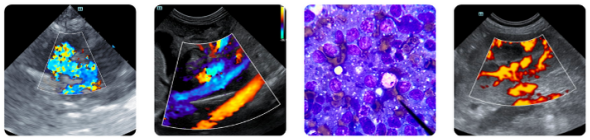

PATIENT

Teddy Vandiver

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

4 years 2 months

WEIGHT

7.9 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge Animal Hospital

REFERRING VET

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PRESENTING CLINICAL SIGNS

7.9 # (previously 12.8#). Hx of FIV +. Patient presented for PU/PD 2/13/26 - azotemia was noted on bloodwork and mild anemia. Patient was started on kidney diet, naraquin, and clavamox (O was unable to administer a full course) to cover for acute on chronic kidney disease. Patient re-presented 4/1/26 for weight loss and inappetance. Admitted to the hospital d/t progressive azotemia and further work up, Patient was dehydrated on exam.

Chronic meds: Cerenia EOD, Miratax EOD, unable to administer naraquin, unable to get patient to eat kidney diet.

Hosptialized today for IVF diuresis (received 4 hours of fluids prior to scan), B complex in fluids, Cerenia, Miratax, Zeniquin (did not tolerate clavamox PO previously.)

Diagnostics: 1/26/24 bloodwork: Creat 1.4. 1/21/25 bloodwork: Creat 2.0, BUN 44, albumin 2.4. 2/13/26 bloodwork: Creat 4.8, BUN 109, USG 1.016. HCT 29.8%. 4/1/26 bloodwork: Creat 7.9, BUN > 130. USG 1.016, quiet sediment. HCT 36.8%

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

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.

Kidneys are bilaterally small/normal in size, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. Left kidney measures 3.63 cm and contains moderate pyelectasia measuring 0.48 cm in the transverse view. Right kidney measures 3.49 cm and contains moderate pyelectasia measuring 0.33 cm in the transverse view.

Adrenal Glands

The right adrenal gland is normal in size (0.26 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

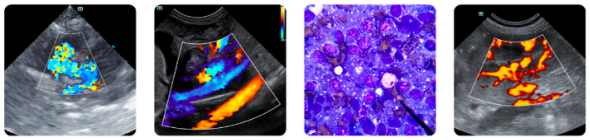
The left adrenal gland is normal in size (0.39 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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.



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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. Incidentally, the gallbladder is bilobed, which is a normal anatomic variant.

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 moderate to severely 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

- Moderate bilateral chronic kidney disease changes with moderate bilateral pyelectasia which could be in part secondary to the reported fluid therapy, received prior to the ultrasound. Although other causes of pyelectasia including ascending infection versus other can't be ruled out.
- 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 or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, or reevaluated since finishing antibiotics, 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.

Patient's reported clinical signs are likely in large part due to the suspected progressive chronic kidney disease +/- a concurrent acute on chronic insult. Having said that, dehydration secondary to

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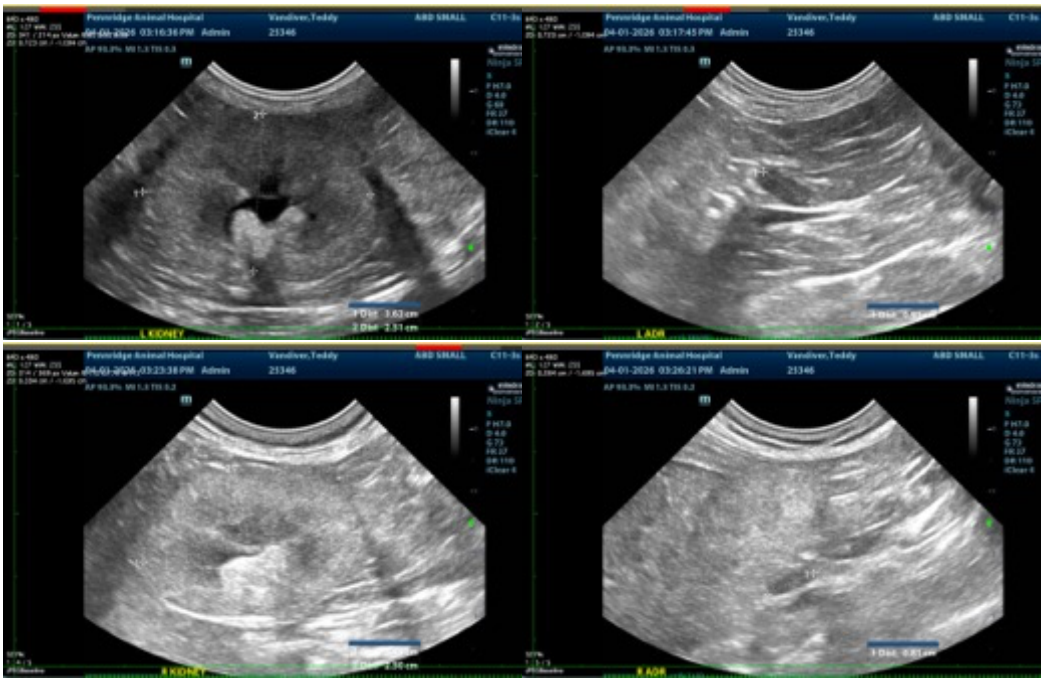
concurrent bowel disease which could be contributing to decreased appetite, other gastrointestinal signs, etc. can't be ruled out.

Therefore, additionally, given the bowel changes noted 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.
- Ideally, biopsies of the GI tract, being sure to include ileum if possible, are recommended to definitively diagnose and therefore manage the infiltrative bowel disease.
- If biopsies cannot be obtained, empirical therapies could include a probiotic (if diarrhea is present, such as visbiome or proviable), empirical deworming with a 5-day course of Panacur and, if tolerated, a transition in diet, based on trial-and-error response, beginning with a hydrolyzed protein diet. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several trials may be required.
- Additional considerations could include cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.).



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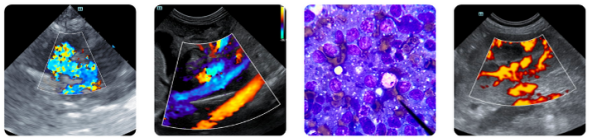

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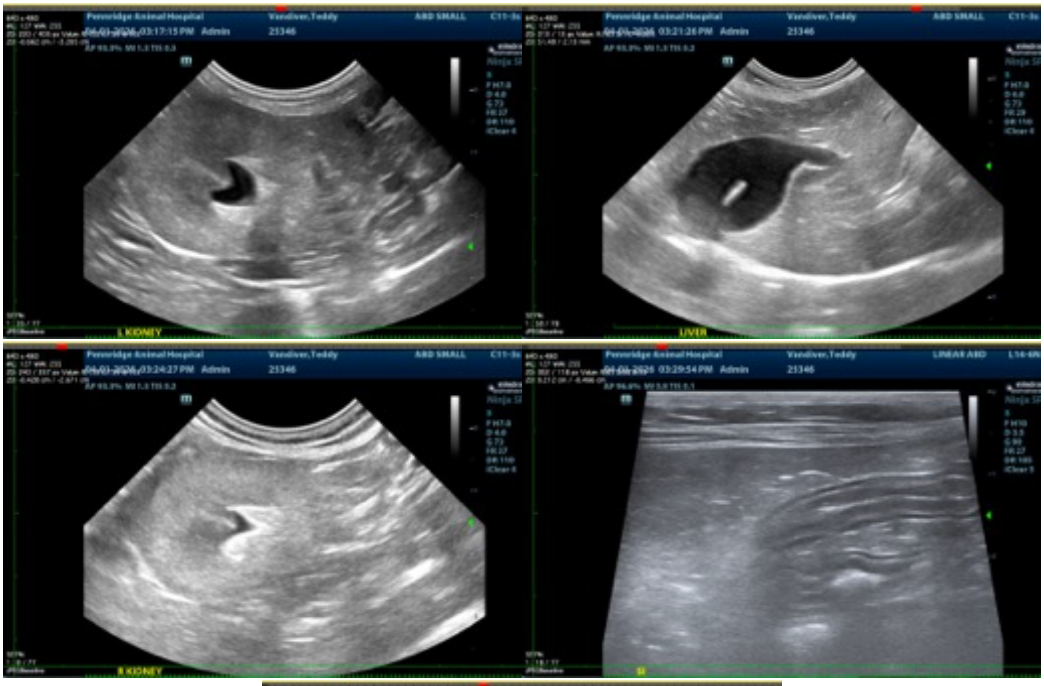

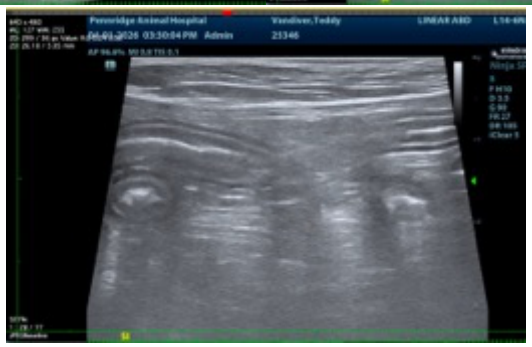

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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