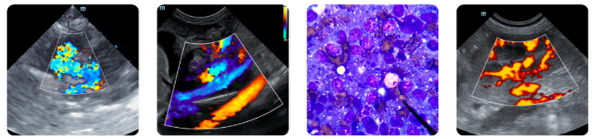


PATIENT

Charlotte Chan

SPECIES

Feline

BREED

DSH

SEX

SF

AGE

6 years 3 months

WEIGHT

5.6 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Mariusz Chmielinski

HOSPITAL NAME

Apex Veterinary Services

REFERRING VET

Alpine 24/7 – Petzoic
Dr. Cory Pinel, DVM, DACVS-SA,CPI

INVOICE

11880

DATE

5/5/2026

PRESENTING CLINICAL SIGNS

Abdominal ultrasound recheck following previous obstructive ureterolithiasis and right ureteral re-implantation surgery performed by Dr. Cory Pinel. Previous AUS performed January 27, 2026.

Abnormal PE/Chem/CBC/UA Results: Clinically doing very well, Eating/drinking well, urinating normally, Normal creatinine and SDMA reported, CBC/Chem WNL, Mild low-normal potassium noted.

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 irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is trace pyelectasia and pinpoint non-obstructive mineral densities noted bilaterally. Left kidney is compensatorily large measuring 4.55 cm. The right kidney is small in size, measuring 2.92 cm.

Additionally, mild hydroureter proximally is still visible with some concern for an approximately 0.28 cm in diameter mineral density within the ureter approximately 1.0 cm from the kidney. The dilation of both the ureter and the pelvis are very mild/scant.

Adrenal Glands

The right adrenal gland is normal in size (0.33 cm) shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.25 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

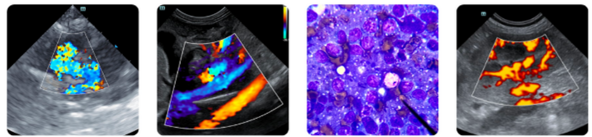
Spleen is subjectively large in size (1.2 cm thick at the hilus) with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a mildly coarse/heterogenous echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

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.

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 mildly 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 chronic kidney disease changes bilaterally with a compensitorily large kidney in the left, and a small kidney in the right. Some mineral within the proximal ureter is still suspected but there is no evidence of obstruction noted in these images at this time, as the dilation has significantly improved.
- Scalloped spleen – can be associated with benign or malignant infiltrative disease. Common causes include a reactive spleen secondary to immune stimulus or early infiltrative round cell neoplasia such as lymphoma or mast cell tumor.
- Mild/emerging 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

As previously recommended, if not already evaluated, fine needle aspirates of the spleen could be considered if patient's coagulation status is appropriate.

The bowel changes are mild/subtle and should be interpreted in combination with any clinical history of gastrointestinal disease, including unintentional weight loss. Especially in the face of a normal appetite.

Recommendations regarding the remaining suspected mineral within the ureter depend in part on the exact procedure that was performed. If the ureter was completely bypassed, as is done with a

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subcutaneous ureteral bypass system, or sub placement, mineral within the ureter is not significant. In other scenarios, it could be, in which case continued monitoring of kidney values, the appearance of the kidneys, etc. may be warranted.

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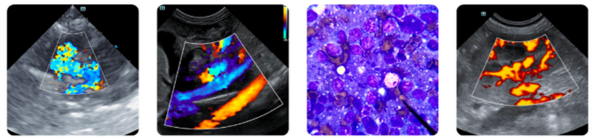
SonoPath.com info@sonopath.com 1.800.838.4268



Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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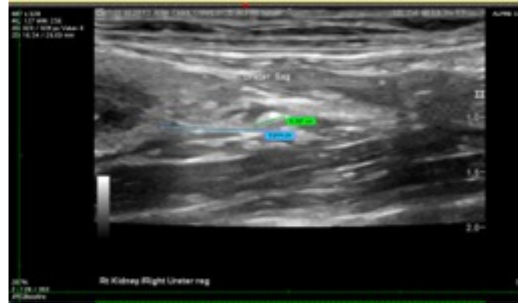

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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