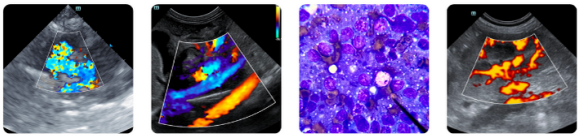


PATIENT

Robbie Acker

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

5 years 8 months

WEIGHT

14.5 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Kerri Becker

HOSPITAL NAME

Bergen County VC

REFERRING VET

Dr. Moore

INVOICE

10911

DATE

12/10/2025

PRESENTING CLINICAL SIGNS

Progressive azotemia, large kidney on rads. Possible bladder stones. PU/PD

Abnormal PE/Chem/CBC/UA Results: Gluc-190 Creat-4.2 BUN-84ALP<10 tbili-1.0 RBC-6.15 MCV-53.2.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, or distinct sediment or cystoliths are observed. Some subtle echogenic debris, or even mineral/sand debris, can't be ruled out but is very subtle if present. Hard shadowing from the colon mimics some mineral density right along the urinary bladder wall in some images. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is small in size (2.7 cm), irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. Mild pyelectasia is present measuring 0.24 cm in the sagittal view, and punctate non-obstructive nephroliths are present.

The left kidney is large in size (4.9 cm), irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. Marked pyelectasia/emerging hydronephrosis is noted measuring 1.7 cm in the sagittal view. Punctate mineral densities are suspected with no visible evidence of obstruction by mineral noted in these images at this time.

Adrenal Glands

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

The left adrenal gland is normal in size (0.44 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

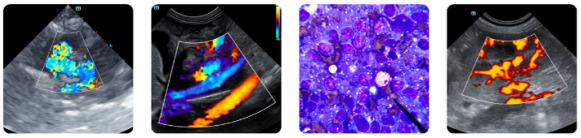
The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

The 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.

The 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



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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 moderately 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

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 no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Bilateral chronic kidney disease changes, most significant in the right kidney. With bilateral pyelectasia most significant in the left kidney. The pyelectasia, especially in the left kidney, could indicate a partial, non-visible ureteral obstruction, or potentially previous ureteral obstruction, ascending infection versus other.
- Subtle urinary bladder debris can't be ruled out but isn't definitively visible.
- Moderate inflammatory bowel disease (IBD) 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.

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.

If a representative of patient's disease sample is unable to be obtained from the urine, direct sampling of the left renal pelvis could be considered if patient's coagulation status is appropriate. Additionally, and/or alternatively, if azotemia progresses and/or obstruction is suspected, advanced imaging such as an abdominal contrast CT scan could be considered.

A blood pressure is also recommended if not recently evaluated.

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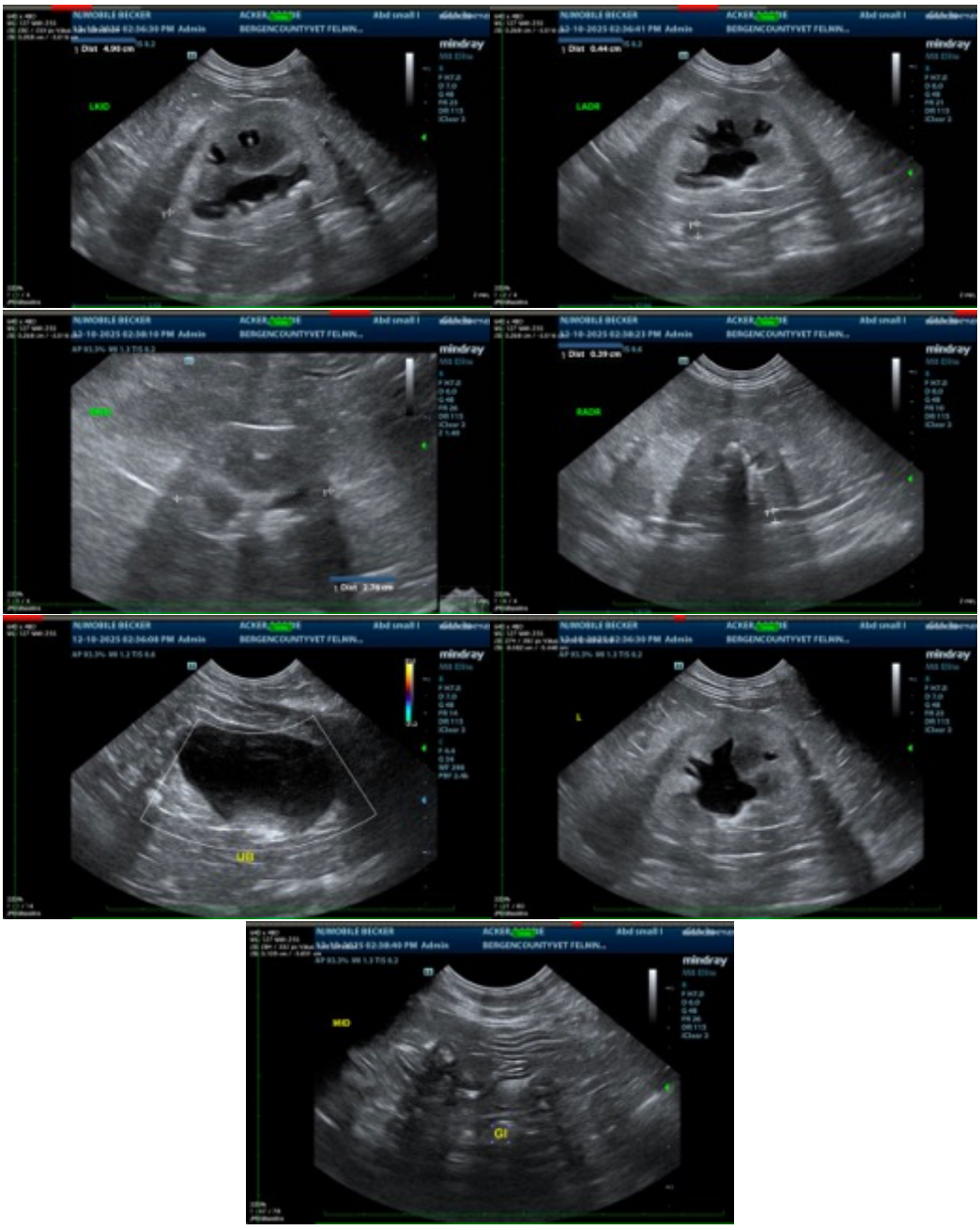
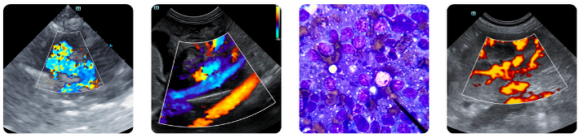
Given the concurrent gastrointestinal changes described above, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

In the meantime, in addition to supportive/symptomatic medical management of clinical signs, beginning empirical therapy for a possible acute on chronic kidney insult, possible pyelonephritis, etc., could be considered while monitoring for improvement.



The information and recommendations provided are based on the images presented by the referring



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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