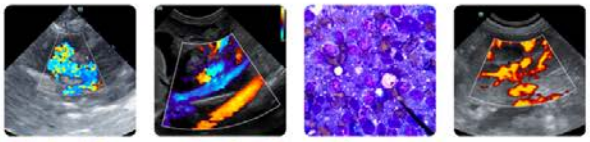

PATIENT

Magdelena Hatt

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

16 Years 6 Months

WEIGHT

4 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

VCA Bridgeport Animal Hospital

INVOICE

75639

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PRESENTING CLINICAL SIGNS

AUS to further evaluate hypercalcemia. Progressed from total Ca 12.6 H in Nov 2025 to tCa 15.5 H in May 2026. Patient had intermittent vomiting last week, hair and some bile. Still eating. Recent hyperthyroidism diagnosis and started on methimazole, gained 1 lbs since starting meds. Meds: Methimazole

Abnormal PE/Chem/CBC/UA Results: May 2026: - CBC: Hct 33%-n, Plts 244-n, remainder NSF - Chem: Alb 2.6-low normal, norma LES, BUN 17-n, Cr 1.2, SDMA 14.4 (<15), tCa 15.5 H (8.2-10.8), prev 12.6 H, Phos 2.8-n, Mg 1.8-n, remainder NSF - UA: USG 1.018, trace pro, trace bld, inactive sediment - Renal tech positive - Keyscreen fecal: NPD

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 bilaterally 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 is small-normal at 3.52 cm. Right kidney is small at 2.72 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.38 cm at cranial pole and 0.35 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.41 cm at cranial pole and 0.47 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

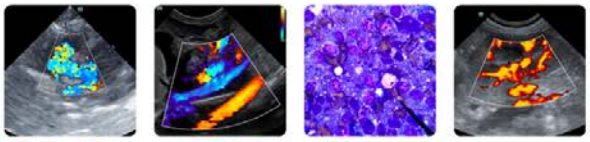
Spleen

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 appears normal without distension or congestion. Multifocal intrahepatic biliary mineral densities are noted.

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.



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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 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 empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. The lumen is very subjectively mildly distended with firm hard shadowing stool.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. 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

- Firm stool/early or emerging constipation cannot be ruled out, although ultrasound is not the most specific diagnostic for constipation, and this finding should be confirmed either clinically or radiographically, etc. prior to further investigation.
- Pancreatic age-related remodeling/Chronic pancreatitis – Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.
- The intrahepatic biliary mineral densities are likely incidental.
- Moderate bilateral chronic kidney disease changes, most visibly significant in the right kidney.
- Mild to moderate amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is not a definitive ultrasonographically visible intraabdominal explanation for patient's reported progressive hypercalcemia. Next recommended diagnostic steps include:

A malignancy panel (PTH, PTHrP, iCa) to Michigan State College of Veterinary Medicine is recommended for further investigation of the reported hypercalcemia.

While patient's reported gastrointestinal signs may be secondary to the recently diagnosed and managed hyperthyroidism or the hypercalcemia directly +/- emerging constipation, emerging small bowel diseas cannot be ruled out in the face of largely normal appearing bowel. Therefore, additionally 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.

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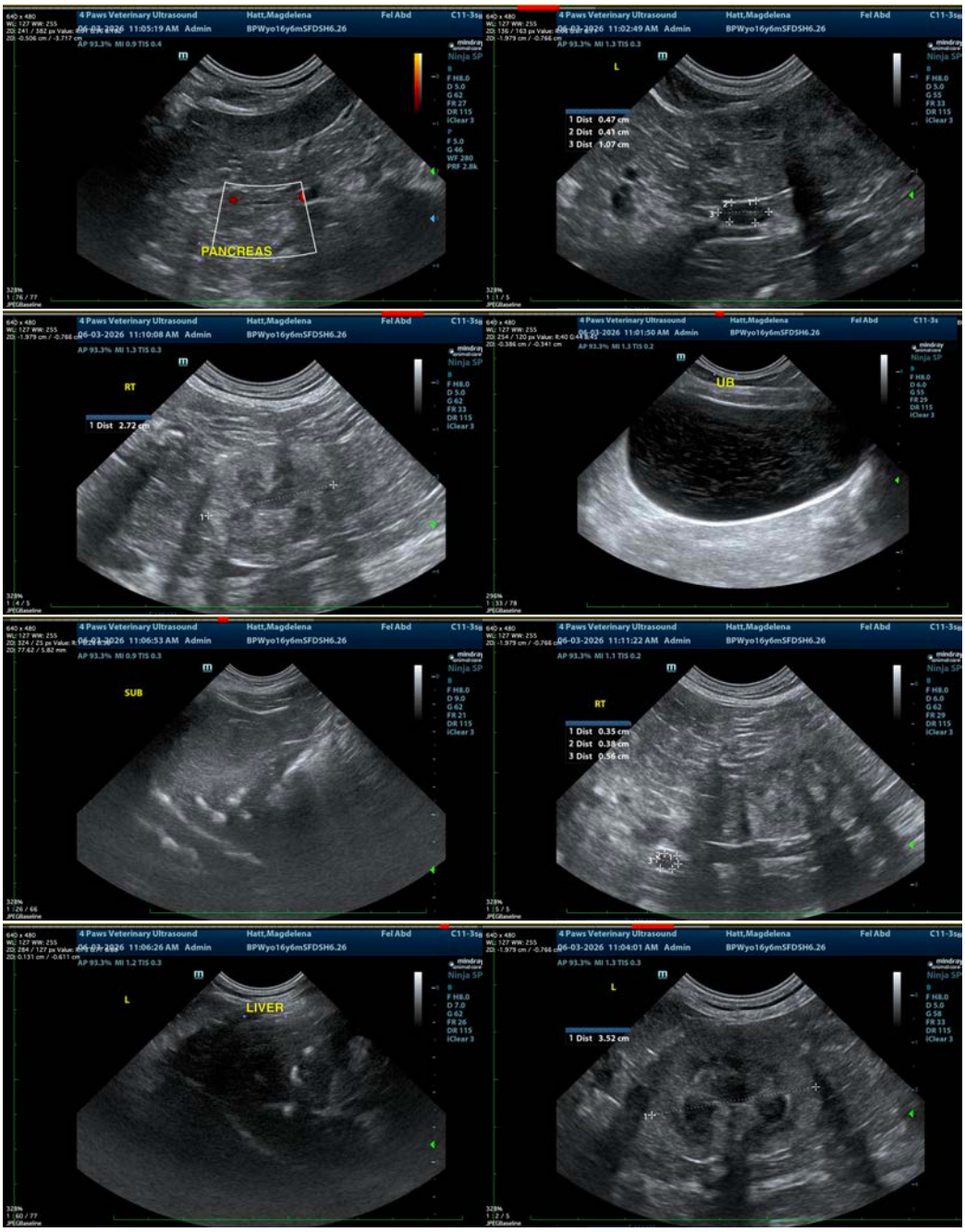
Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.



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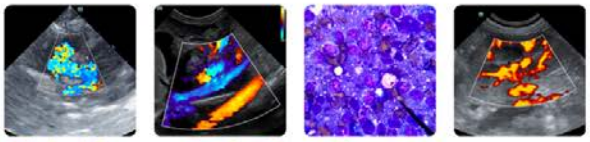

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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