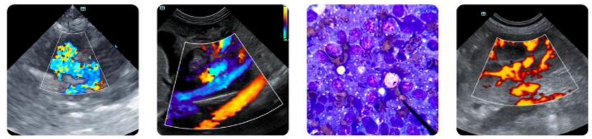


PATIENT

Tyler Mathey

SPECIES

Feline

BREED

American Shorthair

SEX

MN

AGE

17Y

WEIGHT

8lbs

INTERPRETED BY

Beth Johnson, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Julia Bakker, DVM

HOSPITAL NAME

Orange Blossom Veterinary Imaging

REFERRING VET

Molly Caldwell, DVM

INVOICE

73896

DATE

2-23-26

PRESENTING CLINICAL SIGNS

- Recent hematuria of unknown origin
- -Known Chronic kidney disease - r/o progressive renal failure, glomerulonephritis, interstitial nephritis-

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 a large amount of echogenic non-shadowing debris, most consistent with exfoliated cells, crystals, mucous and/or small blood clots likely combined with incidental suspended lipid. Both sterile inflammation as well as urinary tract infection can 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 right kidney is bilaterally small in size (3.46 cm), irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. No mineral is observed. Moderate pyelectasia is also present in the right kidney.

The left kidney is uniformly enlarged/swollen (4.5 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. Some free fluid is noted around the left kidney.

Adrenal Glands

The left adrenal gland is normal in size (0.5 cm at cranial pole and 0.4 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The right adrenal gland is normal in size (0.37 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

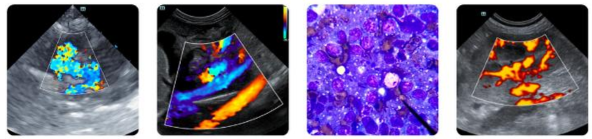
Spleen is subjectively large in size with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

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. See “other”.

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 marked/significant 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, 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

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 a trace amount of anechoic free fluid primarily adjacent to the left kidney.

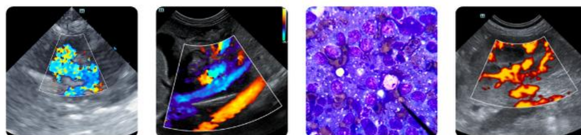
No definitive lymphadenopathy but in the mid to cranial abdomen there is an approximately 3.3 x 3.7 cm in size, round, mixed density/mass characterized primarily by mildly heterogeneous but largely solid hyperechoic center surrounded by anechoic fluid. In some views, it appears to originate from the liver but in some views, it appears too caudal for that with other differentials including part of the urinary tract, pancreas, GI lymph node, other.

ULTRASONOGRAPHIC FINDINGS

- Bilateral chronic kidney disease changes with bilateral pyelectasia including marked pyelectasia in the left kidney concerning for pyelonephritis although lower urinary tract obstruction contributing to the marked pyelectasia in the left kidney from a nonvisible mineral obstruction, stricture, vs other cannot be ruled out.
- A large amount of echogenic urinary bladder debris.
- Splenomegaly – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- Marked/significant 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.
- Concurrent chronic low grade smoldering pancreatitis is suspected.
- As described above, the mid to cranial abdominal density/mass/partially fluid filled structure is of unknown definitive origin. Differentials include an abscess, hematoma, complicated cyst vs infiltrative neoplastic lesion or mass cannot be ruled out without tissue sampling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urine culture is recommended if not recently evaluated.



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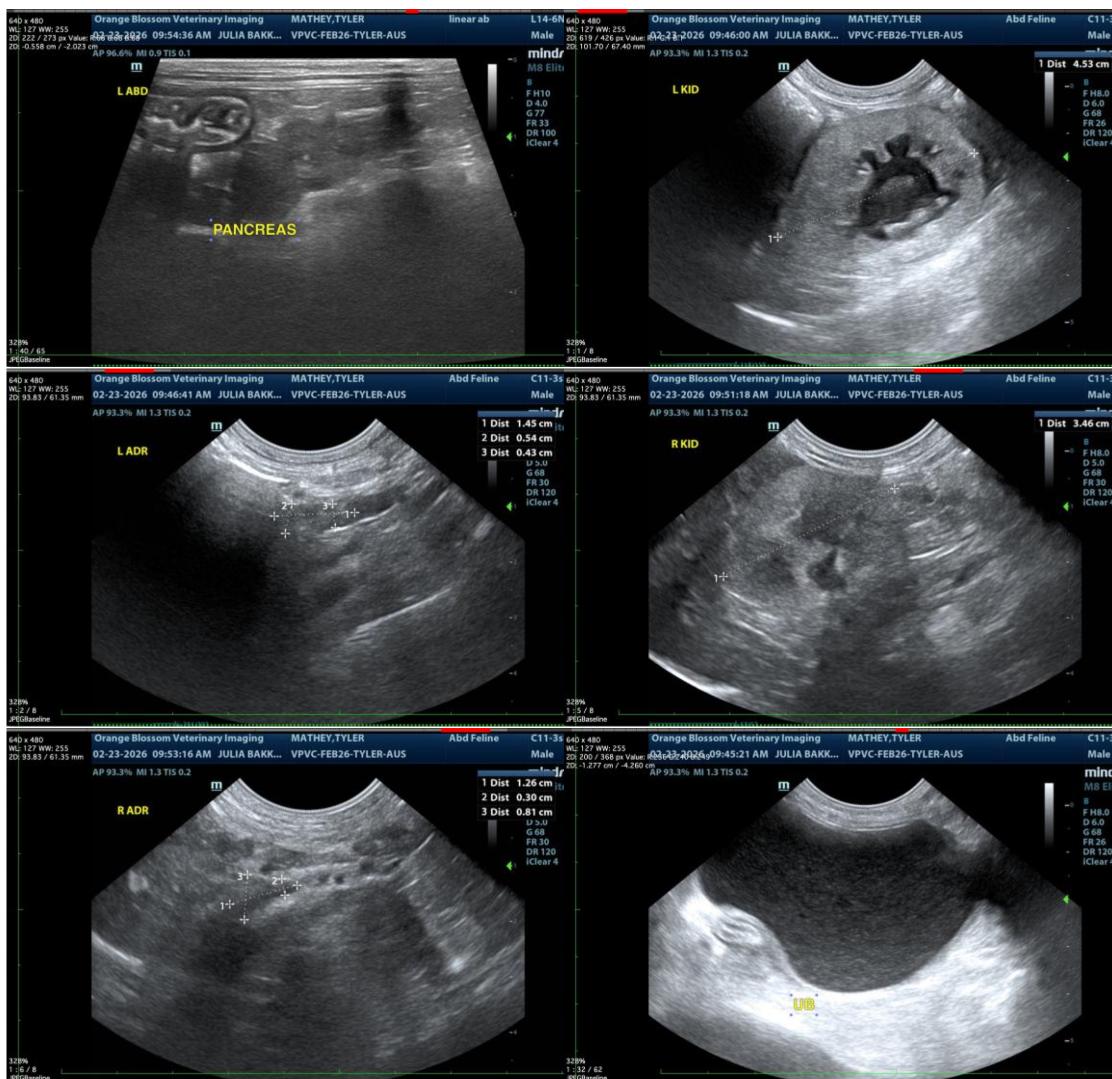
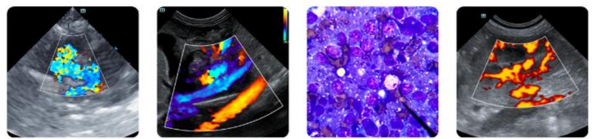
Pending the results of the urinalysis and urine culture results from the urinary bladder, direct sampling of the left renal pelvis could be considered if patient's coagulation status is appropriate. Additionally, sampling of the cranial abdominal structure/mass +/- spleen via FNA could be considered if patient's coagulation status is appropriate.

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.





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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