



PATIENT

Rufus Weston

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

9 Years

WEIGHT

6.9 kg

INTERPRETED BY

Beth Johnson, DVM
 DACVIM

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Chippawa Animal
 Hospital

REFERRING VET

Dr. Kilkenny

INVOICE

72705

DATE

2/4/26

PRESENTING CLINICAL SIGNS

Owner reports a progressive decline with a sharp deterioration over the past 4-5 days. Primary concerns are severe PD/PU, weakness, lethargy, weight loss, and recent hyporexia.

History of recent health status - Rufus is a known diabetic whose glucose has been poorly regulated for months despite being on 4 units of insulin BID. The last glucose sensor was removed 3 weeks ago and showed consistently high readings. The owner is concerned about poor quality of life and has questioned if Rufus could have Cushing's disease. The owner administered 50 mL of SQ fluids at home yesterday due to perceived dehydration. 0.5kg weight loss

Current Medications: Prozinc insulin BID, cerenia, mirtazapine, sq fluid therapy

Abnormal PE/Chem/CBC/UA Results: Labs attached

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.

Kidneys are large in size (left kidney 5.96 cm, right kidney 5.53 cm) with increased cortical echogenicity. Normal smooth peripheral margination and shape are maintained. 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

The right adrenal gland is unable to be well visualized in these images.

The left adrenal gland is normal in size (0.54 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

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. 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

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The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material, or infiltrative disease; however, visualization is partially inhibited by gas.

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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 mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material, or infiltrative disease; however, visualization is partially inhibited by gas.

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

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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.

WEIGHT

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Free Abdomen

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There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

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Kelly Reschny

PRIMARY FINDINGS

- Feline renomegaly – These renal changes can be seen with glomerular or interstitial nephritis, FIP, amyloidosis, acute tubular necrosis or infiltrative neoplasia such as lymphoma. Normal variant due to fat deposition cannot be ruled out but is less common in an enlarged kidney.
- Hyperechoic hepatomegaly – This appearance is most consistent with benign hepatic lipidosis or endocrine/DM hepatopathy. Infiltrative disease such as amyloidosis or round cell neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.
- 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.

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SECONDARY FINDINGS

- Mild amount of echogenic urinary bladder debris.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further evaluation for infiltrative disease, including possible round cell neoplasia resulting in especially the enlarged kidneys +/- the liver changes could be considered via fine needle aspirates of the kidneys +/- liver and/or even spleen if patient's coagulation status is appropriate.



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If not recently evaluated, a 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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Pending results of above, further evaluation for concurrent diseases potentially resulting in insulin resistance such as acromegaly versus other could be considered.

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Ultimately, however, a change in insulin may be warranted if high doses of the current insulin are not proving effective and another contributing factor or underlying disease isn't diagnosed.

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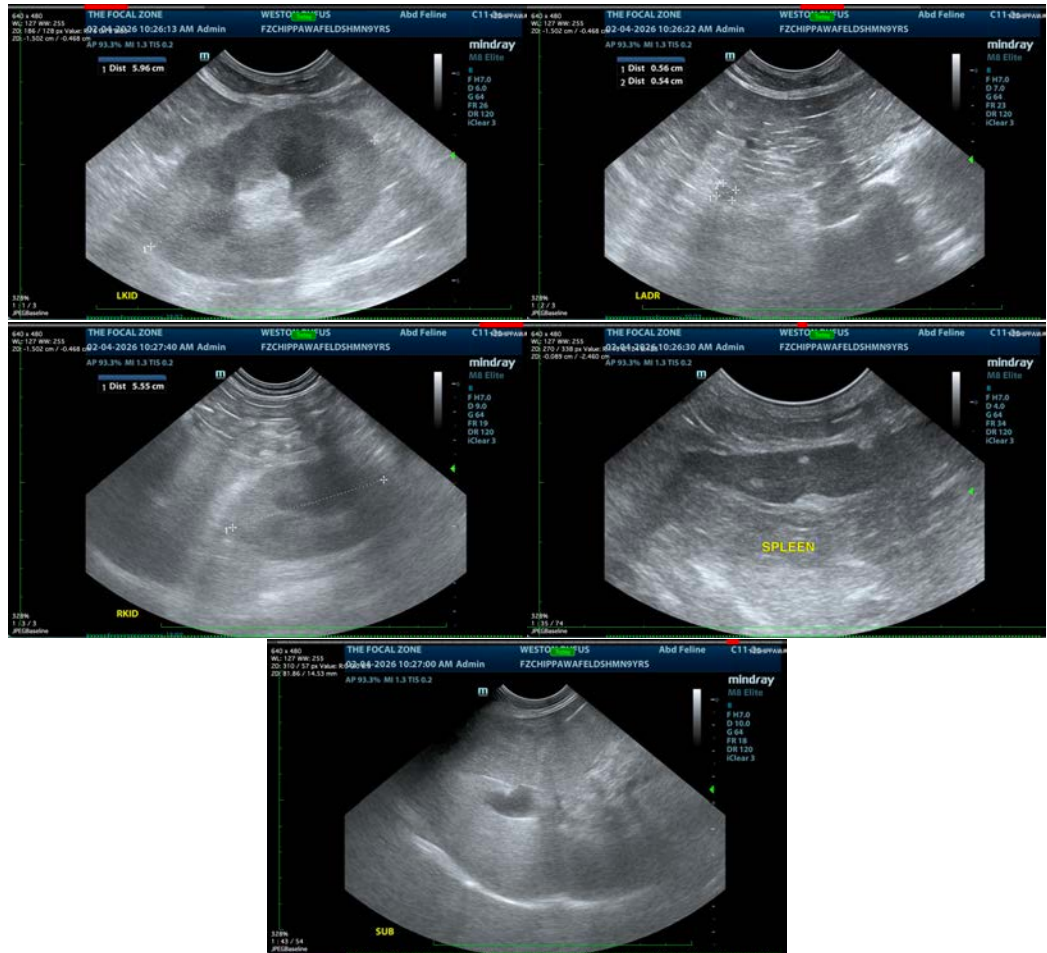
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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