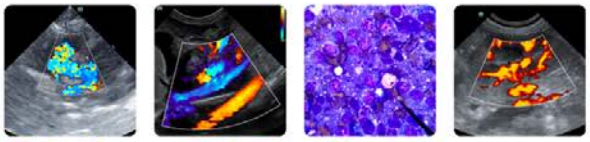


PATIENT

Teddy Mantei

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

9 Years 8 Months

WEIGHT

9.67 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Kaplan

HOSPITAL NAME

Ramsey Veterinary Hospital

REFERRING VET

Dr. Kaplan

INVOICE

73858

DATE

3/20/26

PRESENTING CLINICAL SIGNS

Normal physical exam. New distant aggressive behavior towards O

Abnormal PE/Chem/CBC/UA Results: BP 120 mmHg Total Protein 9.1 Globulin 6.2 Lymphocyte 84.5 Eosinophils 187 USG 1.013 PH 5.0

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 bladder neck and proximal urethra. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.83×2.68 cm, and the thickness of the cortex is 0.44 cm in the sagittal plane.

The right kidney is normal in shape and size: 4.25×2.67 cm, and the thickness of the cortex is 0.55 cm in the sagittal plane.

In both kidneys, the cortex is hyperechoic compared to the liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: the left adrenal gland measures 0.26 cm at the cranial pole and 0.28 cm at the caudal pole. The right adrenal gland is partially visualized and measures 0.35 cm.

Spleen

Splenic thickness is 0.73 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

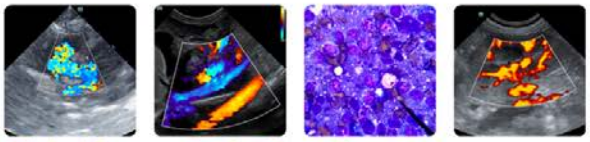
The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma is uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The wall is thin and the contents are primarily anechoic. No dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty and folded, with preserved wall layering (mural thickness not provided). The pylorus measures 3.29 mm.

Duodenum: 1.22 mm. Jejunum: 1.95 mm (mucosa: 1.39 mm; submucosa: 0.35 mm; muscularis propria: 0.14 mm). Ileum: 1.43–1.60 mm with preserved wall layering (muscularis measurement not provided). The ileocecal junction measures 3.23 mm, with muscularis thickness of 1.03 mm.



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No signs of inflammation, ileus, or foreign material are identified. Colon: 0.91 mm, with formed feces in the descending segment.

Pancreas

The evaluated pancreatic areas do not show evidence of overt inflammation or neoplastic disease.

Free Abdomen

No abdominal effusion or peritonitis is observed. Cranial mesenteric lymph nodes measure 3.90–4.66 mm in thickness, with normal shape and echogenicity. Ileocecal lymph nodes are not visualized, but the surrounding regions appear unremarkable. No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Bilateral renal cortical hyperechogenicity.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Intestinal wall thicknesses are within normal limits, and the muscularis-to-mucosa ratio in the jejunum (~0.10) is well below values typically associated with small cell lymphoma or chronic enteropathy, making clinically significant infiltrative enteropathy unlikely based on this study.

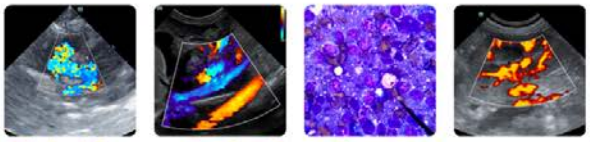
Significative bilateral renal cortical hyperechogenicity is identified, indicating structural renal change (chronic interstitial or glomerular nephropathy). However, in the absence of reported azotemia, these findings may represent early or subclinical renal disease, correlation is advised.

There is no evidence of infiltrative gastrointestinal disease, lymphadenomegaly, or organ involvement to explain the marked hyperglobulinemia.

Recommendations

- Further characterization of hyperglobulinemia: serum protein electrophoresis (polyclonal vs monoclonal).
- Infectious disease testing as clinically indicated (FIV/FeLV, coronavirus/FIP assessment depending on suspicion).
- Repeat CBC with absolute lymphocyte count and blood smear evaluation.
- Renal function assessment (biochemistry, SDMA, and UPC).

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status and ongoing response to treatment.



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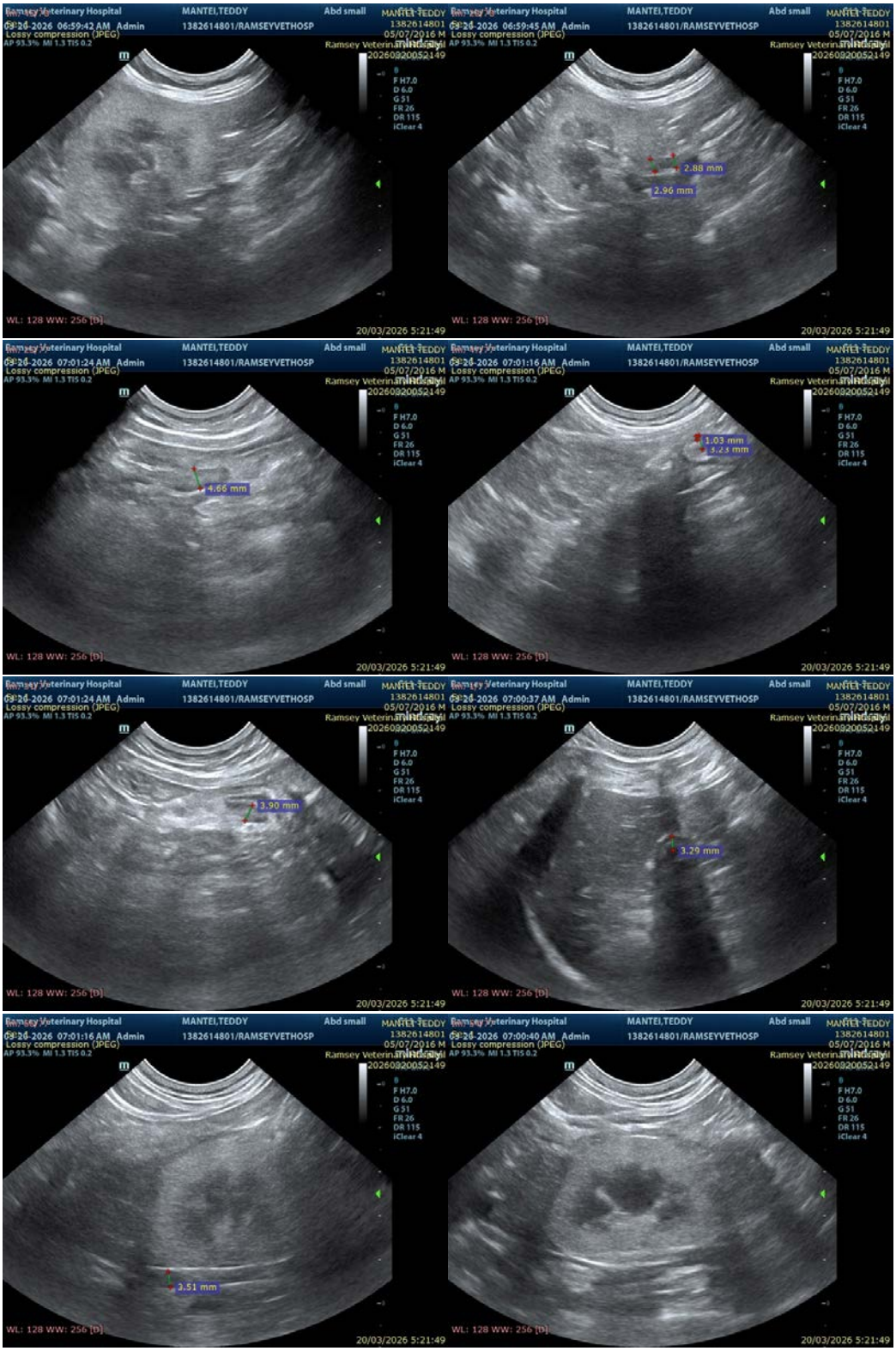

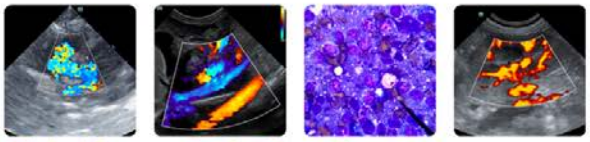

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com