PATIENT

Mickey Bench

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

15 Years

WEIGHT

2.4 kg

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Chippawa Animal Hospital

REFERRING VET

Dr. Dowell

INVOICE

14153

DATE

03/09/26

PRESENTING CLINICAL SIGNS

- Mickey presented On Feb 24 2026 for diarrhea of several days' duration. He has had previous episodes of diarrhea noted approx once a year for 5 years. His stools are typically soft. He has been on various therapeutic diets in the past (GI fiber, Select protein, Gastrointestinal) without noticeable improvement. His appetite has been good but can be picky and he doesn't eat kibble. He has some outdoor access but isn't noted to be a hunter.
- His Body condition score is 3/9, with poor musculature. He is dehydrated 8-10%. He has a grad 2-3/6 heart murmur (previous noted, unchanged) loudest on the right side, and tachycardia. Bowel loops do not feel ropey/thickened and contain watery contents. No sold feces are palpable
- Current Medications
- Subcu fluids prn

Abnormal PE/Chem/CBC/UA Results: Inflammatory Leukogram – Lab results show elevated white blood cell count (22.2 x10^9/L), primarily due to high neutrophils (19.71 x10^9/L) and monocytes (0.73 x10^9/L). Anemia – Lab results show a low hematocrit (0.30 L/L), low hemoglobin (84 g/L), and low MCHC (280.0 g/L), indicating a mild, hypochromic, non-regenerative anemia. Inappropriately Dilute Urine – Urinalysis shows a low specific gravity of 1.012 despite a clinical history of dehydration. Hematuria – . Urinalysis shows 2+ blood and 30-50 red blood cells per high power field. Metabolic Acidosis – Indicated by low TCO2 (8 mmol/L) and high chloride (127 mmol/L) on the chemistry panel. Proteinuria – Urinalysis shows 1+ (0.3 g/L) protein. Trypsin-like Immuno-reactivity (TLI) 115.9 (normal 12.0 - 82.0)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

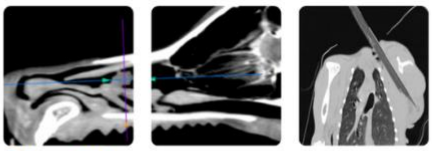
The kidneys have a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. Hyperechoic, shadowing foci present in renal parenchyma and calyces consistent with nephrocalcinosis. The left kidney measured 3.92 cm in length. The right kidney measured 3.7 cm in length.

Adrenal Glands

Adrenal glands are bilaterally enlarged with slightly irregular capsules and heterogeneous architecture. The left adrenal gland measured 0.84 cm in thickness. The right adrenal gland measured 0.51 cm in thickness.

Spleen

The spleen was normal with age-appropriate homogeneous parenchyma and a smooth capsule with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.



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Liver

The liver is subjectively normal in size with normal contours and structure. There is age-appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

Gall bladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis: mucosa layer ratio. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was not visualized. Sections of colon are visualized with gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The visible pancreas was observed to be largely isoechoic to surrounding omental fat.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

No masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

- Normal GI tract.
- Bilateral adrenomegaly.
- Degenerative renal changes with nephrocalcinosis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Colon is ultrasonographically normal with no signs of mural disease. Colonic wall is of normal thickness with no cause of described clinical signs. GI panel (TLI/PL/cobalamin/folate), fecal pathogen PCR, and empiric broad spectrum deworming and treatment with probiotics should be considered. Colonoscopy may reveal pathology not visible on ultrasound.

Bilateral adrenomegaly is of uncertain clinical significance. It may be a variation of normal, may represent response to stressful illness or may indicate underlying hormonal disease.

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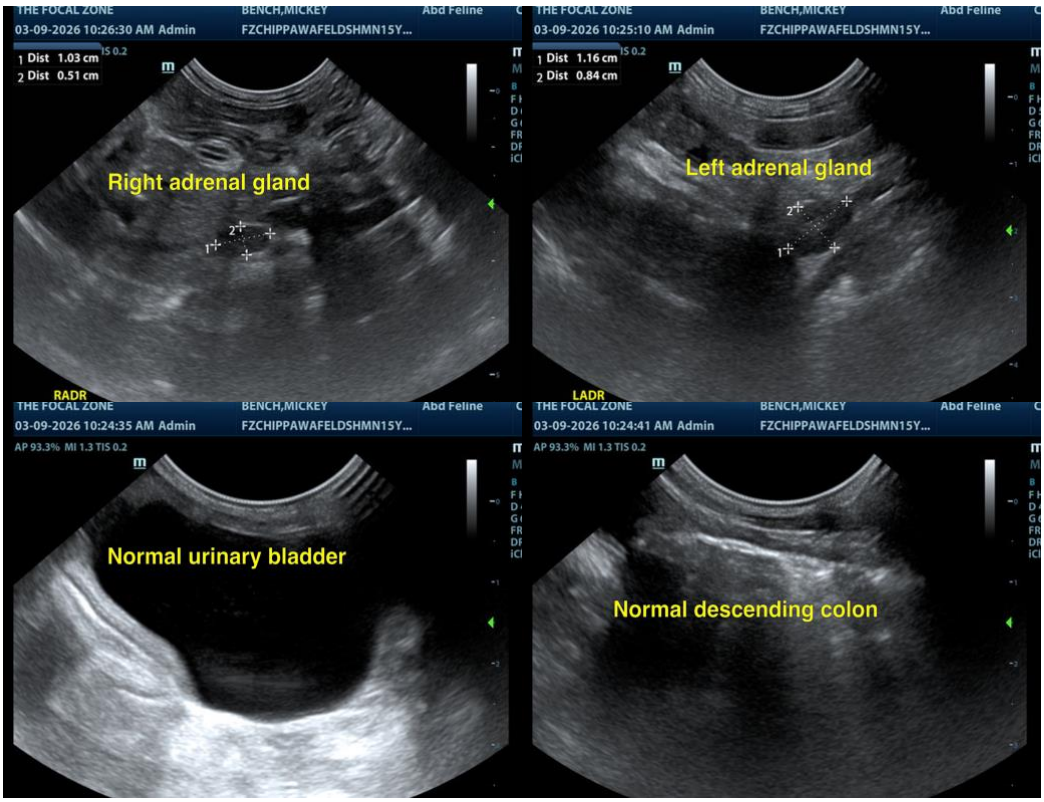
Hyperadrenocorticism, hyperaldosteronism and acromegaly are endocrine diseases which can cause adrenomegaly in the cat. Adrenal gland function testing could be considered if indicated (plasma aldosterone level - requires concurrent assessment of potassium, IGF-1, LDDST).

Hyperaldosteronism is a common cause of systemic hypertension. There is often, but not always, a high/high normal sodium and low/low normal potassium with this disease.

Hyperadrenocorticism and acromegaly are often, but not always, seen in cats with uncontrolled diabetes mellitus.

Rarely adrenomegaly can be seen with infiltrative disease such as lymphoma or fungal disease, but this is generally not the only sign of these diseases.



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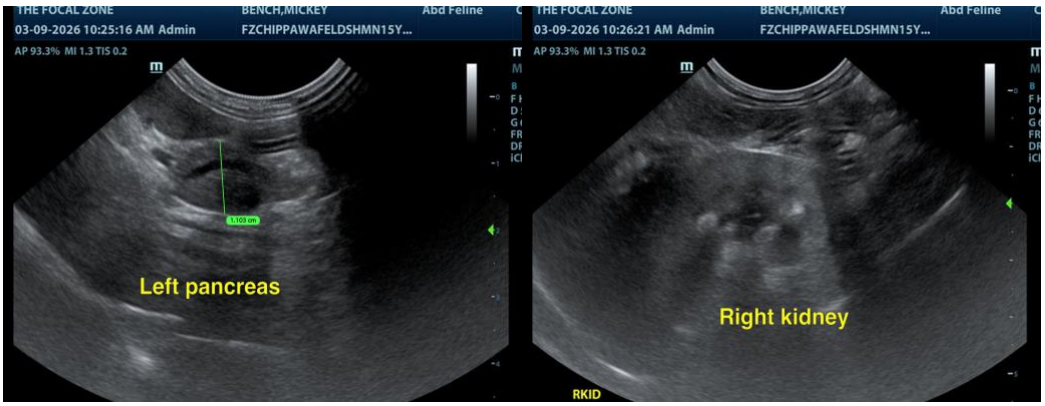

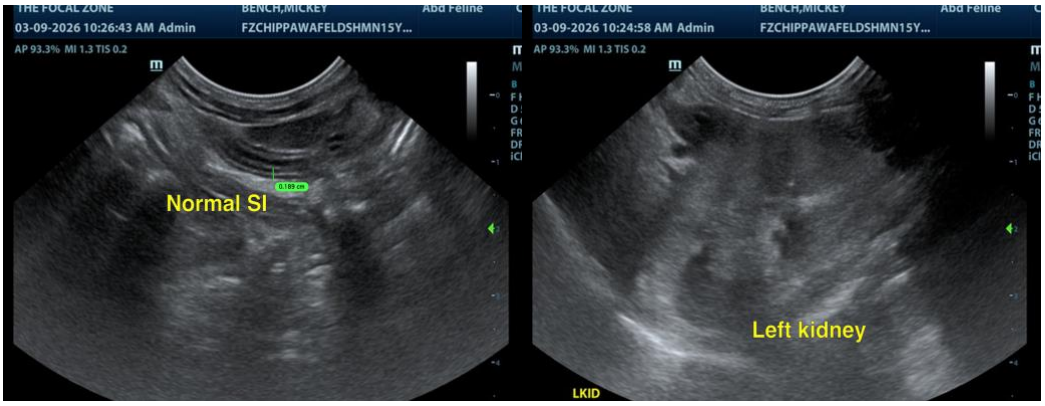

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com