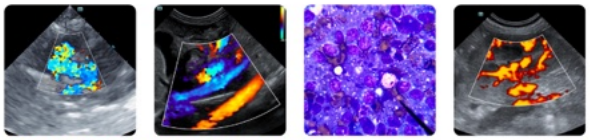


PATIENT

Chicory Brailsford

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

13 years

WEIGHT

7.12 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Renee Ziegler Post

HOSPITAL NAME

For Cats Only VC

REFERRING VET

Dr. Ziegler Post

INVOICE

77726

DATE

5/19/26

PRESENTING CLINICAL SIGNS

History: Patient had an Echo submitted on 5/13/26.
Echo Invoice no. 16174
• Noncardiogenic pleural effusion. • Prominent right heart owing to noncardiac thoracic disease. INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS Differentials include occult neoplasia such as lymphomatosis, especially given the chyle formation. Abdominal sonogram is recommended if not already performed to assess for primary disease that may be metastatic to the chest. Idiopathic chylothorax is also possible. Chest CT, cytospin of a fresh pleurocentesis sample with immediate slide preparation is warranted to assess for exfoliating neoplasia. I do not believe that there is a primary cardiac component in this patient.
Abdominal ultrasound to screen for cancer
RX- Phosphate Binder, Potassium Gluconate, Vitamin B12, Subcutaneous Fluids (50 ml every other day), Mirataz, and Maropitant Citrate

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 predominantly anechoic with scant suspended echoes. 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 mildly irregular in contour and measures 3.84×2.54 cm. The renal cortex is mildly hyperechoic compared to the liver parenchyma. A small cortical cyst measuring approximately 2.60×4.70 mm is present. Corticomedullary definition is markedly decreased. A 3.96 mm nephrolith is identified. There is no evidence of pyelectasia or hydronephrosis. Doppler color interrogation demonstrates a normal vascular pattern.

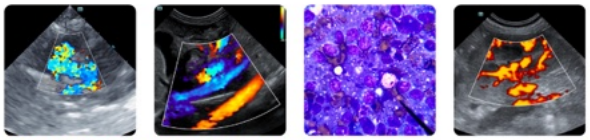
The right kidney is smaller, measuring 3.19×1.70 cm and also mildly irregular in contour. The renal cortex is mildly hyperechoic compared to the liver parenchyma. Corticomedullary definition is diffusely decreased/lost. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Doppler color interrogation demonstrates a normal vascular pattern.

Adrenal Glands

Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.25 cm. The right adrenal gland not confidently visualized

Spleen

Splenic thickness is 0.51 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 hepatic parenchyma appears homogeneous and isoechoic relative to the falciform fat, with normal echotexture. A few very small hyperechoic foci measuring approximately 2.17×2.39 mm are identified within the hepatic parenchyma. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The wall is thin and smooth. A moderate amount of non-shadowing biliary sludge is present. No dilation of the common bile duct is identified, measuring approximately 1.56–1.84 mm in diameter.

Gastrointestinal

The stomach is empty and folded, with mural thickness measuring 1.22 mm and preserved wall layering. Duodenum: 1.72 mm. Jejunum: 2.16 mm. Mucosa: 1.43 mm. Submucosa: 0.43 mm. Muscularis propria: 0.40 mm. Ileum: 1.56 mm. Mucosa: 0.52 mm. Submucosa: 0.67 mm. Muscularis propria: 0.34 mm. Wall layering remains preserved. The ileocecocolic junction measures 2.75 mm in thickness, with mucosa measuring 0.86 mm and muscularis propria measuring 0.89 mm. No evidence of gastrointestinal obstruction, ileus, or foreign material is identified. The colon measures 0.72–0.74 mm in thickness and contains scant soft fecal material within the descending segment.

Pancreas

The pancreas measures approximately 6.58 mm in thickness. The pancreatic parenchyma is isoechoic relative to the adjacent mesenteric fat. The pancreatic duct measures 1.14 mm in diameter. No convincing evidence of active peripancreatic fat inflammation is identified.

Free Abdomen

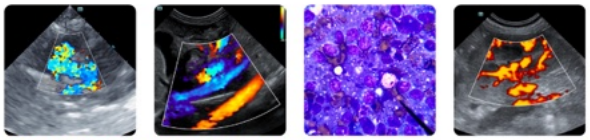
No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Bilateral chronic renal changes, more pronounced on the left, including decreased corticomedullary definition, mild cortical hyperechogenicity, mild contour irregularity, small cortical cyst, and left nephrolithiasis.
- Moderate biliary sludge.

SECONDARY FINDINGS

- Mild pancreatic enlargement with mild pancreatic duct dilation.
- Mild muscularis propria prominence involving the ileocecocolic junction.
- Few tiny hyperechoic hepatic foci.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The dominant abdominal ultrasonographic abnormalities involve the kidneys and are most compatible with chronic bilateral renal parenchymal disease. Findings including decreased corticomedullary definition, mild cortical hyperechogenicity, mild contour irregularity, a small cortical cyst, and nephrolithiasis support chronic degenerative/interstitial renal change. No evidence of obstructive nephropathy is identified at this time.

Moderate biliary sludge is present without gallbladder wall thickening, biliary obstruction, or additional sonographic evidence of clinically significant hepatobiliary disease. In this context, the sludge is favored to represent an incidental finding related to altered bile stasis/motility rather than clinically significant obstructive biliary disease.

Mild pancreatic enlargement and mild pancreatic duct dilation may reflect chronic/age-related pancreatic remodeling or mild chronic pancreatopathy. No convincing ultrasonographic evidence of active pancreatitis is identified during the current examination.

The ileocecocolic junction demonstrates mild disproportionate muscularis propria thickening. The muscularis-to-mucosa ratio at the ileocecocolic junction is approximately 1.03, which mildly exceeds expected feline reference values. This finding may be seen with chronic inflammatory enteropathy and, less specifically, low-grade alimentary lymphoma. However, the remainder of the gastrointestinal tract is relatively unremarkable sonographically, without significant diffuse intestinal muscularis thickening, loss of mural layering, obstruction, abdominal lymphadenomegaly, or abdominal effusion.

Importantly, no sonographic evidence of abdominal metastatic disease, marked infiltrative neoplasia, or a definitive primary abdominal cause for the reported chylous pleural effusion is identified during the current examination. Small-cell lymphoma or other occult infiltrative disease cannot be completely excluded sonographically, particularly in cats, but the abdominal findings remain relatively subtle overall at this time.

The tiny hepatic hyperechoic foci are nonspecific and may represent incidental benign mineralized/fibrotic change.

Recommendations

- Correlation with pleural fluid cytology/cytospin results and thoracic imaging findings is recommended.
- Given the history of chylous pleural effusion, thoracic CT may still be clinically valuable if concern for occult thoracic neoplasia or lymphatic obstruction remains high.
- Clinical monitoring and follow-up abdominal ultrasound may be considered if gastrointestinal signs progress or if clinical suspicion for infiltrative intestinal disease increases over time.
- Correlation with renal values, SDMA, blood pressure, and serial urinalysis is recommended given the chronic renal changes identified.

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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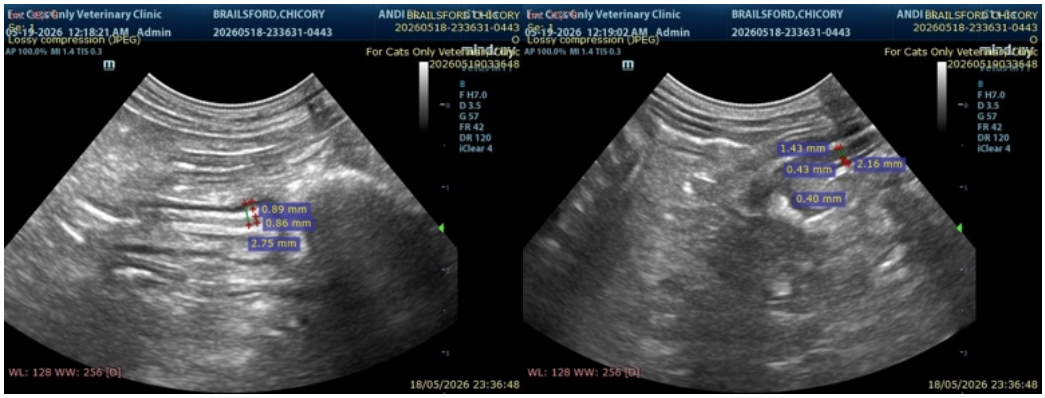

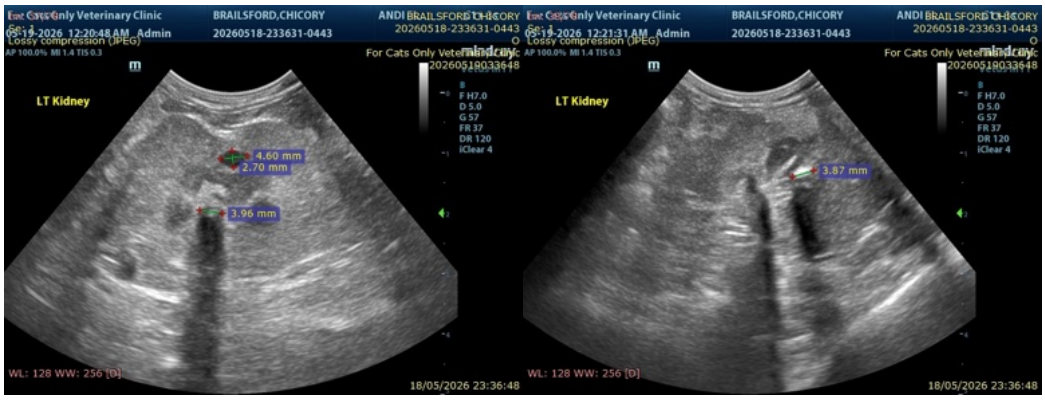

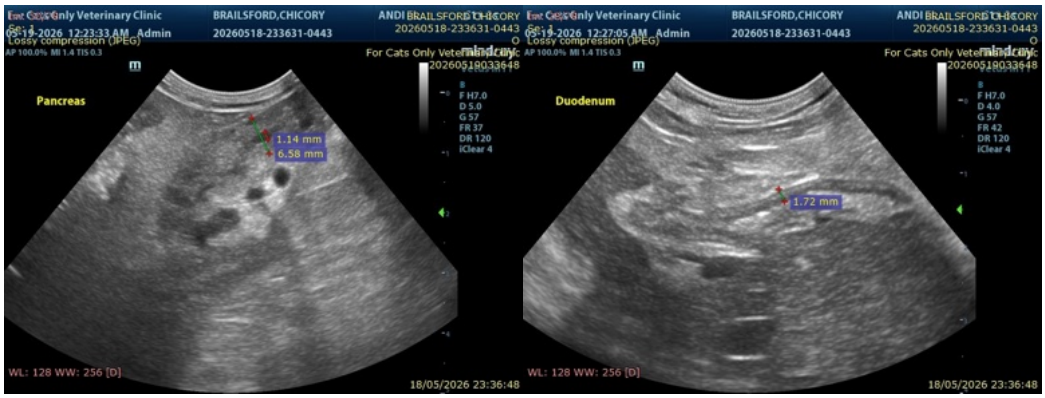

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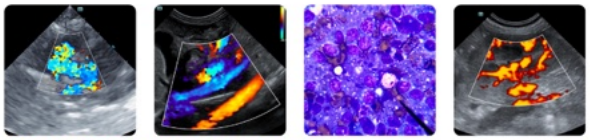

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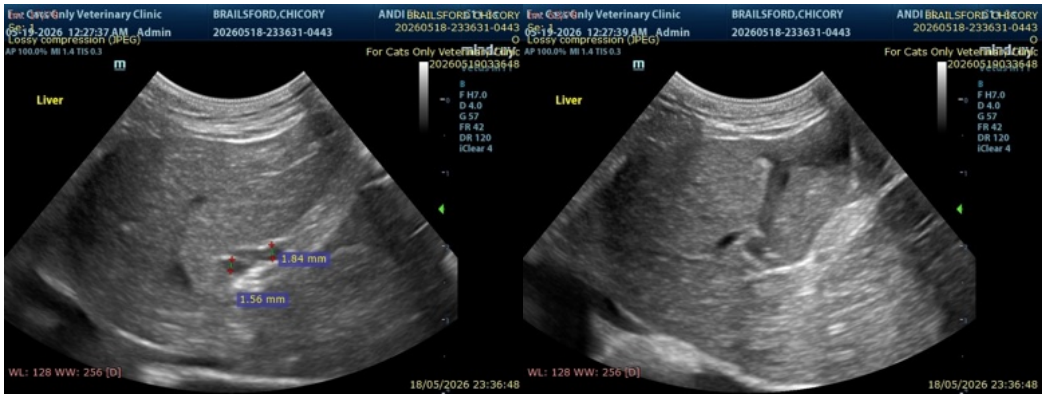

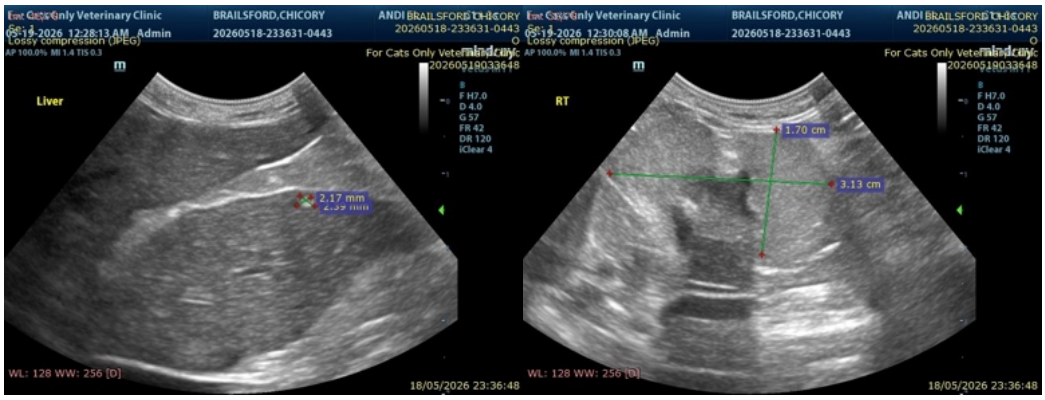

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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