



PATIENT

Niblet Stewart

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

3 years

WEIGHT

8.56 lbs

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Janel Schietzelt, DVM

HOSPITAL NAME

Dreaming Summit AH

REFERRING VET

Dr. Schietzelt

INVOICE

75296

DATE

5/11/26

PRESENTING CLINICAL SIGNS

History: Patient presents for annual wellness. New patient to our clinic, rescued from a shelter last year (was found as a stray prior) and was diagnosed with stomatitis had full mouth extractions, as well as elevated kidney values. Vet there recommended starting k/d. Owner states pet doing well at home, no v/d, eating well, no pu/pd, indoor only.

Recheck labs showed a progressive renal azotemia (labs attached) as well as moderate anemia. On exam stable,, vitals WNL other than light pink gingiva

-Concern for renal dysplasia, polycystic kidney disease, pyelonephritis, other

Abnormal PE/Chem/CBC/UA Results: -Renal azotemia (SDMA 29, Creatinine 3.3, BUN 45), USG 1.015, no bacteria or WBC in urine, urine culture and sensitivity pending still -Mild hypoalbuminemia (2.5) -Anemia (HCT 19.1%, RBC 5.59, Hemoglobin 5.8) -Moderate leukocytosis (28,000) with neutrophilia (20.5), monocytosis (0.89) and eosinophilia (1.236) -FeLV/FIV/heartworm triple SNAP- Negative for all -Fecal pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is predominantly anechoic with scant suspended echoes. Normal appearance of the bladder neck and proximal urethra. No calculi are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic change.

The left kidney is mildly irregular in contour, measuring 3.33×2.14 cm, with a cortical thickness of 0.48 cm in the sagittal plane. The renal cortex is hyperechoic compared to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is identified.

The right kidney is normal in shape and size, measuring 3.53×2.07 cm, with a cortical thickness of 0.34 cm in the sagittal plane. The renal cortex is hyperechoic compared to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is identified.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.23 cm at the cranial pole and 0.23 cm at the caudal pole. The right adrenal gland measures 0.22 cm at the cranial pole and 0.20 cm at the caudal pole.

Spleen

Splenic thickness is 0.62 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.



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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.

The gallbladder lumen is normally distended. The wall measures 0.70 mm in thickness, and the contents are predominantly anechoic. No dilation of the cystic duct or common bile duct is identified.

Gastrointestinal Tract

The stomach is empty and folded, containing a small amount of fluid. Gastric mural thickness measures 3.01-4.05 mm with preserved wall layering. There is subjective prominence of the submucosal layer, measuring 2.04-2.37 mm. The pylorus measures 3.22 mm. The duodenum measures 1.82 mm. The jejunum measures 2.12 mm, with preserved wall layering. The mucosa measures 1.02 mm, the submucosa 0.69 mm, and the muscularis propria 0.38 mm. The ileum measures 1.67 mm, with preserved wall layering. The mucosa measures 0.52 mm, the submucosa 0.76 mm, and the muscularis propria 0.44 mm. The ileocecal junction is not confidently visualized. The descending colon measures 1.29 mm in thickness and is completely empty and collapsed.

Pancreas

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

Free Abdomen

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

PRIMARY FINDINGS

- Bilateral renal cortical hyperechogenicity.
- Mild irregular contour of the left kidney.

SECONDARY FINDINGS

- Mild diffuse prominence/thickening of the gastric submucosal layer.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The kidneys demonstrate mild bilateral cortical hyperechogenicity and subtle irregularity of the left renal contour, compatible with chronic renal parenchymal disease. In the context of the documented renal azotemia, inadequately concentrated urine, and marked nonregenerative anemia, these findings support clinically significant chronic kidney disease. However, the kidneys remain relatively preserved



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structurally, without marked reduction in size, severe architectural distortion, cystic change, hydronephrosis, or imaging features strongly supportive of congenital dysplastic disease or polycystic kidney disease.

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Although pyelonephritis cannot be entirely excluded sonographically, there is no evidence of renal pelvic dilation, pelvic debris, asymmetric pyelectasia, or focal cavitary renal lesions. Likewise, the degree of leukocytosis appears disproportionate to what would typically be expected with stable chronic kidney disease alone, suggesting persistent active inflammation somewhere within the body, potentially oral, gastrointestinal, renal/interstitial, or multifactorial in origin.

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The overall clinical picture raises concern for an underlying chronic systemic inflammatory process rather than uncomplicated early-onset degenerative chronic kidney disease alone. Particularly notable are the young age of the patient, severe historical stomatitis requiring full-mouth extractions, marked inflammatory leukocytosis with neutrophilia and monocytosis, mild eosinophilia, mild hypoalbuminemia, and the relatively modest ultrasonographic renal changes compared with the severity of the laboratory abnormalities. Collectively, these findings suggest the possibility of chronic inflammatory or immune-mediated multisystem disease with secondary renal involvement, potentially including chronic tubulointerstitial nephropathy.

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The mild diffuse prominence of the gastric submucosal layer is nonspecific and does not appear strongly suggestive of infiltrative neoplasia or severe infiltrative gastritis. This appearance may be seen with mural edema, mild hypoproteinemia-associated change, systemic inflammatory disease, or nonspecific reactive change.

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Recommendations

- Correlation with pending urine culture results is recommended, as pyelonephritis cannot be completely excluded despite the absence of classic ultrasonographic changes.
- UPC ratio and systolic blood pressure assessment are recommended if not already performed, given the degree of renal dysfunction, proteinuria, and young age of the patient.
- Serial monitoring of renal values, phosphorus, potassium, hydration status, urine concentrating ability, and hematocrit is advised.
- Given the marked nonregenerative anemia, monitoring for progression of CKD-associated anemia and consideration of supportive management are recommended.
- If eosinophilia, gastrointestinal signs, hypoalbuminemia, or inflammatory leukogram abnormalities persist, additional investigation for chronic inflammatory gastrointestinal disease, parasitism, immune-mediated disease, or multisystem inflammatory disease may be considered.
- Referral nephrology/internal medicine consultation may be beneficial given the young age of onset and complex clinicopathologic presentation.

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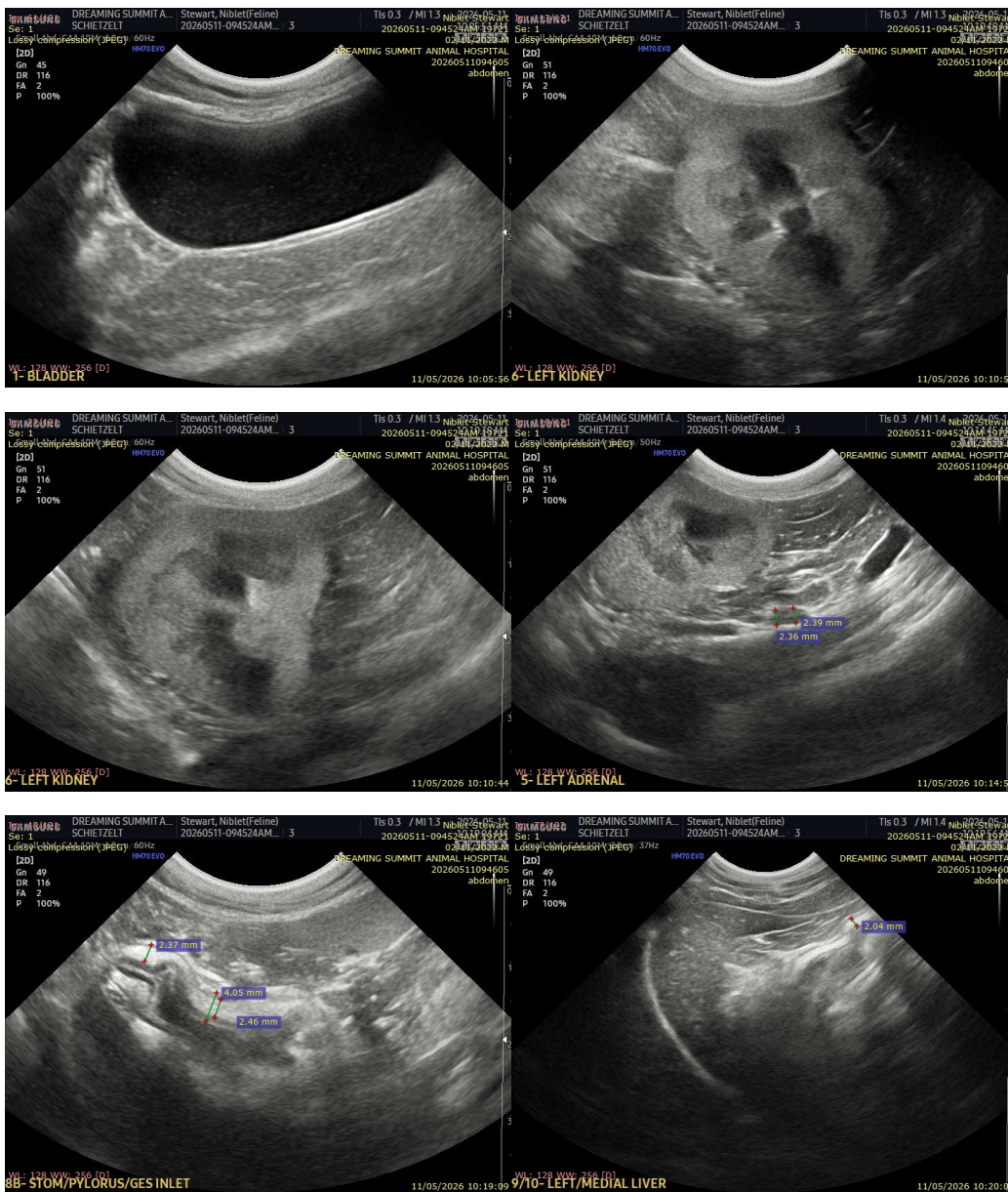
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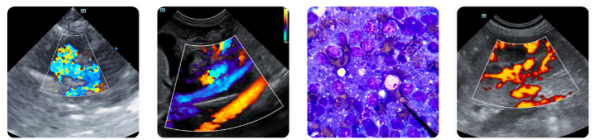
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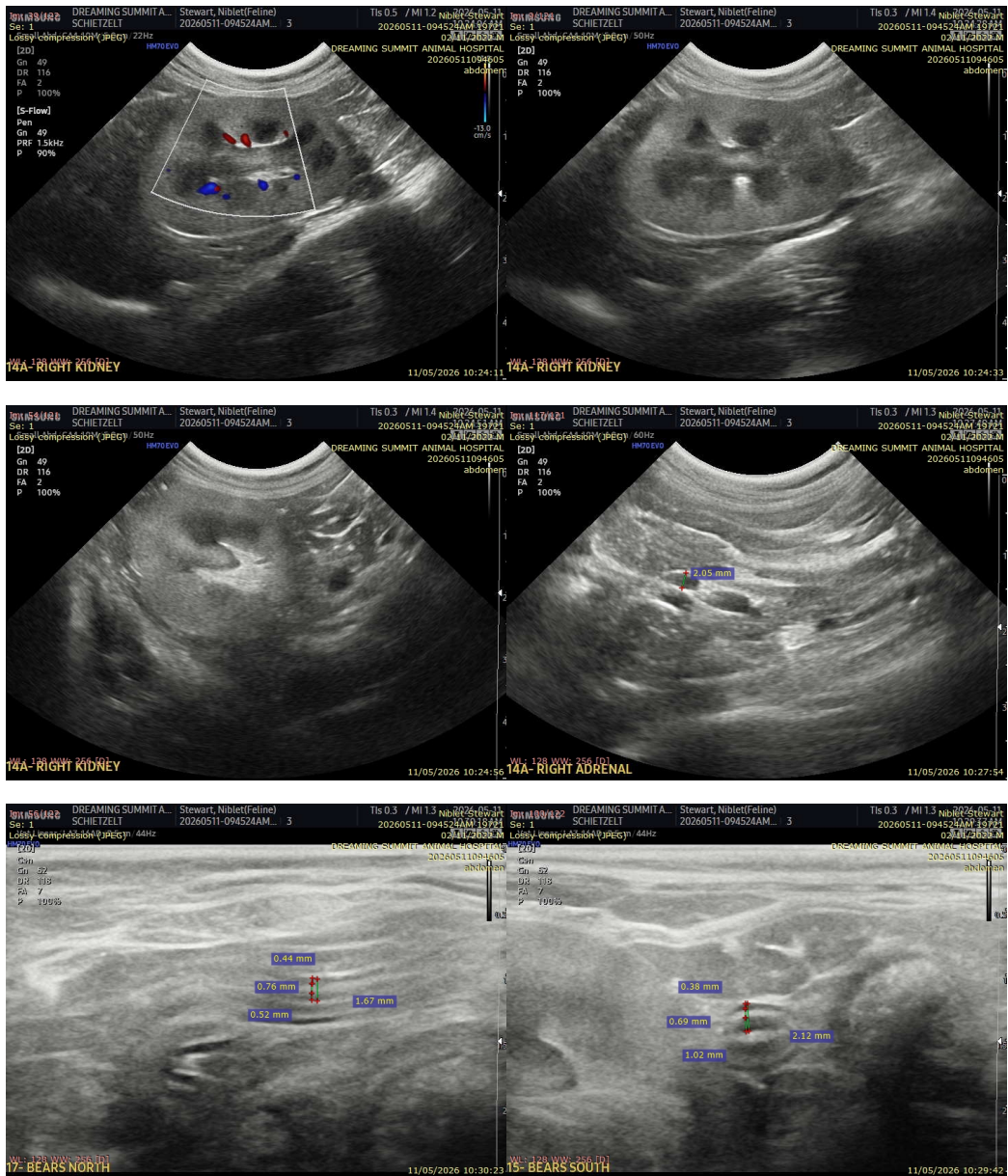
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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