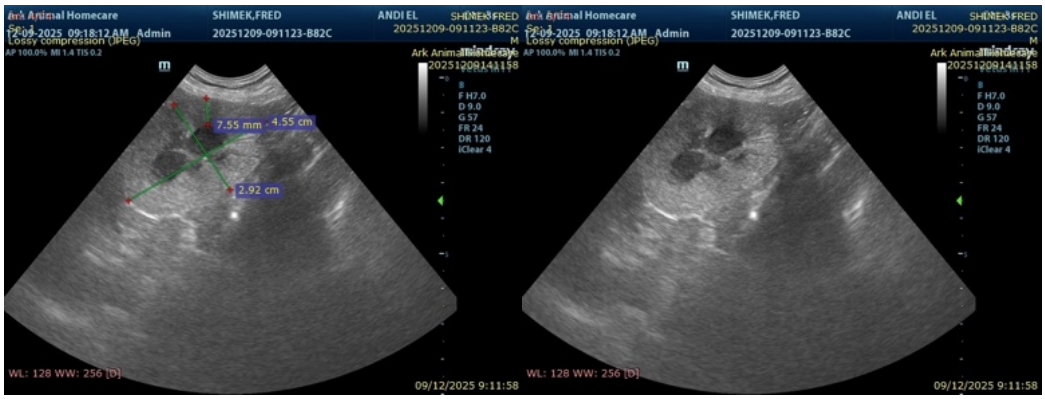
While lymphoma cannot be entirely excluded, cytology from the spleen and kidney will be valuable in helping to rule out this differential, which is important for guiding further diagnostic and therapeutic decisions. Histopathology would be required for a definitive diagnosis.

Recommendations

- Await cytology results.
- Performing a complete renal Doppler study (including RI and PI indices) would help to assess renal vascular resistance and provide additional information on renal hemodynamics in the context of diffuse kidney disease. While Doppler findings cannot reliably distinguish specific histologic entities (glomerulonephritis vs amyloidosis), they may help characterize the severity and nature of renal involvement.
- Measure systemic blood pressure.
- Monitor proteinuria with repeat UPC measurements (every 2–4 weeks initially) and consider initiating or adjusting antiproteinuric therapy as indicated.
- Consider serum protein electrophoresis with immunofixation (if not already performed) to better characterize the monoclonal component.
- Implement renal-protective management, including renal diet, phosphorus control, and omega-3 fatty acids (if cardiologically appropriate).
- Repeat urine cystatin B in 4–6 weeks to assess progression of tubular injury.
- Consider renal biopsy only if cytology is non-diagnostic and a definitive distinction between glomerulonephritis and amyloidosis is required; risk–benefit assessment is essential in Stage 2–3 CKD.
- Evaluate a coagulation profile if additional invasive procedures (renal biopsy) are considered, given the presence of a monoclonal gammopathy.



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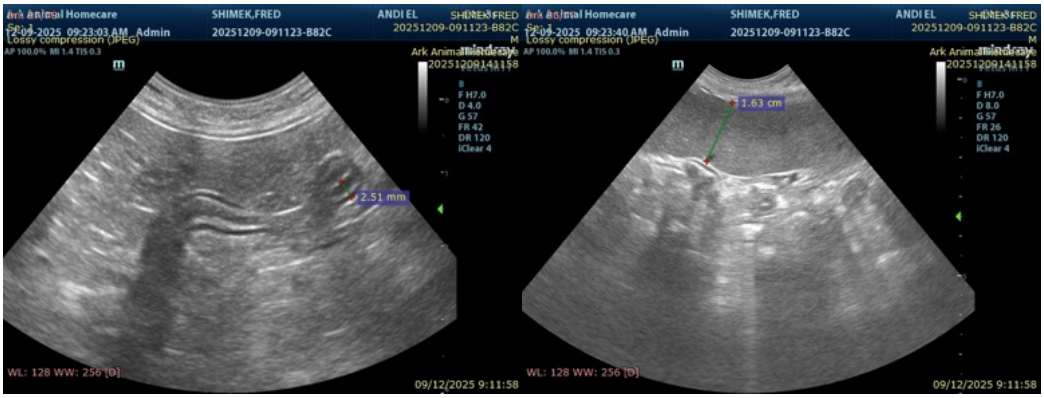

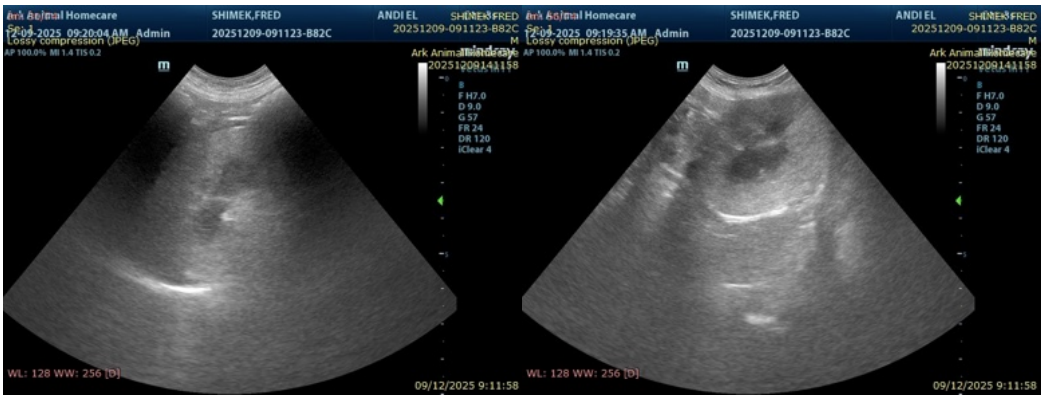

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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