

PATIENT

Gizmo Gallagher

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

7.5 Years

WEIGHT

5.16 kg

INTERPRETED BY

Beth Johnson, DVM
 DACVIM

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Grand River VH

REFERRING VET

Dr. Gallagher

INVOICE

35636

DATE

11/24/25

PRESENTING CLINICAL SIGNS

History: Nov 3rd in and out of litter box, bladder small, cysto revealed dark muddy brown urine with blood clots. USG 1.052, pH 5, protein 3+, blood 2+, WBCs 6-10/hpf, RBCs greater than 100/hpf. No crystals. Treat with Metacam, Gaba, Alprazolam and did well. Creatinine at that time 138, Urea 9.4, K 4.4 rest WNL. Nov 15 off Alpraz and Metacam. Nov 16 not eating, Creatinine 1020, Urea 34.9, K 6.8, cysto showed USG 1.016, Blood 50, WBCs 2/hpf, RBCs 2/hpf, no bacteria or crystals. Started 5 days IVF therapy, maropitant. Nov 17 - Creatinine 1108. Urea 38.3, K 4.5 and added Baytril, Famotidine. Continue supportive care and IVF, add metoclopramide and add transdermal mirtazapine. Normotensive, eating with Mirtaz, no skin tent, moist MM.

Abnormal PE/Chem/CBC/UA Results: Last bloodwork Sat Nov 22 showed Creatinine 169, Urea 7.6 but Monday not doing as well so recheck bloodwork today showed Creatinine 448, Urea 16.6. BP 135/86(99) Urine culture negative UPC 3.1

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal in size (3.78 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Right kidney is normal in size (3.98 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

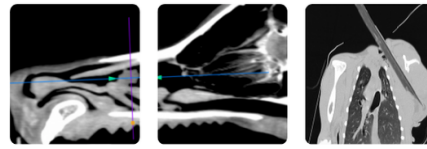
Left adrenal gland is normal in size (0.39 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.43 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver



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Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

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The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

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The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

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Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

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Free Abdomen

There is no visible free peritoneal effusion noted in these images.

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There is no apparent pathologic lymphadenopathy noted in these images.

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ULTRASONOGRAPHIC FINDINGS

- There is a very mild amount of echogenic urinary bladder debris, but no definitive ultrasonographically visible reason for the intermittent and progressive azotemia or evidence of kidney disease.

REFERRING VET

Dr. Gallagher

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Chronic and/or potentially acute on chronic episodes of kidney disease can't be ruled out by a relatively unremarkable appearance of the kidneys on ultrasound, and therefore, should be interpreted in combination with laboratory changes, etc.

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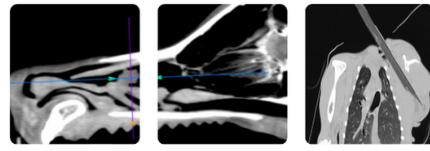
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Given this patient's history, further workup/evaluation for ongoing kidney insults, including medications, toxins, infections, etc., is recommended.

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In the meantime, in addition to supportive/symptomatic medical management of clinical signs, beginning medical management for chronic kidney disease, including management of proteinuria maybe warranted. If tolerated, part of this treatment could include a transition in diet. Full



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consultation and/or referral to a veterinary internist, if available, could be considered.

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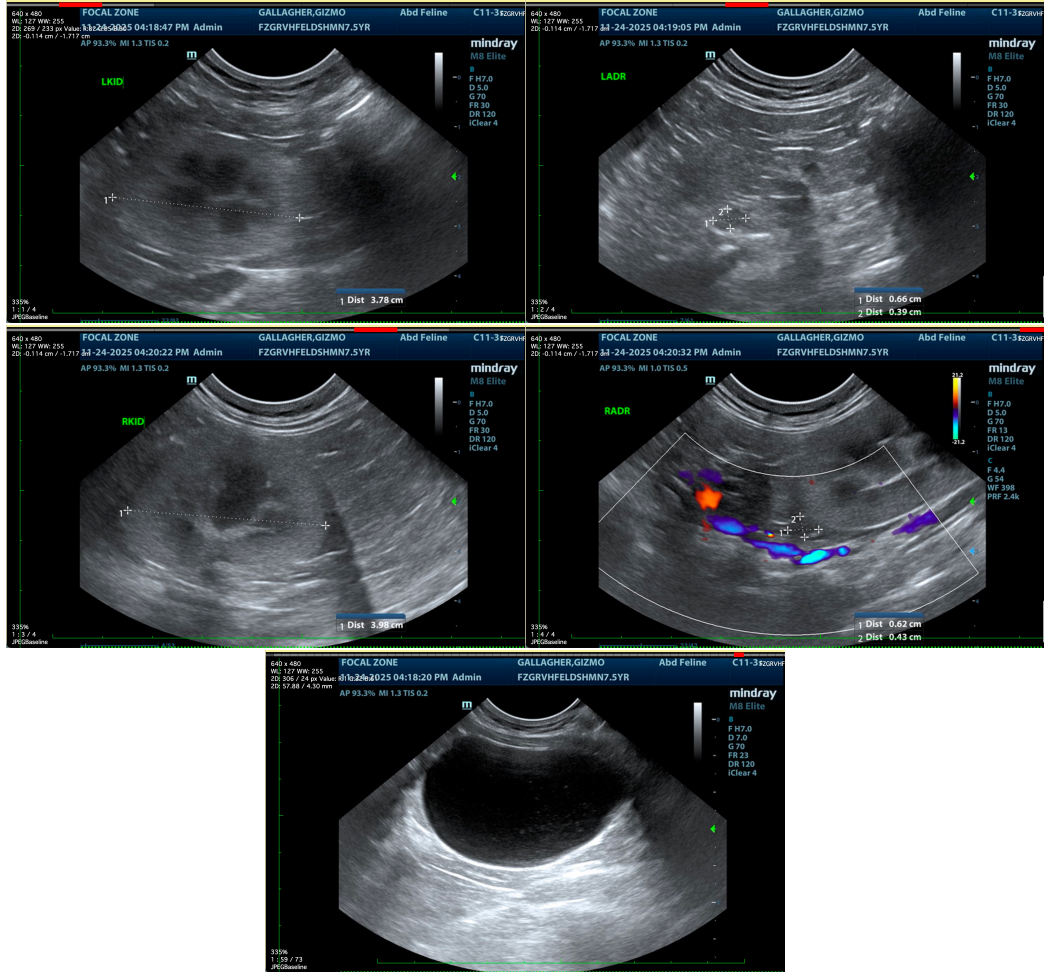
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM DACVIM

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