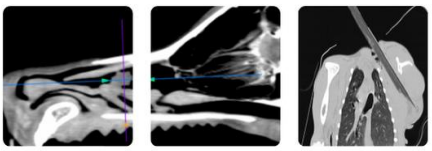

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PATIENT

Abby Burk

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

12Y

WEIGHT

~4.5kg

INTERPRETED BY

Beth Johnson, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

HREVC

REFERRING VET

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INVOICE

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DATE

5-26-26

PRESENTING CLINICAL SIGNS

General: Lethargic, non-ambulatory. Examination performed under sedation.
EEN: No obvious discharge noted.
Throat/Oral/Dental: MM are pink and moist. Full oral exam deferred due to patient temperament.
Cardiovascular: Tachycardia noted (HR 180 BPM at referring veterinarian). No murmur auscultated, but patient was growling. Peripheral pulses appear normal with no pulse deficits. Respiratory: Normal lung sounds, no crackles or wheezes auscultated, normal respiratory effort.
Gastrointestinal: Abdomen soft and non-painful on palpation. No organomegaly or masses noted.
Musculoskeletal: Non-ambulatory. Significant weight loss noted historically. No pain on palpation of spine or long bones.
Urogenital: Urinalysis reveals significant pyuria, hematuria, and bacteriuria.
Current Medications
IVF PLA 15ml/kg/hour; Marbofloxacin 12.5 mg PO q 24 hx 14d; methodone 0.2mg/kg IVq4 q.
Abnormal PE/Chem/CBC/UA Results: Creatinine 937 [71 - 212 µmol/L] Urea (BUN) 38.3 [5.7 - 12.9 mmol/L] Radiographic Findings thoracic rads clear Primary Question to Be Answered in This Exam rule out 1- Acute on chronic kidney injury 2- Pyelonephritis 3- Obstructive ureterolith 4- Neoplasia

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended (empty). Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. In the face of urinary signs and/or suspected urinary bladder pathology, reassessment after complete filling is recommended.

Kidneys are bilaterally uniformly enlarged/swollen (Left: 4.5 cm, Right: 4.5 cm) with an overall hyperechoic echogenicity and slight loss of corticomedullary definition. Normal smooth peripheral margination and shape are maintained. The renal pelvises are dilated (Left: 0.6 cm sagittal view, Right: 0.6 cm sagittal view) 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

Left adrenal gland is normal in size (0.35 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.45 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). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

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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.

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 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, 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.

In some images labeled “Left,” there is an anechoic tubular structure measuring 0.28 cm dilated but does not appear to have blood flow in the included Doppler images of this structure. Given the other pathology, a dilated ureter cannot be ruled out.

ULTRASONOGRAPHIC FINDINGS

- The appearance of the kidneys is consistent with chronic kidney disease and potentially an acute on chronic exacerbation secondary to pyelonephritis and/or even lower urinary tract obstruction without a definitively visible cause cannot 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.

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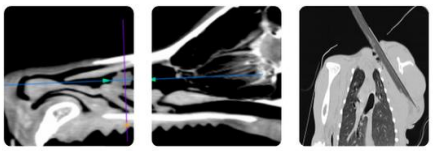

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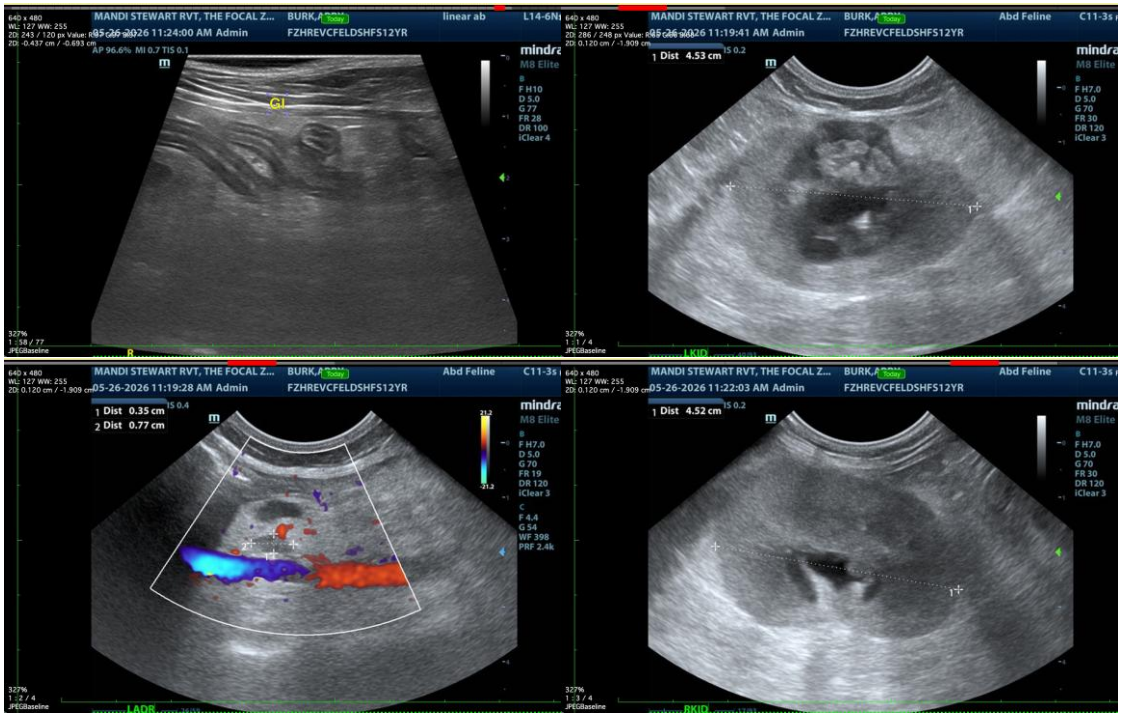
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urine culture is recommended if not recently evaluated.

A blood pressure is recommended if not recently evaluated.

While likely unrelated to patients reported clinical presentation at this visit, emerging bowel disease cannot be ruled out and especially in the face of any gastrointestinal history, may warrant further investigation beginning with 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.

In the meantime, in addition to supportive/symptomatic medical management if clinical signs, empirical medical management of possible acute on chronic kidney insult from possible pyelonephritis is recommended but very close monitoring is recommended to help identify if improvement is not noted and ureteral obstructions are suspected more aggressive intervention may be necessary to preserve kidney function. If this differentiation is difficult to make with follow up, advanced imaging including abdominal contrast CT scan or other contrast radiography may be helpful.



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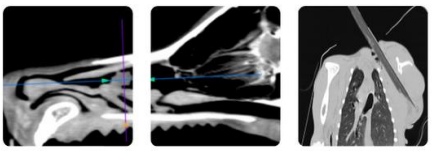

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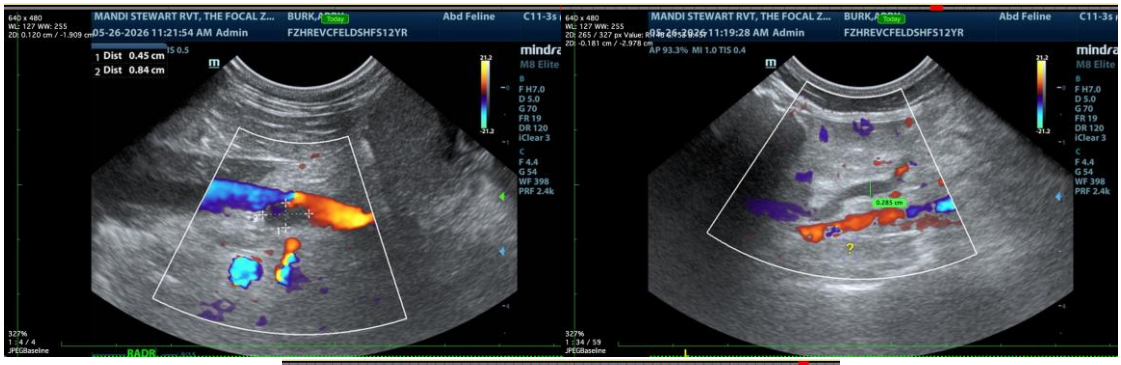

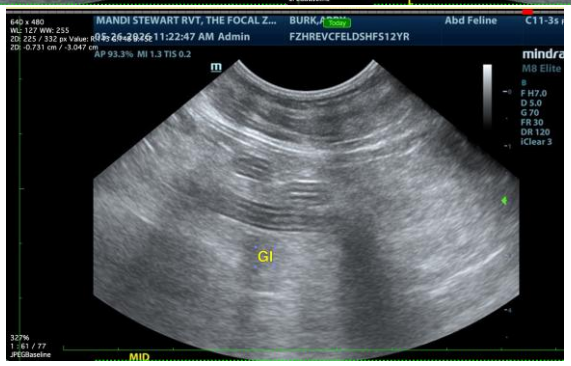

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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