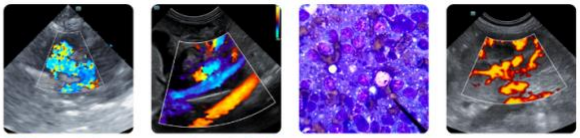


SonoPath www.animalsoundsnw.com info@animalsoundsnw.com 541.357.9423

PATIENT

Peepers Nosler

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

14 Years

WEIGHT

7.75 Pounds

INTERPRETED BY

Beth Johnson, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Rebecca Hamilton

HOSPITAL NAME

Countryside AC

REFERRING VET

Dr. Cox

INVOICE

35723

DATE

12/1/25

PRESENTING CLINICAL SIGNS

History: Weight loss, intermittent vomiting, urinary concerns. Meds: Buprenex 0.1 ml BID
Abnormal PE/Chem/CBC/UA Results: blood: Reticulocyte Hemogoblin 14.5, Urine: USG 1.03, prot 1+. Blood/Hemoglobin 2+.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is small in size (2.78 cm), irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no mineral observed. Marked pyelectasia is present, measuring at least 0.7 cm in the transverse view. Multifocal mineral densities are noted, including what I suspect is mineral within the pelvis and mineral within a mildly dilated proximal ureter isn't definitively visible, but can't be definitively ruled out. The left kidney measures XX cm.

Right kidney is overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. The right kidney measures 3.62 cm.

Adrenal Glands

The areas of both adrenal glands are examined without evident adrenal gland pathology.

Spleen

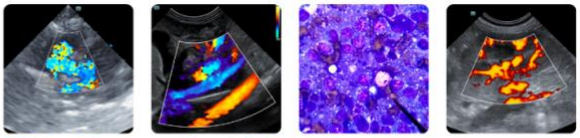
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

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.

Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. The cystic and common bile duct, while not pathologically distended, are diffusely tortuous in these images.

Gastrointestinal



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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.

The visible small intestine demonstrates areas of moderate to severely thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

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

Pancreas

Pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. No pancreatic duct dilation is noted. In some views of the right cranial abdomen, there appears to be a subtle, possible mineral density or bright echogenic structure that could represent nonobstructive gastrointestinal mineral density or even gas, but a small mineral density at the level of the duodenal papilla can't be definitively ruled out.

Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Moderate inflammatory bowel disease pattern- Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.
- Chronic kidney disease changes in the left kidney with mineral and pyelectasia demonstrating some concern for possible historical, potentially resolved, partial or even full acute ureteral obstruction without a definitive cause visible in these images. Concurrent ascending infection contributing to the change can't be ruled out.
- Chronic low grade smoldering pancreatitis +/- cholangitis and/or even "triaditis" should be suspected in the face of appropriate clinical signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

A T4 +/- free T4 is recommended if not recently evaluated.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI

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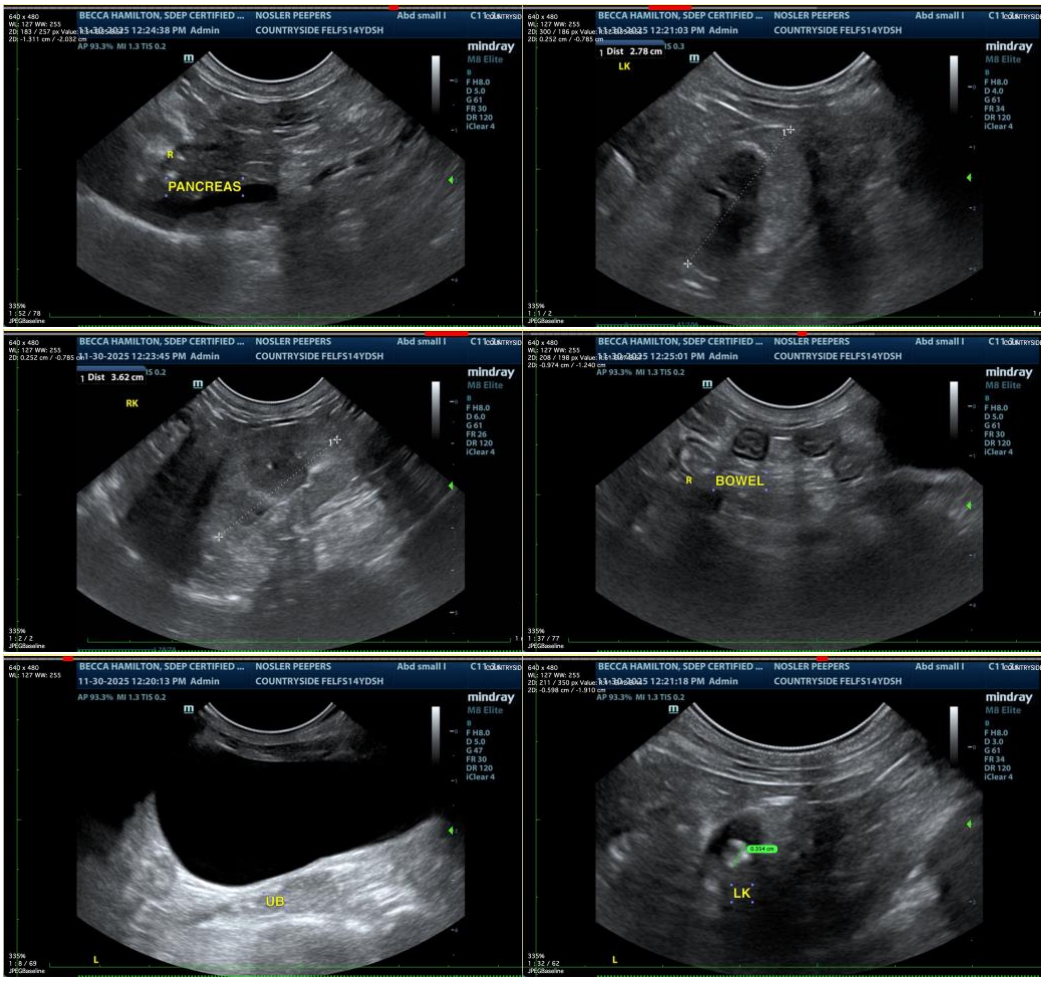
Laboratory is recommended for further evaluation of GI and pancreatic function.

As described above, patient's reported vomiting could be secondary to the kidney changes, bowel changes, and/or even concurrent hepatobiliary changes, and should therefore be further worked up and managed based on the initial results of the above. In the face of largely normal lab work, ultimately biopsies of the GI tract may be necessary for definitive diagnosis, and therefore to further guide medical management.

In the meantime, advanced imaging of the left kidney and ureter, i.e., abdominal contrast CT scan, or potentially follow up ultrasonographic monitoring could be considered to help further evaluate and monitor the dilation/possible obstruction if present, etc.



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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

info@sonopath.com