



DATE PRESENTING CLINICAL SIGNS

12/11/25 **Patient History:** Presented for exam on 12/4/25 for not eating, lethargy and foul-smelling vomit. On palpation patient was painful in abdomen.

PATIENT

Nyla Rutherford

Current Medications: Gave Cerenia 10mg/mL 0.56mL and Buprenorphine 0.2mL SQ at 12/4/25 exam and Buprenorphine 0.6mg/mL 0.2mL transmucosally BID sent home with owner.

Labwork Results: Diagnostics attached, BW attached. Rads- enlarged, irregular kidneys on radiograph.

SPECIES

Feline

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Imaging Performed by: Rachel Brillhart, RDMS.

BREED

DSH

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

SEX

Spayed Female

Urinary System

The 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.

AGE

8/29/20

The kidneys are bilaterally enlarged and irregular in shape with loss of normal architecture as a result of multiple cortical anechoic cysts of varying sizes bilaterally. The left kidney measures 5.4 cm. The right kidney measures 7.54 cm, with the largest cyst being in the right kidney and measuring approximately 3.5 cm in diameter in the cranial pole. Overall echogenicity is mildly increased as a result of increased acoustic enhancement from the cysts, and loss of normal corticomedullary distinction is appreciated. Mild pyelectasia is noted bilaterally. Some of the cysts appear to contain slightly "hazy" subtly echogenic possible debris.

WEIGHT

12.4 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

Adrenal Glands

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

HOSPITAL NAME

Abbey Animal Hospital

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.

REFERRING VET

Dr. Cyr

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.

INVOICE

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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

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 mildly 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.

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

- Polycystic kidneys – Cysts may be inherited or acquired and may be a subclinical incidental finding or the result of chronic degenerative kidney disease. This finding should be interpreted in combination with breed (inherited polycystic renal disease is more common in some breeds including, but not limited to, Persian cats, cairn terriers and bull terriers), laboratory findings and clinical signs. Complicated kidneys or even early or emerging abscesses, hematomas, etc. can't be definitively ruled out.
- Very mild/possibly emerging 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 or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.
- Chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

In my opinion, based on ultrasonographic appearance alone, the kidneys are the most significant pathology, with possible contribution to the nausea from gastrointestinal or pancreatic disease, although the GI and pancreatic changes are very mild/subtle. Therefore, if not recently evaluated:

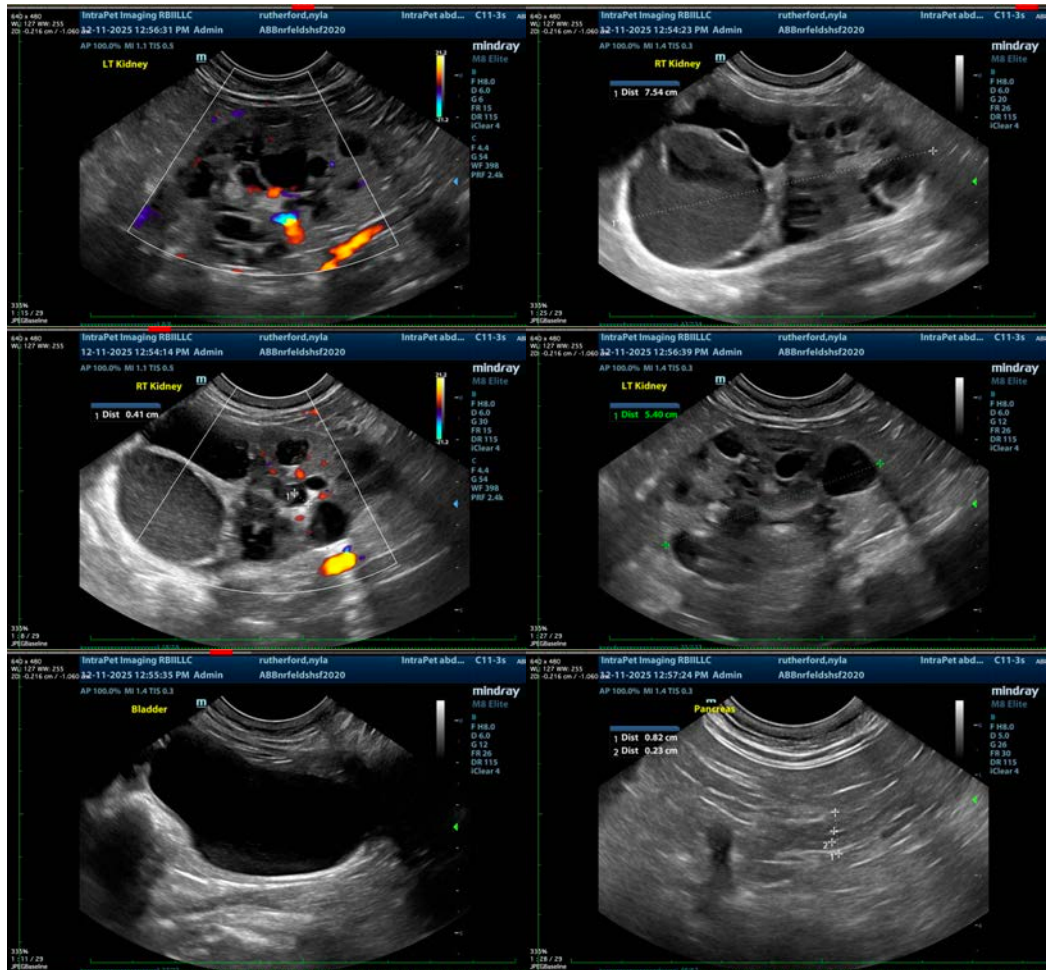
Urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

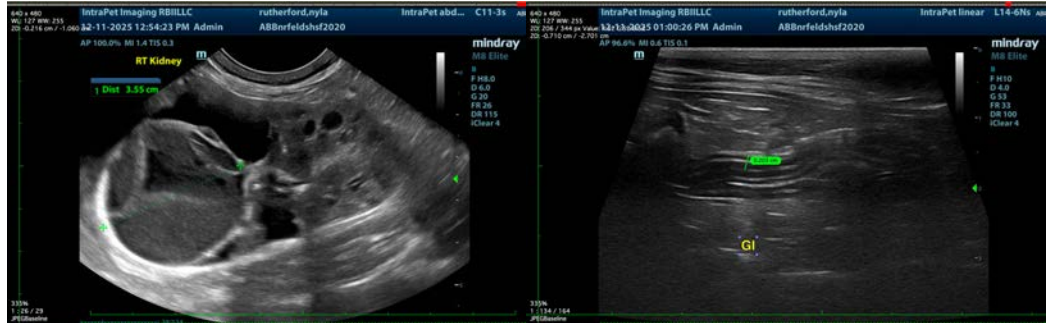
A blood pressure is recommended.

Direct sampling of the kidney cysts for cytology, culture and sensitivity, etc. could also be considered if patient's coagulation status is appropriate.

Additionally, given the history and bowel changes, 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.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.





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.

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