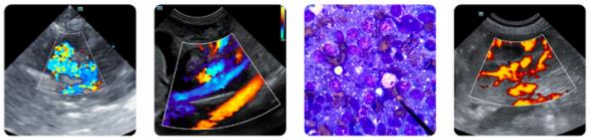

PATIENT

Chewy Kenning

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

12 Years

WEIGHT

6.74 kg

INTERPRETED BY

Bradley Harris, DVM, DACVECC, DACVIM (Cardiology)

IMAGING PERFORMED BY

Dr. Mariusz Chmielinski, DVM

HOSPITAL NAME

Apex VS, Ltd.

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PRESENTING CLINICAL SIGNS

History: Presenting Complaint: Acute lethargy, hypersalivation, inappetence, and hypotension. Recently diagnosed with chronic kidney disease by rDVM (June 5, 2026). Appetite has been poor for approximately 3 weeks with intermittent diarrhea. Marked clinical deterioration over the preceding 24 hours despite anti-nausea therapy. Semintra started morning of presentation.

Abnormal PE/Chem/CBC/UA Results: Clinical Findings: QAR to dull mentation BCS 3.5/9 Hypotensive despite fluid bolus (BP initially 94/72 mmHg, MAP 79; subsequent readings as low as MAP 47–60) Mild pyrexia (39.4°C) Pale pink mucous membranes Stringy hypersalivation Decreased urine production reported by owner Abdominal palpation: gassy/gurgly abdomen Previous B/W June 5 Creatinine 227 µmol/L >> now 540 BUN now 25.9 mmol/L HCT 36% Thrombocytosis (491 x10^{9}/L) Findings consistent with IRIS Stage 2–3 CKD.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic urine. The bladder, trigone, and pelvic urethra are unremarkable with normal wall thicknesses and normal tone. The ureters were not visualized, which is a normal finding. The bladder contains a minimal amount of suspended echogenic mobile debris. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size. The cortices are hyperechoic with a decrease in corticomedullary distinction. There are mild renal cortical cystic changes. The right renal capsule is moderately irregular, and the left renal capsule is minimally distorted, consistent with chronic degenerative changes and renal infarcts. The left kidney measures 4.93 cm. The right kidney measures 3.5 cm.

Adrenal Glands

Both adrenal glands are visualized and have normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measures 0.32 cm. The right adrenal gland measures 0.34 cm.

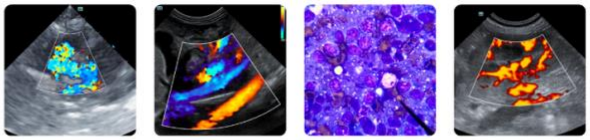
Spleen

The spleen is smooth with homogeneous parenchyma and hyperechoic to liver and renal cortical parenchyma. The capsule is without noticeable irregularity or deformation. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis. No evidence of acute or chronic inflammatory, neoplastic, or infarct are documented. The spleen measures 0.85 cm at the hilus.

Liver

The liver is subjectively normal in size and contour with a hyperechoic parenchyma that is hyperechoic to the falciform fat. The gallbladder has thin walls which contain anechoic bile. There is no evidence of intra- or extrahepatic biliary dilation. The cystic and common bile ducts were normal.

Gastrointestinal



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The stomach is mildly distended with echogenic luminal contents. There's hyperechoic irregular shadowing material within the fundus that appears non-obstructive. The pylorus and pyloroduodenal junction are patent. The small intestine is minimally distended with normal wall thickness. There are multiple segments that have a thickened muscularis layer that distorts the normal 1:3 muscularis to mucosal ratio. The ileocecocolic junction is patent. The colon contains normal shadowing feces.

Pancreas

The base and limbs of the pancreas are isoechoic to surrounding omental fat. The pancreatic duct and capsular contour are normal. There is no overt evidence of active inflammatory or neoplastic disease.

Free Abdomen

There are several prominent ileocecocolic and jejunal lymph nodes with normal length to width ratio and isoechoic parenchyma and a scant volume of free perineal effusion noted.

ULTRASONOGRAPHIC FINDINGS

- The urinary bladder contains echogenic, suspended debris contrasted with anechoic urine. This is often related to urinary tract infection but may represent exfoliated debris or sterile inflammation.
- There is increased renal cortical echogenicity and thickening with a mildly irregular capsular contour. Multifocal cystic cortical changes are noted. This is secondary cystic formation consistent with chronic age related degeneration and remodeling. There is no evidence of abscessation or suspicion of neoplasia.
- The intestinal submucosa is slightly irregular, thickened and hyperechoic suggestive of low grade, chronic disease. There is mild uniform prominence of the gastric mucosa as well as areas of "ropey" small intestinal wall with slight disruption of the normal 1:3 muscularis/mucosal ratio. This is most consistent with chronic enteropathy. No concerning lymphadenopathy or evidence of mechanical obstruction is present. Chronic inflammatory bowel disease is likely with a low possibility of an early neoplastic event such as lymphoma.
- Mild gastric luminal contents with partially shadowing echogenic material is likely consistent with hair or other foreign material. There's no evidence of obstruction noted at this time.
- The slightly prominent ileocecocolic and jejunal lymph nodes display no loss of parenchymal detail or change in echogenicity. This is most consistent with reactive lymphadenitis or lymphatic hyperplasia.
- The liver is subjectively enlarged and uniformly hyperechoic to falciform fat without disruption of normal architecture. This finding is most consistent with hepatic lipidosis, however infiltrative disease such as round cell neoplasia cannot be completely excluded.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urinalysis and urine culture via cystocentesis are recommended to evaluate the urinary tract changes for potential urinary tract infection.

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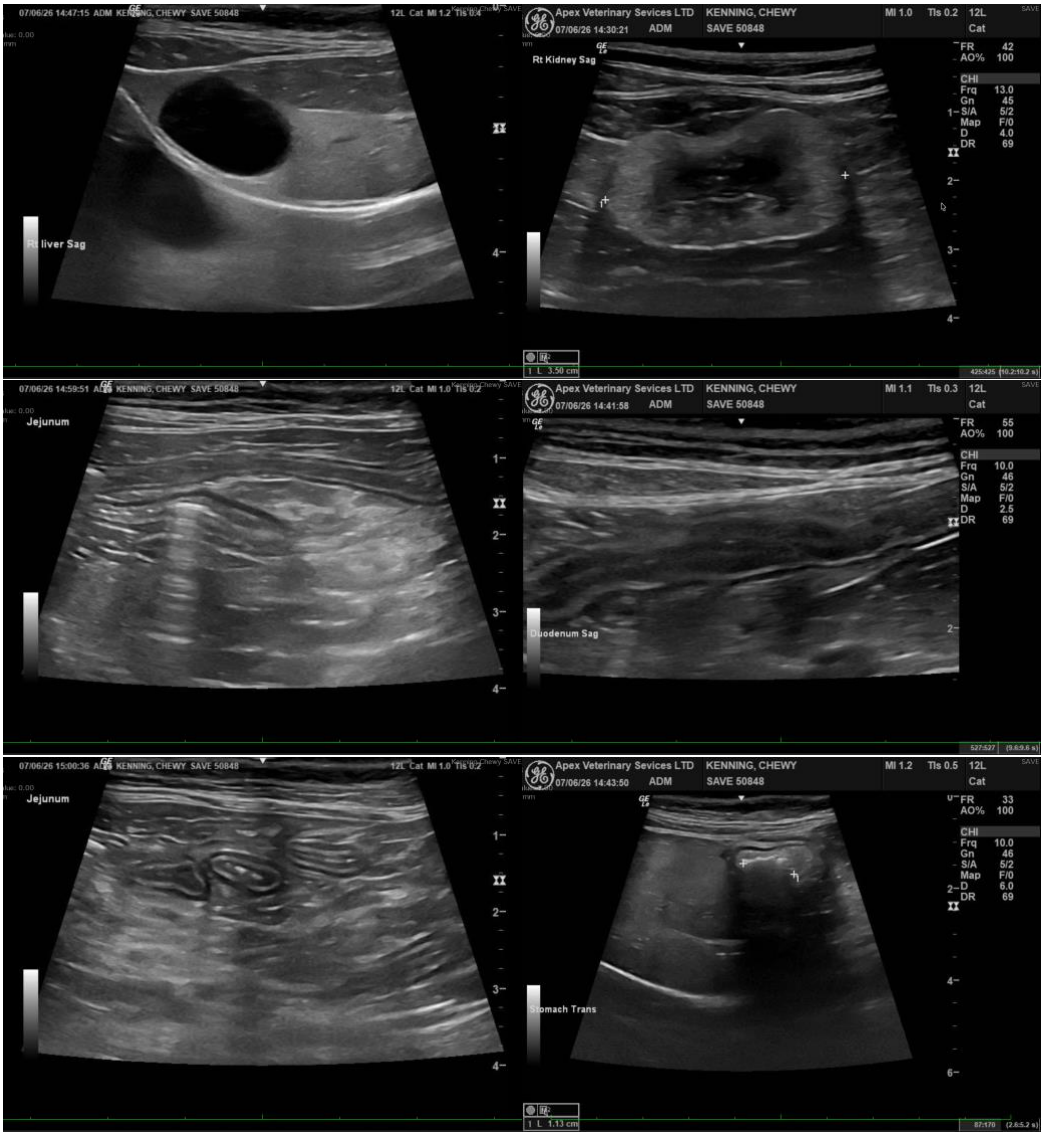
A gastrointestinal panel (TLI, PLI, B12, folate) via Texas A&M gastrointestinal laboratory is indicated to further evaluate for potential chronic enteropathy. Ultimately, gastrointestinal biopsies may be required for a definitive diagnosis.

Fine needle aspirates of the liver with cytology are recommended. A coagulation profile and platelet estimate prior to sampling are indicated to ensure the absence of coagulopathy. Occasionally some tissues are poorly exfoliative, or cytology is non-specific, in which case biopsy with histopathology may be required for a definitive diagnosis.



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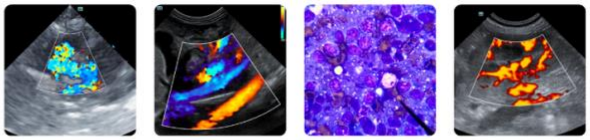

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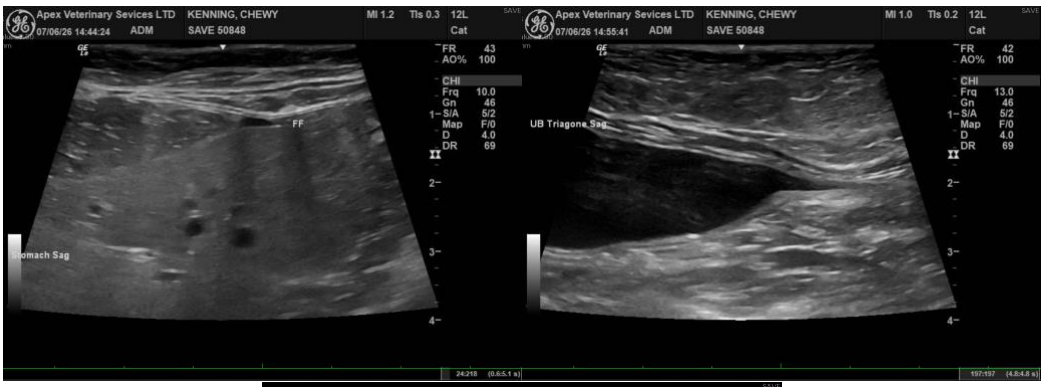

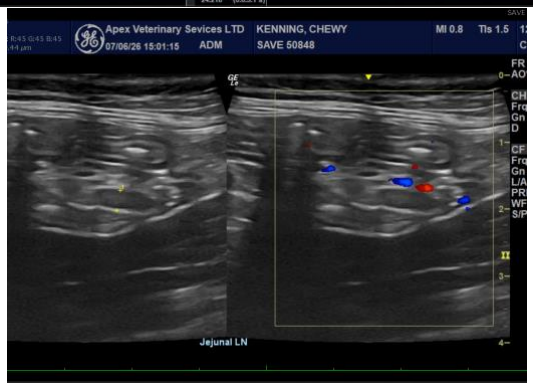

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Bradley Harris, DVM, DACVECC, DACVIM (Cardiology)

info@SonoPath.com