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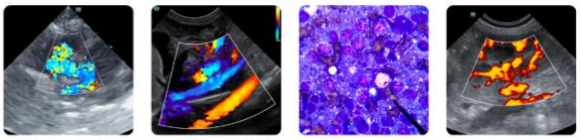

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Freya Campbell

SPECIES

Female Spayed

BREED

DMH

SEX

Female Spayed

AGE

8

WEIGHT

10.7 lbs

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Stewart's Mt View AH

REFERRING VET

Dr. Stewart

INVOICE

22414

DATE

1-21-26

PRESENTING CLINICAL SIGNS

- P on Flovent inhaler for asthma. presented for dental for severe periodontal dz. resorptive lesions, extractions 109/209-boarding after procedure. 12/1- vomited diarrhea weight loss- p lethargic and spacey, concern for ARF, IV fluid therapy and supportive tx started- bloodwork returning to normal
- 12/10/25- Developed Horn er's syndrome
- P appetite improving slowly, Horner's improving, owner reports behavior change
- Returned 1/19 for not eating 2 days HCT 20%, WBC 17, Neu 10.8, Bands suspected

Abnormal PE/Chem/CBC/UA Results: 12/3/25 Chem SDMA 78 Crea 8.9, BUN 117, Phos 13.6, K 5.7 triple test neg

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. Luminal contents are mostly anechoic. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (4.17 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. A hyperechoic medullary band is observed adjacent to the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal. Perirenal fat is hyperechoic.

The right kidney is normal in size (3.95 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. A hyperechoic medullary band is observed adjacent to the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal. Perirenal fat is hyperechoic.

Adrenal Glands

The left adrenal gland is normal size (0.42 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.42 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.84 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A moderate-to-large amount of gravity-dependent, echogenic debris/sludge is observed within the lumen. The cystic and common bile ducts are visible but not overtly dilated. The duodenal papilla is normal-in-size (0.37 cm in width).

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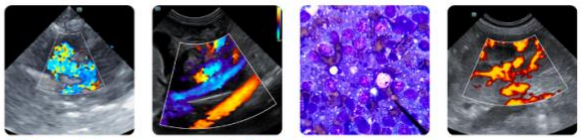

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Gastrointestinal

The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The pancreas is visible, with normal peripheral contours. The parenchyma is slightly hyperechoic relative to surrounding omental fat and homogenous in appearance. No focal lesions are observed. The pancreatic duct is not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph Nodes

Two prominent medial iliac lymph nodes are visualized (the largest measuring 1.04 x 0.66 cm) and is slightly cystic in appearance. In addition, a 0.3 x 0.34 cm gastric lymph node is seen. One-to-two prominent mesenteric lymph nodes are also visualized (one measuring 0.83 x 0.57 cm).

Free Abdomen

There is no obvious evidence of free fluid.

Other

A brief echocardiogram reveals no obvious evidence of pericardial or pleural effusion in the visible window.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bilateral nephropathy with concurrent cranial retroperitonitis. Considerations include acute or acute-on-chronic renal disease. Possible causes include infection, toxin, hypotensive event, neoplasia (less likely), other.

Secondary Findings

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The hypoechoic pancreas may be a normal variant for this patient or may represent mild pancreatitis. Correlation with the patient's clinical history is recommended.
- Gallbladder debris/sludge

*An obvious cause for the patient's anemia is not definitively identified in this study. Considerations include regenerative causes (i.e., blood loss, hemolysis) vs nonregenerative causes (i.e., chronic renal failure, low-grade GI blood loss, anemia of chronic disease, bone marrow disease, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A CBC with reticulocyte and clinical pathology review is recommended.
- Also consider a slide agglutination test, +/- vector-borne disease testing.
- Feline leukemia and FIV testing is recommended (if not already performed).
- Depending on the results of the above diagnostics, a bone marrow aspirate may be warranted.

Regarding the azotemia, consider the following (if not already performed):

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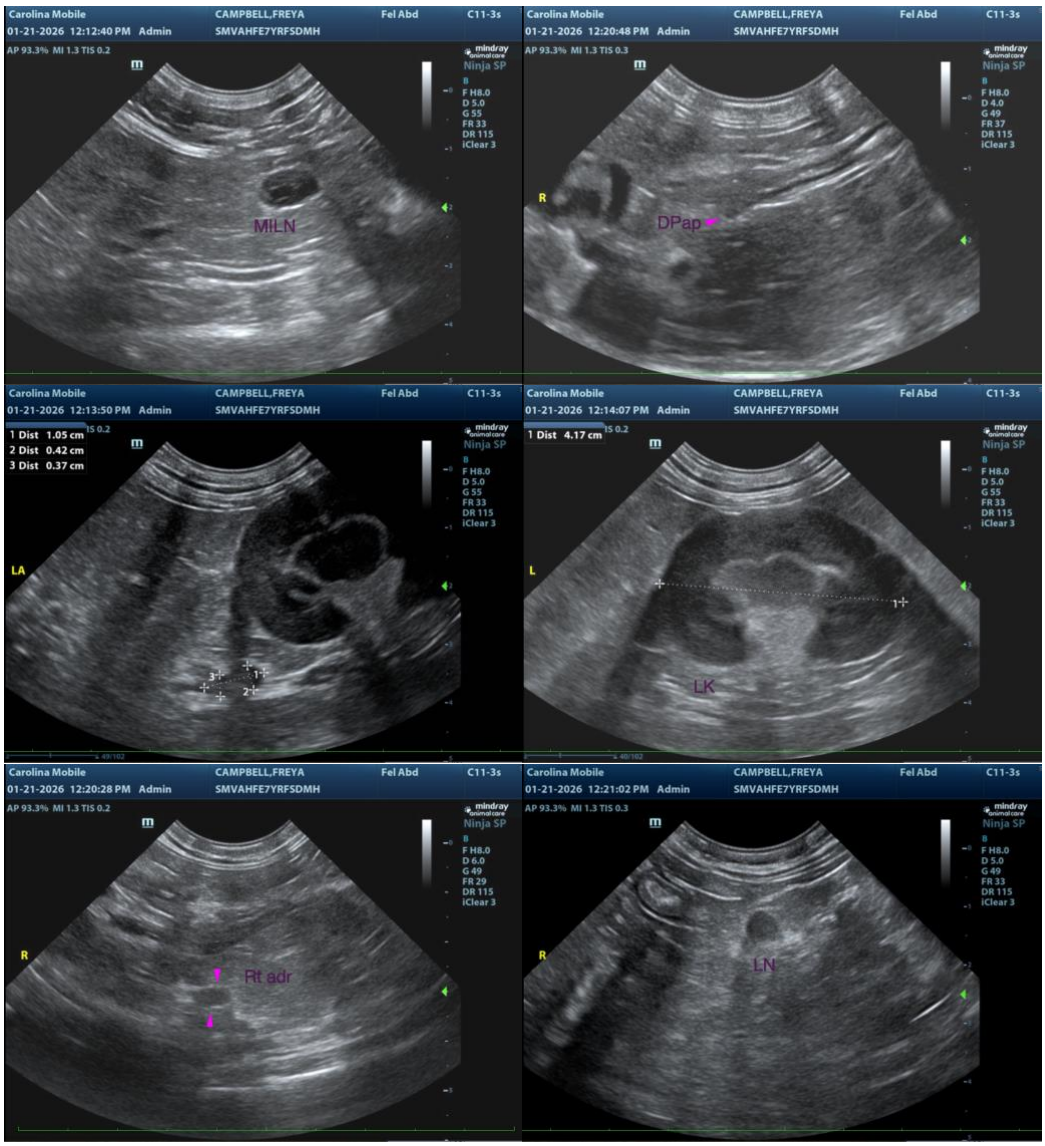
1. Urinalysis with culture and sensitivity
2. UPC if proteinuria is present in the absence of infection
3. Blood pressure measurement

Regarding the neurologic changes, consider consultation with a board-certified neurologist for further evaluation. A T4/free T4 by equilibrium dialysis is also recommended (if not already performed).



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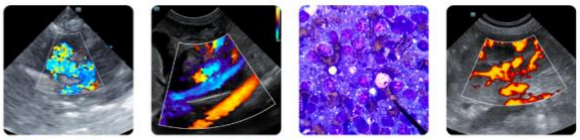

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com