Charleston Mobile Veterinary Services
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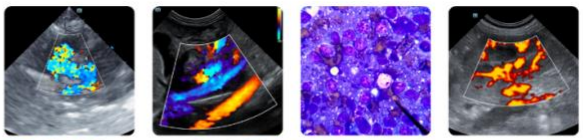

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Ami Winslow

SPECIES

Feline

BREED

DSH

SEX

Male Neutered

AGE

10/7/2012

WEIGHT

4 kg

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Sun Dog Cat Moon

REFERRING VET

Dr Fetterolf

INVOICE

22469

DATE

1-29-26

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Previous AUS performed by you 11/14/2024 (4.76 kg at this time) to work up increased appetite and weight loss after hyperthyroidism ruled-out -> The small intestinal wall changes could be consistent with inflammatory bowel disease, or emerging small cell lymphoma. Bilateral nonspecific chronic renal changes. TAMU GI PANEL all wnl/non diagnostic. He has had loose stool on and off. He remains hungry but continues to lose weight. Client is concerned about a painful tooth; however awake oral exam does not reveal any significant findings. I recommended a follow up AUS to assess for progression of abnormalities noted in 2024 / new findings before moving forward with general anesthesia for a COHAT. Recent T4 normal. Patient tried a limited antigen or hydrolyzed protein diet, but patient would not eat it.

Abnormal lab-work values: Patient does have a heart murmur. BNP (6/25 and 1/26) is normal. He also has a h/o unilateral nasal discharge which has resolved w appropriate antibiotic.

Summary of Abnormal Laboratory Findings
01/07/2026
Renal / Urinary
SDMA: 20.2 µg/dL (↑)
Now clearly elevated; supports declining renal function
Renal Tech Index: POSITIVE (↑)
Predicts development of CKD within 24 months with >95% accuracy
Urinalysis:
Protein: 1+ (↑) – persistent proteinuria
Blood: 3+ (↑)
RBCs: 4–10/HPF (↑)
Cocci bacteria present (<10/HPF) – verified on Wright's stain
Suggests hematuria with possible lower urinary tract involvement (culture recommended)
Pancreatic
Precision PSL: 29 U/L (↑)
Mild elevation; supportive but not diagnostic for pancreatitis
Metabolic
Triglycerides: 24 mg/dL (↓) – mildly low, likely clinically insignificant
Hematology
Platelets: 125 K/µL (↓)
Likely artifactual due to platelet clumping (estimate adequate)
06/27/2025
Renal
Renal Tech Index: POSITIVE (↑)
Early indicator of future CKD despite near-normal traditional renal values
Hematology
WBC: 19.6 K/µL (↑) – leukocytosis
Neutrophilia (↑)
Lymphocytosis (↑)
Monocytosis (↑)
Pattern consistent with inflammation, stress, or chronic disease
Urinalysis
Protein: 1+ (↑
Blood: 2+ (↑)
RBCs: 11–20/HPF (↑)
Persistent hematuria and proteinuria
02/26/2025

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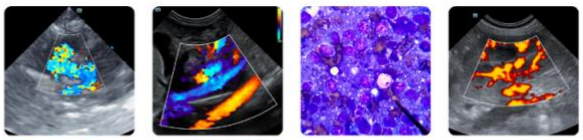

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Renal
Renal Tech Index: POSITIVE (↑)
Confirms ongoing elevated risk for CK
11/15/2024
Hematology
WBC: 17.4 K/µL (↑)
Absolute neutrophils: 11,658/µL (↑)
Mild inflammatory leukogram
10/23/2024
Renal
SDMA: 16.4 µg/dL (mild ↑)
Early renal biomarker elevation (preceded later progression)
Creatinine: 1.5 mg/dL (high-normal)
Protein
Albumin: 4.1 g/dL (↑) – mild, likely dehydration-related
Hematology
WBC: 21.5 K/µL (↑)
Neutrophilia, lymphocytosis, monocytosis
Platelets: 126 K/µL (↓)
Likely due to clumping (estimate adequate)
Key Longitudinal Patterns
Progressive renal concern:
SDMA rising from mildly elevated → clearly abnormal
Repeated positive Renal Tech Index
Persistent proteinuria and hematuria on multiple urinalyses
Intermittent leukocytosis with mixed inflammatory leukograms
Mild pancreatic enzyme elevation without definitive pancreatitis
Thrombocytopenia intermittently reported, likely artifactual

Current Medications: Kitty Biome

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is distended. Luminal contents are 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 (3.59 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.14 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.35 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

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The right adrenal gland is normal size (0.45 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.77 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 curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal. The duodenal papilla is normal-in-size (0.28 cm in width).

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is mildly distended with ingesta and some soft, shadowing material. 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 thickness is normal. There is disruption in the normal 1:3 muscularis: mucosal ratio in some segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas

The base and limbs of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph Nodes

One-to-two prominent mesenteric lymph nodes are visualized (one measuring 0.89 x 0.51 cm). Surrounding mesentery is slightly hyperechoic.

Free Abdomen

There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The small intestinal wall changes could be consistent with inflammatory bowel disease or may be a normal variant for this patient. Changes are similar to the previous sonogram.
- Minor retained gastric ingesta. The soft, shadowing material within the gastric lumen may represent normal ingesta and/or foreign material (i.e., hair). It appears nonobstructive at the time of this study.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

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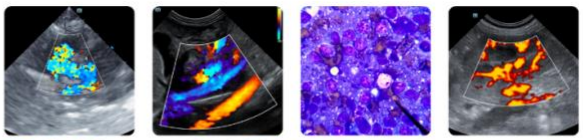

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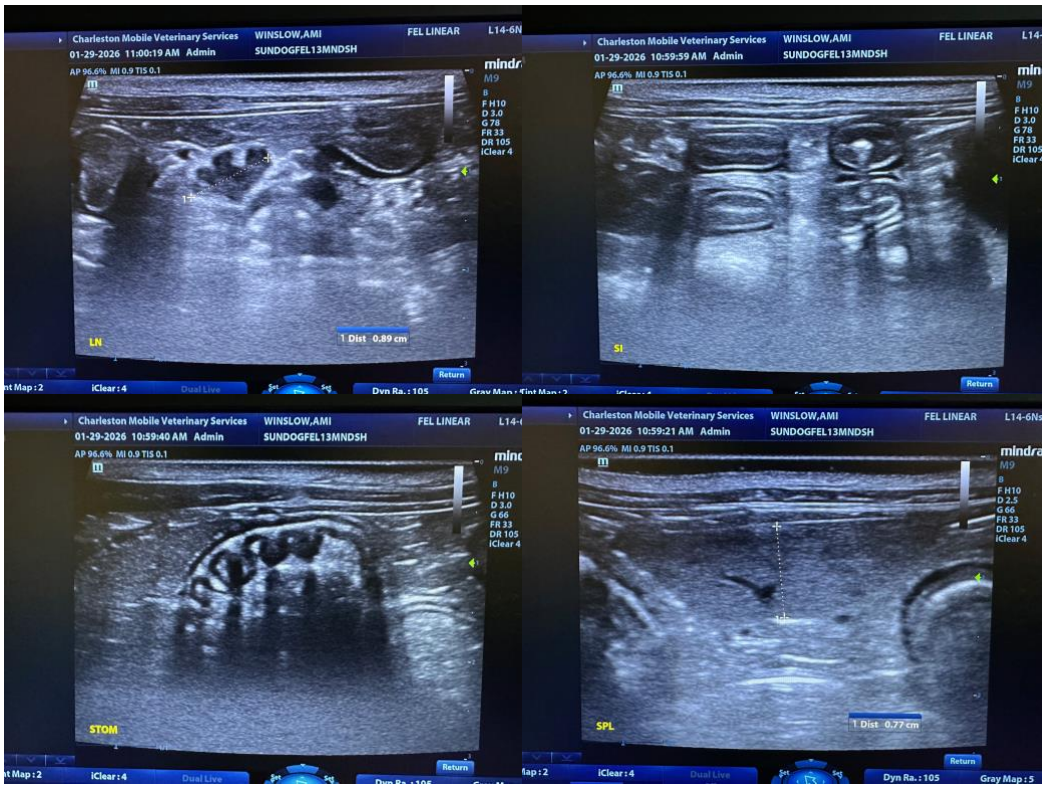
Secondary Findings

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Bilateral nonspecific age-related renal changes with dystrophic mineralization

*Overall, changes are similar to the previous sonogram. An obvious cause for the patient's weight loss is not identified in this study. Considerations include maldigestion/malabsorption, occult neoplasia, dental disease, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A GI panel including serum cobalamin and folate, TLI and PLI is recommended to assess for maldigestion/malabsorption and pancreatic disease.
- Consider three-view thoracic radiographs to assess for occult pathology in the chest.
- Depending on the results of the above diagnostics, further work-up (i.e., GI biopsies) may be warranted.



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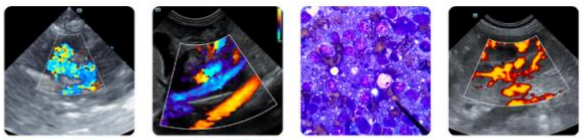

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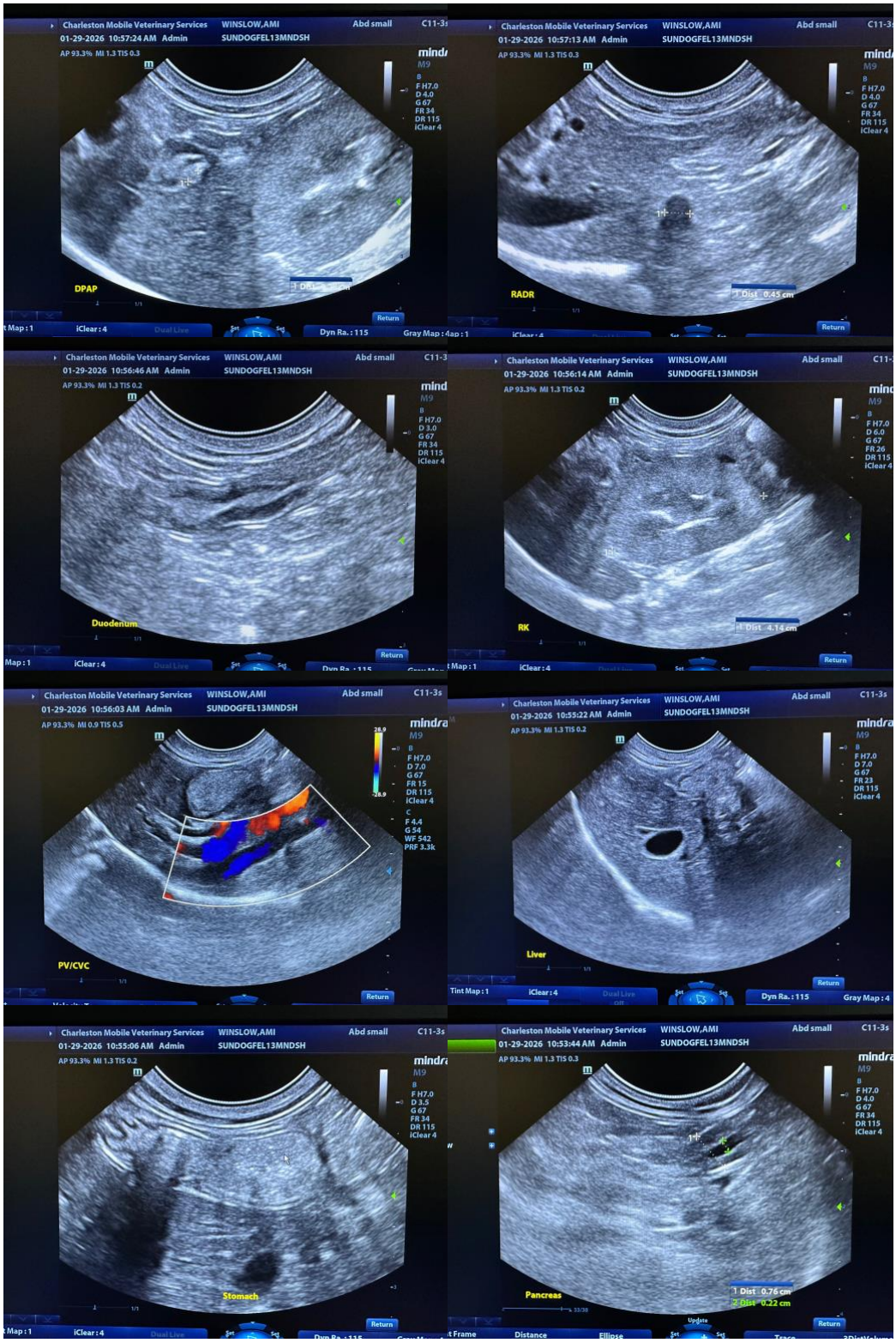

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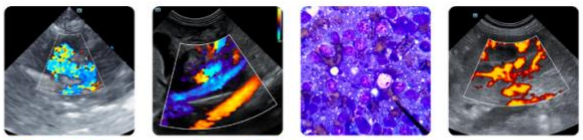

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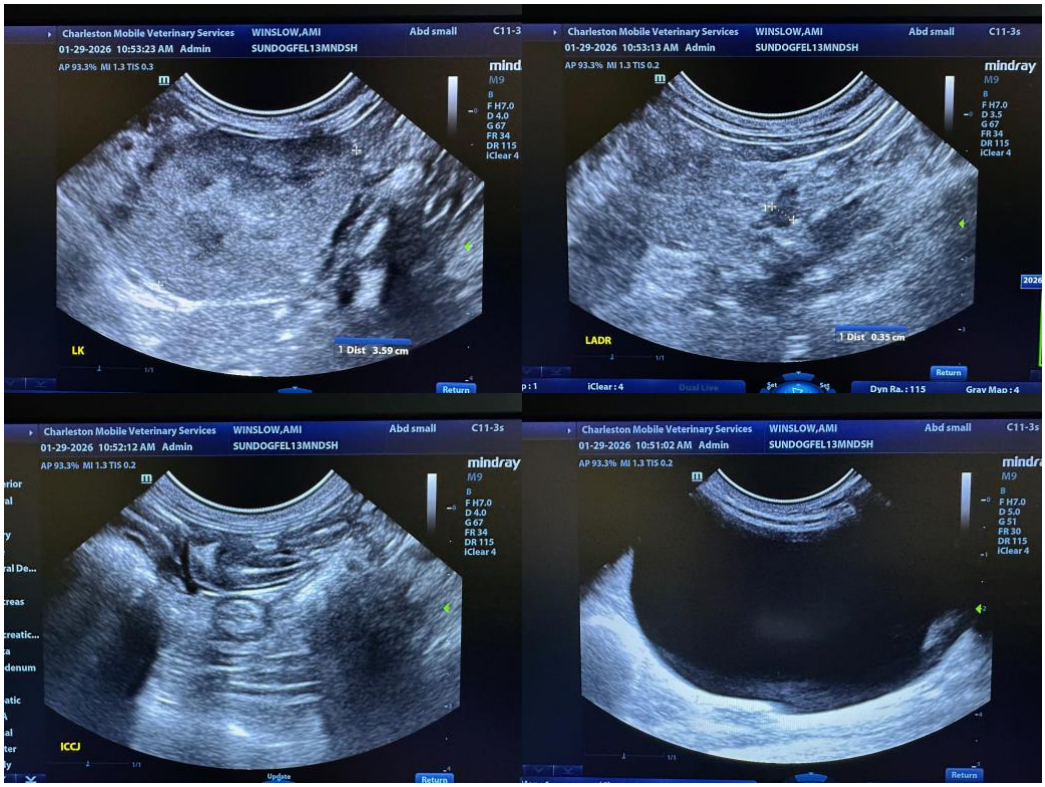

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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