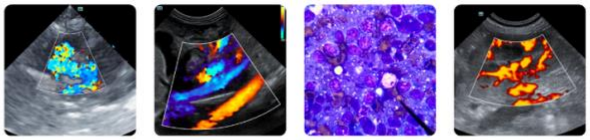




**PATIENT**

Koco Wight

**SPECIES**

Feline

**BREED**

Siamese

**SEX**

Spayed Female

**AGE**

20

**WEIGHT**

5.1 pounds

**INTERPRETED BY**

Alicia Angosto Guerrero, DMV, PgDip, MSc.

**IMAGING PERFORMED BY**

Dr. Kathy Cronin

**HOSPITAL NAME**

Ark Animal Homecare

**REFERRING VET**

Dr. Kathy Cronin

**INVOICE**

15397

**DATE**

04/23/26

## PRESENTING CLINICAL SIGNS

Persistent hematuria since January. Has been treated for UTIs several times in the last few months, infection resolves but hematuria is persistently present in free catch sample even after resolution of infection. Was initially having pollakiuria, but lower urinary tract signs resolved after course of antibiotics. History of CKD and hyperthyroidism Has been losing weight (about 2 lbs since last year) History of small subcutaneous mast cell tumor diagnosed last year Previously had issues with chronic constipation, well-controlled on MiraLAX and lactulose currently Vomits occasionally after eating quickly, this has been chronic and has not changed recently Currently on methimazole, Mirataz, lactulose, MiraLAX

Abnormal PE/Chem/CBC/UA Results: UA 3/26/26 (free catch) - USG 1.014, trace protein, 3+ blood, urine culture 2/8/26 was negative Last bloodwork 1/21/26 (updated bloodwork pending from today's visit) - CBC: eosinophils 0.077 Chemistry: SDMA 24, creatinine 2.8, BUN 45, cystatin B 136, calcium 12.5, T4 0.9 PE: BCS 3/9

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is adequately distended. The bladder wall is thin and smooth. The luminal contents are anechoic. The bladder neck and proximal urethra have a normal appearance. No uroliths or ultrasonographic evidence of inflammatory or proliferative/neoplastic changes are identified.

The left kidney measures 2.61×1.83 cm, with a cortical thickness of 0.39 cm in the sagittal plane.
The right kidney measures 2.63×1.82 cm, with a cortical thickness of 0.37 cm in the sagittal plane.
Both kidneys are slightly small for a cat (typical length ~3.0–4.5 cm). The cortex is isoechoic relative to the liver. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved.
The renal medulla of both kidneys contains multiple, small, diffusely distributed hyperechoic foci without consistent distal acoustic shadowing. These findings are most consistent with medullary mineralization (nephrocalcinosis), rather than discrete nephrolithiasis.
No pyelectasia or hydronephrosis is identified.

### *Adrenal Glands*

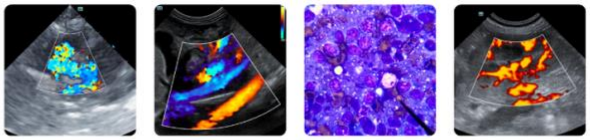
Not visualized.

### *Spleen*

Splenic thickness is 0.81 cm (within normal limits for a cat, typically <1 cm). The contour is irregular. The parenchyma contains multiple hyperechoic areas, compatible with possible fibrosis. Additionally, there is a focal hypoechoic nodule-like lesion measuring 0.84×0.97 cm, slightly protruding from the splenic parenchyma, with a more echogenic central region, located in the mid-body of the spleen. The splenic capsule is normal.

### *Liver*

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





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The gallbladder is adequately distended. The wall measures 1.07 mm (within normal limits; normal feline gallbladder wall typically ≤1–1.5 mm). The contents are predominantly anechoic. No dilation of the cystic duct or common bile duct is observed.

### *Gastrointestinal*

The stomach is empty and folded, with mural thickness of 1.99 mm and preserved wall layering (within normal limits for a non-distended feline stomach).
The pylorus measures 3.06 mm (within normal limits).
Duodenum: 1.68 mm (within normal limits, typically <4 mm).
Jejunum: 2.81 mm total thickness. Layer measurements: mucosa 1.03 mm, submucosa 0.51 mm, muscularis 1.21 mm. The muscularis-to-mucosa ratio is approximately 1.17, which is increased (normal <0.5–0.6 in cats). Wall layering is preserved.
Ileum: 2.06 mm total thickness. Layer measurements: mucosa 0.58 mm, submucosa 0.41 mm, muscularis 0.74 mm. The muscularis-to-mucosa ratio is approximately 1.28, also increased. Wall layering is preserved.
Several intestinal segments display a corrugated appearance. Other segments show mild fluid distension.
The ileocecal junction was not clearly visualized.
Colon wall thickness ranges from 0.62–0.79 mm, within normal limits, with formed feces in the descending colon.

### *Pancreas*

Pancreatic thickness is 5.55 mm (within reported upper normal limits for cats, generally ~4–6 mm depending on region and technique). The parenchyma is mildly hypoechoic relative to surrounding fat. The pancreatic duct measures 1.16 mm (mildly prominent; typical upper reference ~1–1.2 mm in older cats). No hyperechoic peripancreatic fat or free fluid is identified.

### *Free Abdomen*

No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified in the videos provided. The iliac trifurcation is normal.

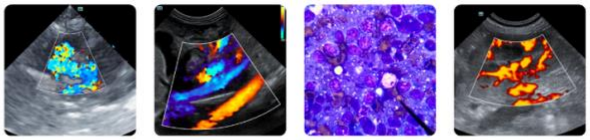
## PRIMARY FINDINGS

- Bilateral renal medullary mineralization (nephrocalcinosis)
- Mildly reduced renal size (consistent with chronicity)
- Splenic irregular contour with multiple hyperechoic areas and one hypoechoic nodule (0.84×0.97 cm)
- Increased muscularis thickness in jejunum and ileum (muscularis-to-mucosa ratios >1) with preserved layering
- Intestinal corrugation and mild segmental fluid distension
- Mild pancreatic hypoechogenicity with borderline pancreatic duct dilation

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No ultrasonographic source for the persistent hematuria is identified.

Renal changes (mildly reduced size and medullary mineralization) are consistent with chronic kidney disease, and the nephrocalcinosis is likely secondary to the documented hypercalcemia.





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The combination of weight loss, hypercalcemia, prior mast cell tumor, and the presence of a splenic nodule is clinically significant. While the splenic lesion could represent nodular hyperplasia in a geriatric cat, systemic or visceral mast cell disease remains a realistic differential, as does lymphoma or other round cell neoplasia.

The intestinal changes (increased muscularis-to-mucosa ratios with preserved layering and corrugation) support a chronic enteropathy. Although this pattern commonly overlaps between inflammatory bowel disease and low-grade lymphoma, the concurrent systemic context (hypercalcemia, splenic lesion, prior mast cell tumor) increases concern for infiltrative or neoplastic disease rather than uncomplicated IBD, although imaging alone cannot differentiate these entities.

Mild pancreatic hypoechogenicity is nonspecific and may reflect mild or chronic pancreatitis; however, in cats, this can also be secondary or incidental and does not materially shift the primary differential considerations in this case.

Overall, this is a geriatric patient with CKD and hypercalcemia, with imaging findings that raise concern for an underlying systemic or multicentric process (including mast cell disease or lymphoma), with chronic enteropathy (including IBD) remaining a differential consideration.

Recommendations

- Fine-needle aspiration of the splenic nodule is recommended, as this represents the most clinically relevant and minimally invasive way to further investigate a possible systemic or neoplastic process in this patient.
- Further characterization of the hypercalcemia (ionized calcium ± PTH/PTHrP) is advised, as it may help clarify whether this is paraneoplastic or related to other causes and is likely contributing to the renal mineralization.
- Given the patient's age, intestinal biopsies are not prioritized; empirical management of chronic enteropathy may be considered if clinically indicated.
- If hematuria persists, periodic monitoring or further lower urinary tract evaluation may be considered depending on clinical progression.
- Monitor renal values.

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

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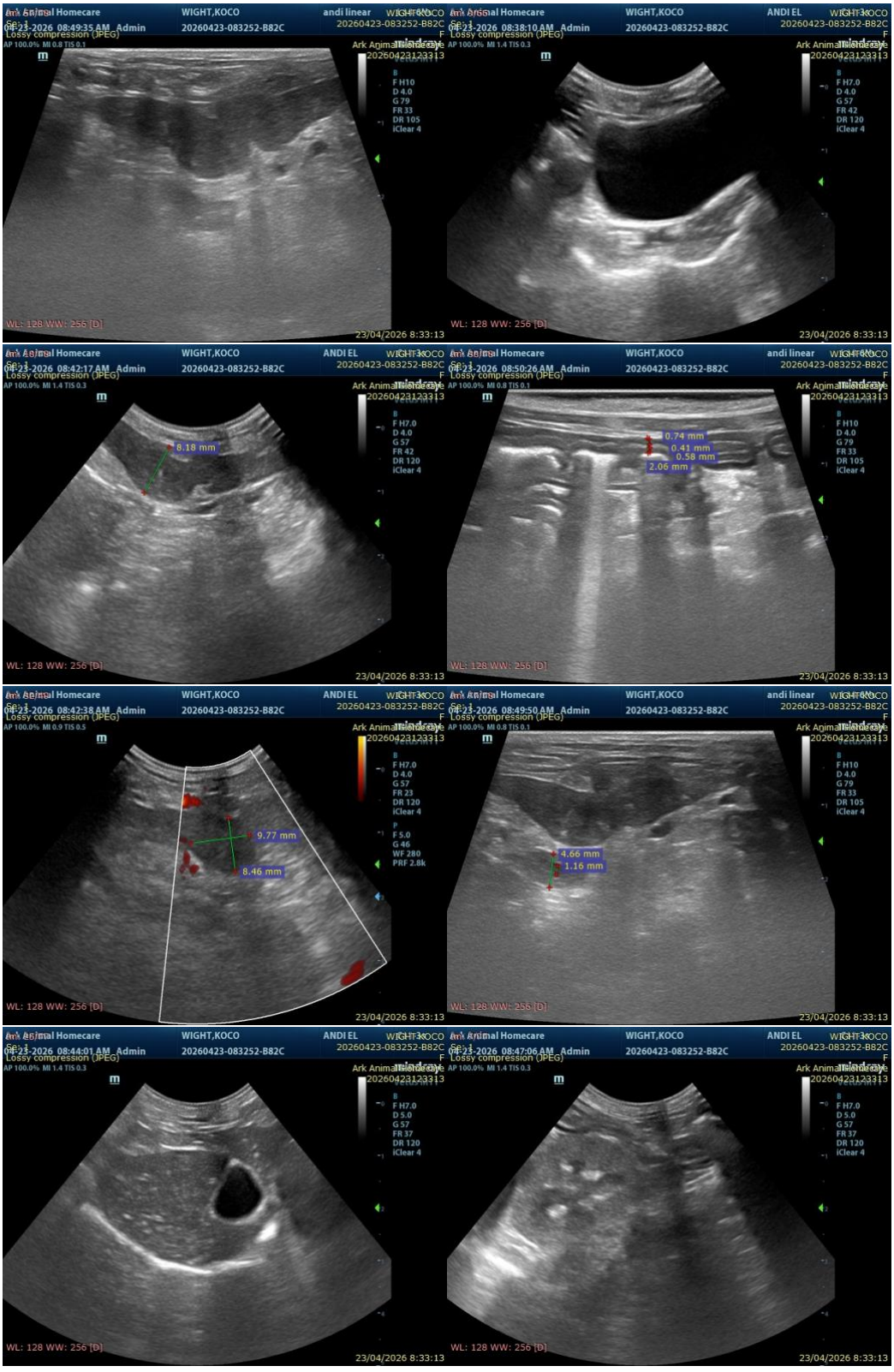

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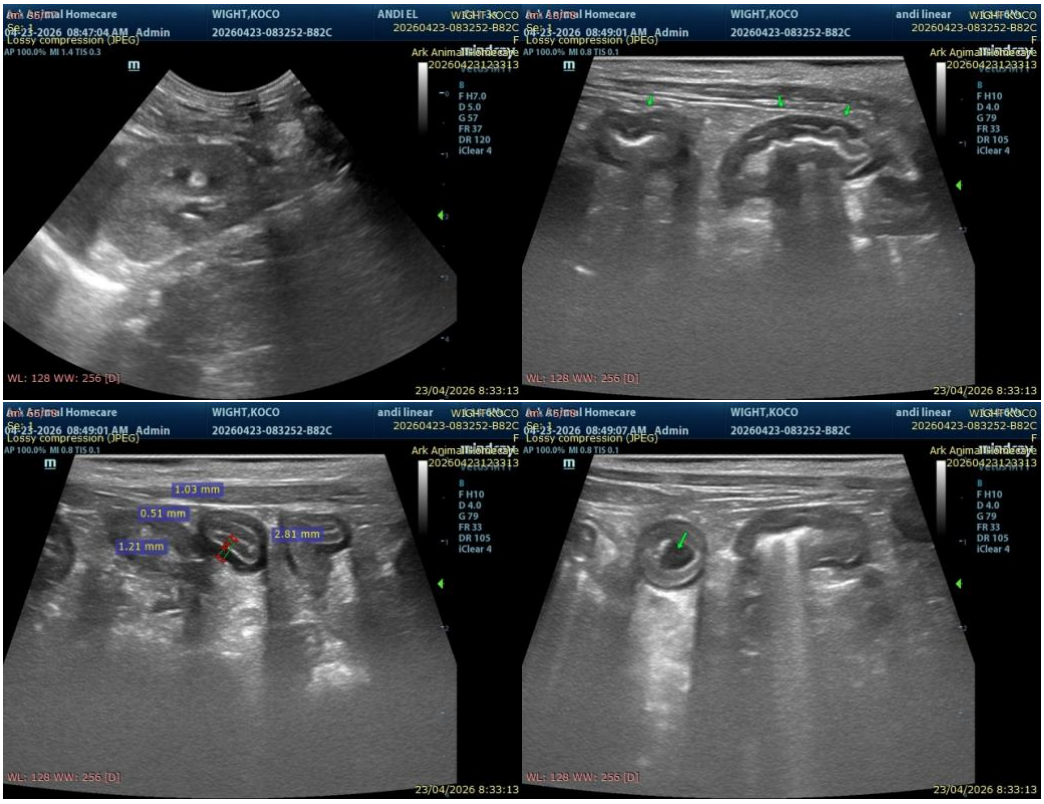


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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