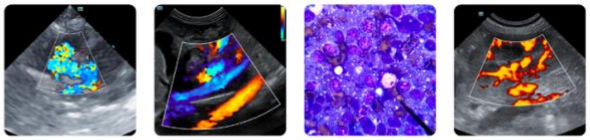


PATIENT

Kitty Kudela

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

15 Years

WEIGHT

5.42 pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Andrea Nason

HOSPITAL NAME

Caravan Vet

REFERRING VET

Dr. Andrea Nason

INVOICE

12655

DATE

12/10/25

PRESENTING CLINICAL SIGNS

Kitty had stable CKD stage 3 as of September of this year. At that time, she was eating a prescription kidney diet and phosphate binder without issue. Kitty presented today for lethargy, anorexia, and vomiting. No known inappropriate ingestion/toxin exposure, last food eaten was housemate's urinary diet (c/d), not currently on phosphate binder. On exam, she's dehydrated (~7%), icteric, and blood pressure is low. Heart/respiratory rate/temp normal, no murmurs/arrhythmias, abdominal palpation soft/non painful, lymph nodes normal. Abdominal scan to evaluate for underlying cause and to help guide therapy.

Abnormal PE/Chem/CBC/UA Results: HCT 25% (was 35% in sept) Crea 2.0 (was 2.4 in sept) BUN 42 (39 in sept) K 2.7 (3.9 in sept) ALT 215, ALP 150, GGT 5, Tbili 13.1, amylase 2472

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.

The left kidney is small, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. The left kidney measures 2.58 cm in length.

Right kidney is normal in size (3.39 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 (0.29 cm at cranial pole and 0.24 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

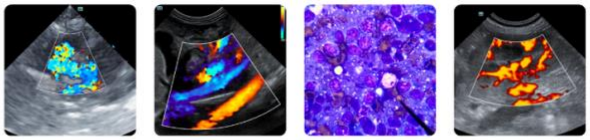
Right adrenal gland is normal in size (0.31 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is moderately heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. 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.

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.

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.

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

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.

Free Abdomen

There is a mild amount of anechoic free fluid in these images.

Mesenteric lymphadenopathy is prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

ULTRASONOGRAPHIC FINDINGS

- The liver changes are nonspecific but indicate a possible microscopic hepatopathy with differentials including both benign etiologies such as bacterial, cholangiohepatitis, lymphoplasmacytic, hepatitis, other infectious or inflammatory hepatopathy, hepatic lipidosis, etc. as well as infiltrative neoplastic disease such as round cell neoplasia i.e. lymphoma versus other and cannot be differentiated without tissue sampling.
- Mild free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.
- Moderately mesenteric lymphadenopathy– infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Moderate chronic kidney disease changes are visible affecting primarily the left kidney.
- Mild to moderate amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- If not recently evaluated, urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification

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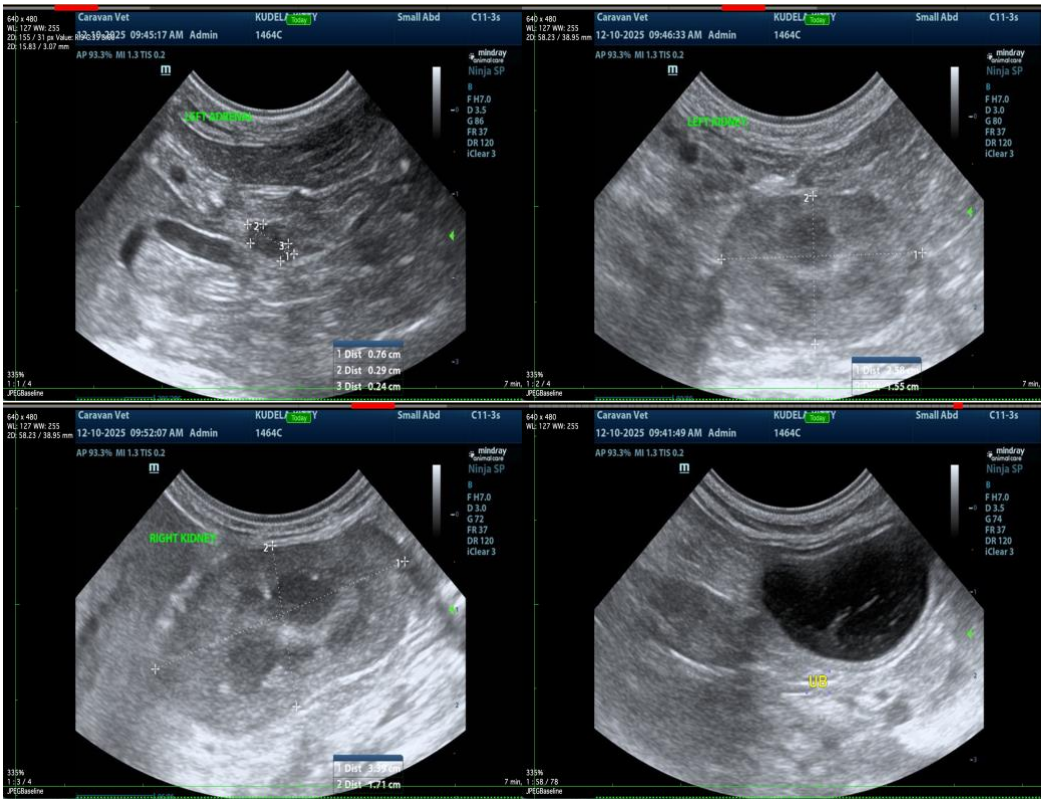
with a urine protein to creatinine ration is recommended.

- Fine needle aspirates of the liver as well as sampling of the free abdominal fluid for analysis and cytology are recommended if patient's coagulation status is appropriate.
- Considerations given the concurrent anemia are for either a prehepatic such as homolysis or an intrahepatic cause for the increased total bilirubin. There is no definitive ultrasonographically visible evidence for posthepatic obstruction.
- Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.



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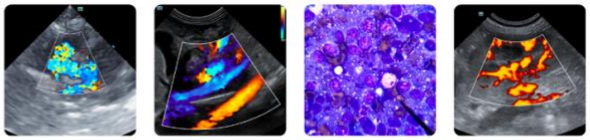

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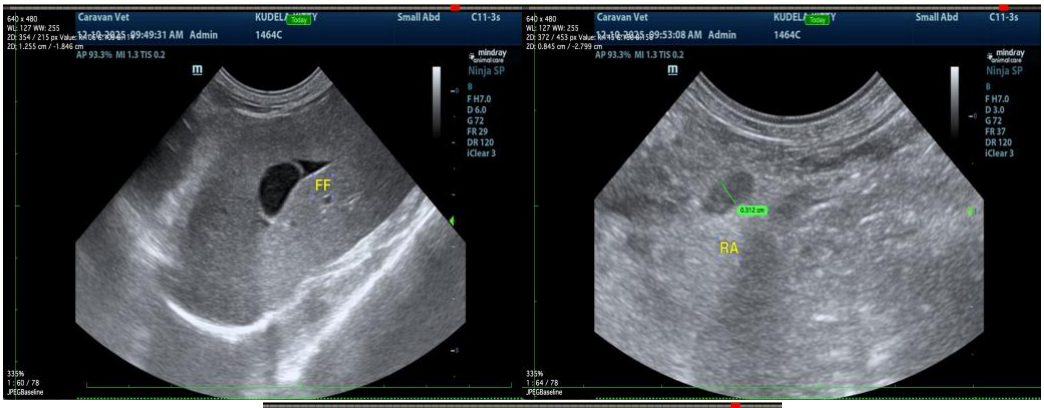

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

info@sonopath.com