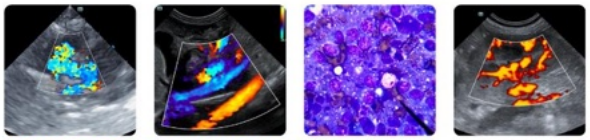


PATIENT

Jasper Dewan

SPECIES

Feline

BREED

Domestic shorthair

SEX

Male, neutered

AGE

1 Yr. 8 months

WEIGHT

5.8 kg.

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

IMAGING PERFORMED BY

Dr. Rankin

HOSPITAL NAME

Silverado VH

REFERRING VET

Dr. Marahar

INVOICE

13417

DATE

12/8/25

PRESENTING CLINICAL SIGNS

History: Jasper is a nearly two-year-old patient with a recent diagnosis of azotemia and a history of chronic constipation, who presented for vomiting and lethargy. On 12/03, the patient was diagnosed with kidney disease, supported by blood work revealing azotemia (SDMA 18, Creatinine 378, BUN 19.6) and a urinalysis showing dilute urine (USG 1.019). Radiographs taken at this time showed a potentially smaller left kidney. This is a significant change from 01/2025, when blood work was within normal limits (SDMA 12, Creatinine 162, BUN 9.2) and radiographs showed kidneys of normal size. The patient has a history of chronic constipation. The recent diagnostic workup was initiated due to the acute onset of vomiting and lethargy. The patient has a significant history of a septic abdomen resulting from a small intestinal perforation that required surgical intervention. On 05/21/2025, the patient also underwent surgery for a septic abdomen, which was confirmed by the presence of pneumoperitoneum on radiographs. Intraoperatively, a mild to moderate amount of free fluid was noted in the abdomen. The source of the sepsis was identified as a two-millimeter punctate perforation in the proximal small intestine, just past the pylorus, for which no obvious cause was found. The area was resected using a punch biopsy.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is small in size (2.55 cm in length) with a slightly irregular shape. The cortex is hyperechoic relative to the liver and subtly heterogeneous in appearance. It is variably thickened. There is poor corticomedullary distinction. Trace pyelectasia is present. There is no evidence of hydroureter.

The right kidney is mildly enlarged (RkAN cm in length) with slightly swollen peripheral contours. The cortex is hyperechoic relative to the liver and subtly heterogeneous in appearance. There is poor corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal size (0.33 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.38 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

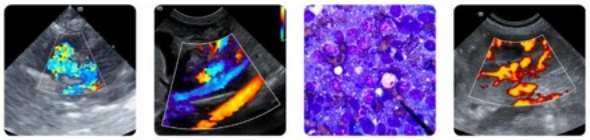
Spleen

The spleen is normal in size (0.93 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 gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.



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Gastrointestinal
The gastric lumen is mildly distended with ingesta. The gastric wall in the region of the fundus is normal in thickness with a normal layering pattern. Near the pyloric antrum, the wall is mildly thickened (up to 0.45 cm) with retention of the 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 ileocecocolic junction and colonic wall are normal. There is no obvious evidence of an obstructive pattern.

Pancreas
The pancreas is normal in size with normal peripheral contours. The pancreatic duct is normal. The base and limbs of the pancreas are isoechoic to surrounding omental fat. No focal lesions are observed. There is no evidence of peripancreatic inflammation or effusion.

Lymph nodes
A 1.05 x 0.76 cm gastric lymph node is visualized. At least 2-3 prominent mesenteric lymph nodes are also seen, one measuring 1.24 x 0.43 cm.

Free Abdomen
Trace free fluid is observed.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Small left kidney with chronic changes. A previous insult (i.e., hypotensive event, infection, toxin) is possible with subsequent chronic changes/atrophy. The right kidney is mildly enlarged, also with chronic changes. The right renomegaly may be secondary to compensatory hypertrophy.
- The mild gastric wall thickening in the region of the pyloric antrum may be a normal variant for this patient or could be secondary to gastritis, fibrosis (i.e., from prior surgery), hypertrophy or less likely, emerging neoplasia.
- The trace ascites may be secondary to increased hydrostatic pressure, increased vascular permeability or low oncotic pressure (if applicable).

Secondary Findings:

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the azotemia, consider the following:

1. Urinalysis with culture and sensitivity
2. UPC (if proteinuria is present in the absence of infection)
3. Baseline blood pressure measurement to assess for systemic hypertension
4. Fluid therapy and other symptomatic measures as needed
5. Transition to a prescription renal diet if the patient is not already receiving one
6. Serial monitoring of the patient's renal values to assess progression of the azotemia

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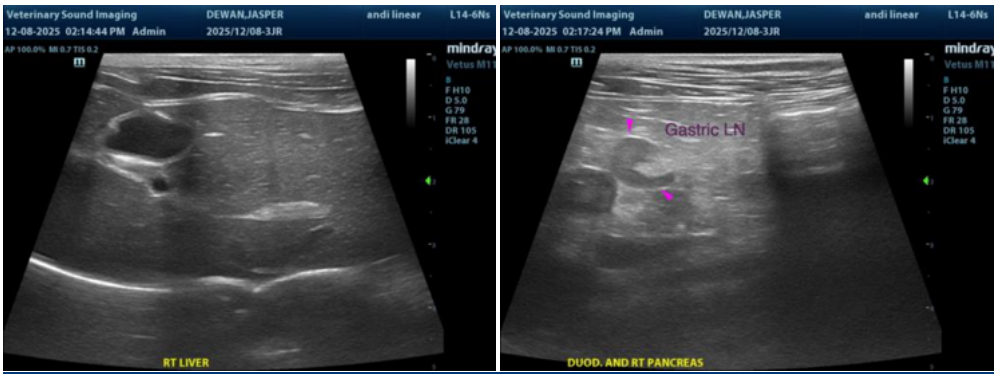

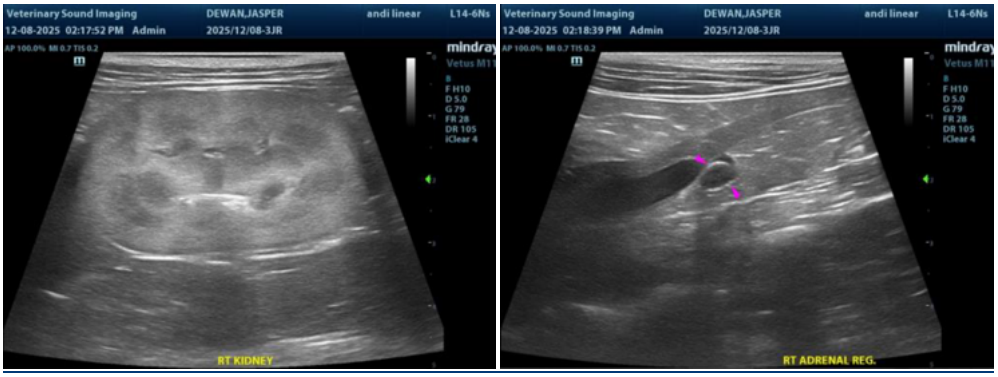

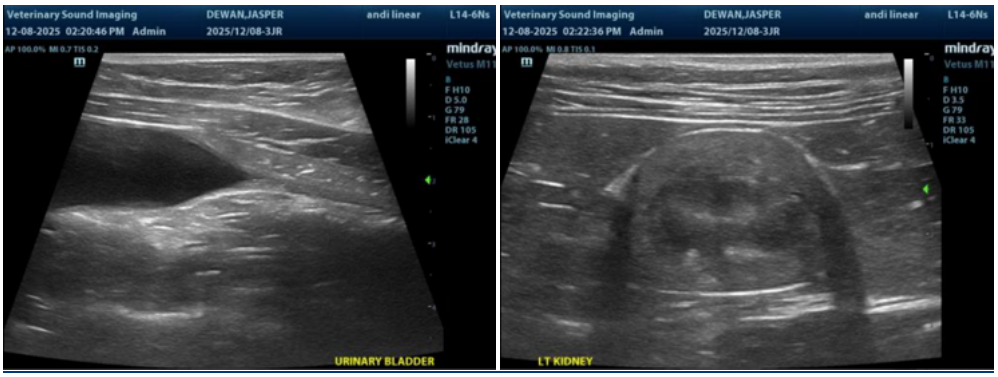

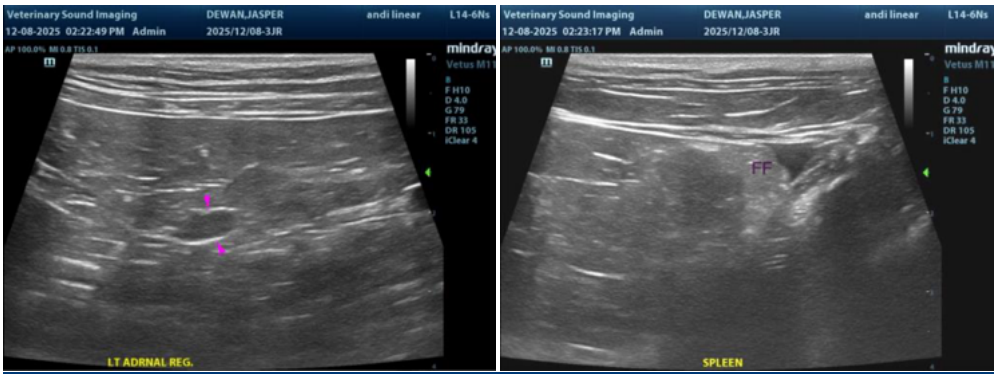

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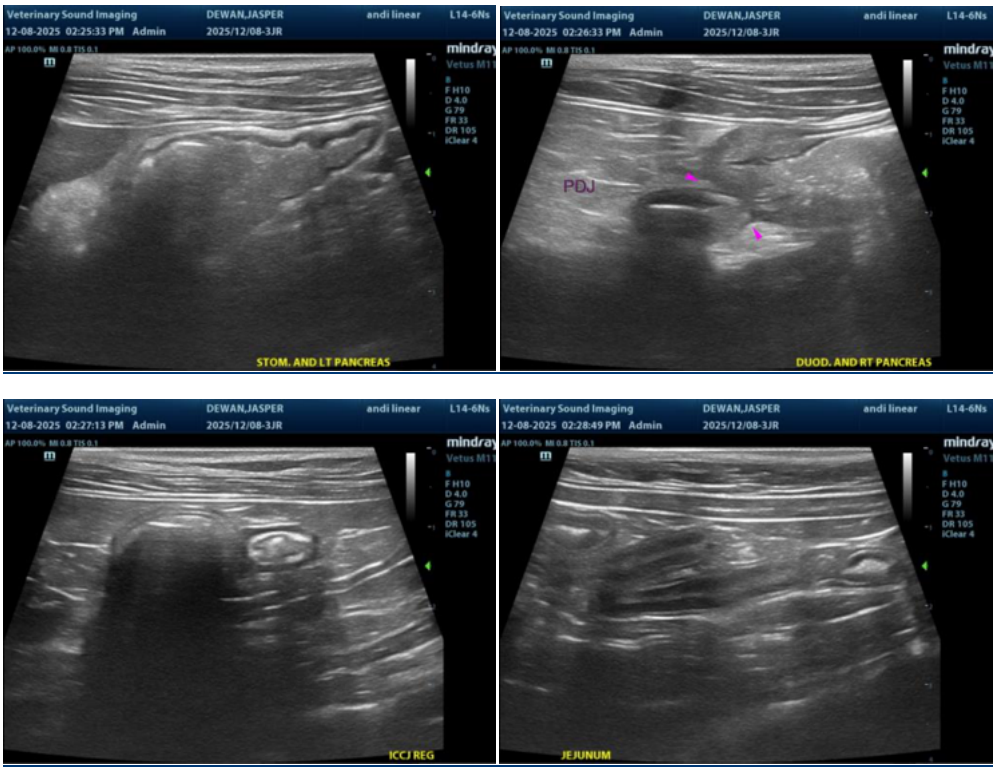

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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