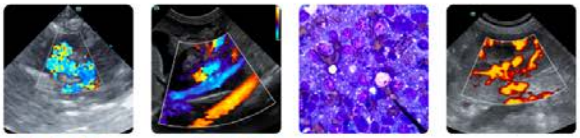


PATIENT

Boris Hornung

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

~8 Years

WEIGHT

4.95 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Hamilton Region Emergency Clinic

REFERRING VET

Dr. Diane Ho

INVOICE

72274

DATE

12/3/25

PRESENTING CLINICAL SIGNS

Presented for painful abdomen, acute anorexia, lethargy. PE revealed 7-8% dehydration, left kidney palpates larger than right, painful, dental ulcers and ptyalism with a bloody tinge. Start IVF, Maropitant, Ondansetron, Ampicillin, Pantoprazole, Tobramycin, Buprenorphine, Mirtazapine.

Abnormal PE/Chem/CBC/UA Results: Dec 1 - BUN greater than 46, P greater than 5.2 USG 1.025, moderate proteinuria, significant hematuria, significant pyuria, rods, culture pending. Dec 2 recheck BW showed BUN greater than 46 and Creatinine 808.

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 exfoliated cells, mucous and/or small blood clots, as well as a large amount of dependent mineral “sand” (crystals) debris. No masses or discrete definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The left kidney is mildly large in size, measuring 4.94 cm. A relatively uniform hyperechogenicity is observed with mildly decreased corticomedullary distinction. There is no pyelectasia noted and no mineral is observed. No overt masses/nodules are observed. Surrounding the left kidney is subtly enhanced hyperechoic fat.

The right kidney is uniformly enlarged/swollen (4.23 cm) with an overall hyperechoic echogenicity and slight loss of corticomedullary definition. Normal smooth peripheral margination and shape are maintained. The renal pelvis is dilated with anechoic fluid and hyperechoic thickened pelvic fat. No overt evidence of neoplasia or mineral is observed. The perinephric area is enhanced by hyperechoic fat and mesentery.

Adrenal Glands

The right adrenal gland is normal in size (0.60 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

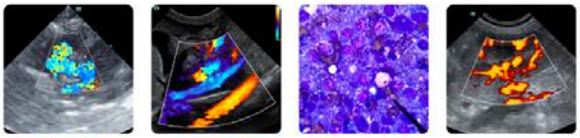
The left adrenal gland is normal in size (0.32 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. 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.



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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 stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out.

If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

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 no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- The appearance of the kidneys is concerning for an acute kidney insult, potentially acute on chronic disease, with differentials including infectious disease such as pyelonephritis, FIP, etc., toxic insult, and/or other acute on chronic etiologies that can't be ruled out. This finding should be interpreted in combination with supporting laboratory and/or urinalysis changes.

- Large amount of echogenic mineral/sand debris within the urinary bladder.

SECONDARY FINDINGS

- Hyperechoic splenic nodules – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.

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 ratio is recommended.

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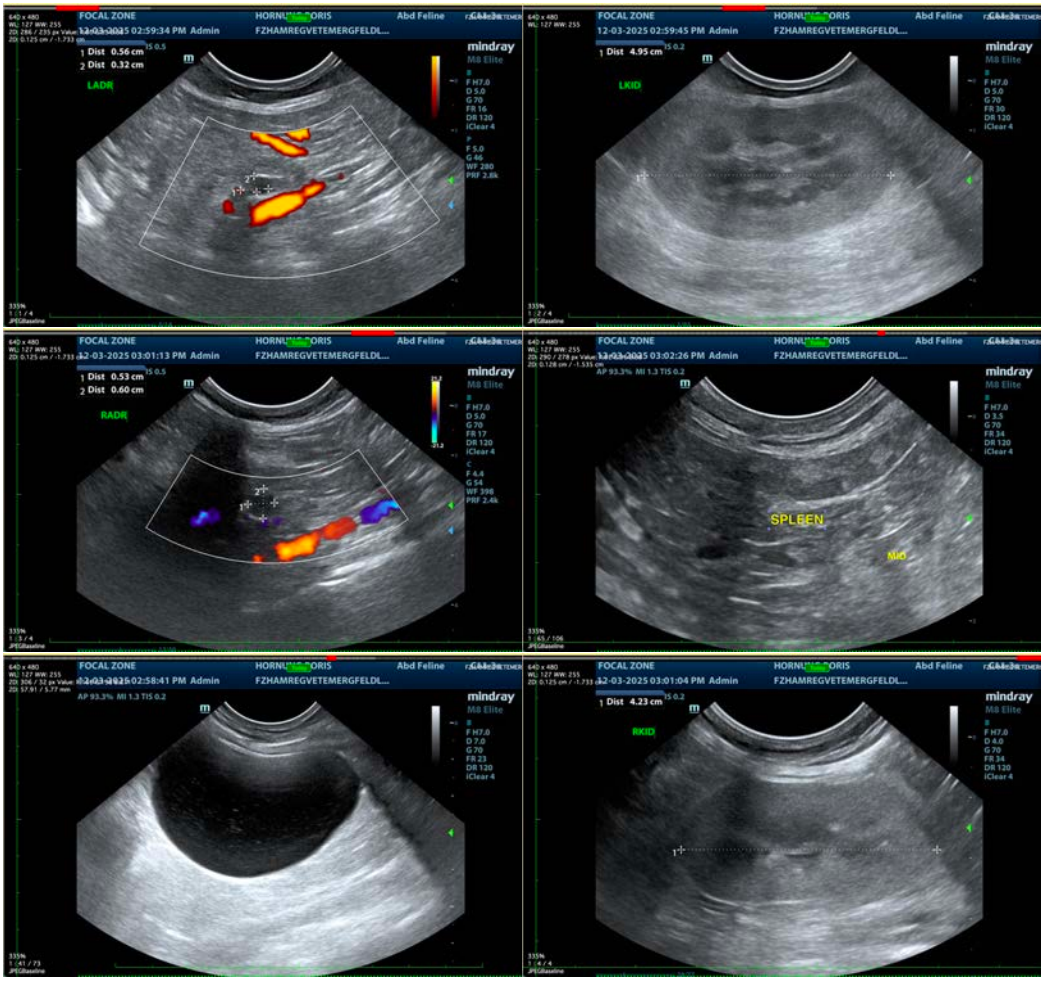
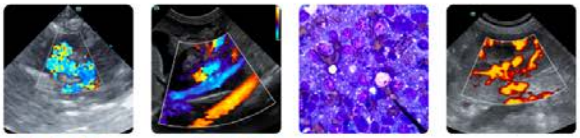
Direct sampling of the kidneys could be considered if there is concern for infiltrative disease affecting the kidneys, especially the larger left kidney, via fine needle aspirate if patient's coagulation status is appropriate.

Otherwise, beginning supportive/symptomatic medical management of clinical signs and medical management for suspected acute on chronic kidney disease, beginning with pyelonephritis, is recommended while monitoring for improvement.

Given the suspected acute nature, if patient doesn't rapidly improve and/or patient declines, consultation with a veterinary internist and/or even referral, if available, for advanced care including potential dialysis may be an option.





SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

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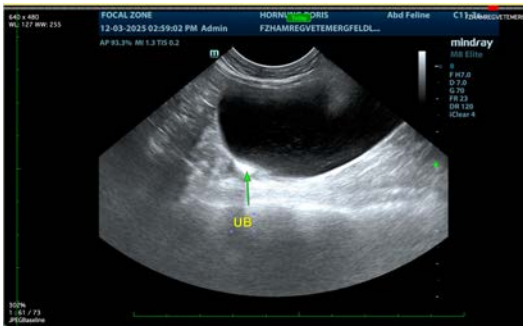

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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