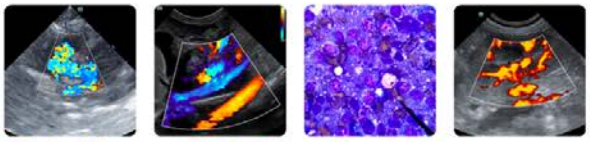


PATIENT

Benny Schlauch

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered Male

AGE

10 Years

WEIGHT

10.3 lbs

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Dr. Megan Bray

HOSPITAL NAME

Taylorsville Veterinary Clinic

REFERRING VET

Dr. Megan Bray

INVOICE

74748

DATE

4/23/26

PRESENTING CLINICAL SIGNS

History of calcium oxalate stones, had a cystotomy in 2021. Patient lives on Hill's Feline c/d. Stage 2 renal disease.

Abnormal PE/Chem/CBC/UA Results: Weight loss noted, no GI symptoms (v/d). Decreased vitamin D. Ionized calcium. Now has Hypercalcemia.

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. Mobile debris present in the urinary bladder. No evidence of inflammatory or neoplastic changes were noted.

The kidneys have a smooth capsule and with mild hazing of corticomedullary definition. No evidence of pelvic dilation was present. Hyperechoic, shadowing foci present in renal parenchyma and calyces consistent with nephrocalcinosis. Left kidney measures 3.94 cm. Right kidney measures 3.66 cm.

Adrenal Glands

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. Left adrenal measures 0.29 cm in thickness. Right measures 0.44 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.

Liver

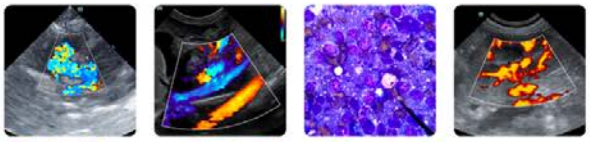
The liver is subjectively normal in size with normal contours and structure. There is age appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

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 diffusely increased and wall layering is distinct with a prominent muscularis layer. There were no focal lesions consistent with obstruction or a mass effect observed.



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The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and 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.

Free Abdomen

No clinically significant lymphadenopathy or abnormalities noted. No free fluid noted.

ULTRASONOGRAPHIC FINDINGS

- Thickened intestine with slightly prominent muscularis layer.
- Aging renal changes with nephrocalcinosis, right worse than left.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No specific cause of hypercalcemia was found on abdominal ultrasound. It commonly causes increased drinking and urination. Thoracic and orthopedic radiographs should be considered. Renal insufficiency can be caused by, or a cause of, hypercalcemia. Hypoadrenocorticism and granulomatous disease (fungal or other) are parathyroid independent differentials for hypercalcemia. Idiopathic hypercalcemia is a diagnosis of exclusion seen in cats.

Small intestinal changes are most consistent with infiltrative disease of the small intestine with inflammatory bowel disease or GI lymphoma being the top differentials. This is an uncommon but possible cause of hypercalcemia. No overt neoplastic criteria present in the bowel given that curvilnear layering is still intact. Ultrasound cannot differentiate between small cell lymphoma and inflammatory bowel disease and GI biopsies are recommended for definitive diagnosis, especially if there is a poor response to empirical efforts or recurrence of clinical signs after initial control. Endoscopic biopsy is less invasive but may miss lesions due to inability to obtain samples from all sections of the GI tract, especially the jejunum which is the most common site of development of disease. Surgical biopsies are more likely to be diagnostic but are more invasive. A GI panel (TLI/PLI/cobalamin/folate) will help determine the severity of SI dysfunction, and need for vitamin supplementation.

Empiric treatment for IBD includes diet trial with either hydrolyzed or select protein diet, vitamin b-12 supplementation, GI support as needed (anti-nausea, appetite stimulant). Treatment with steroids (budesonide vs prednisolone) is often required – biopsies should be acquired prior to treatment with steroids. Steroids may ultimately be tapered to the lowest effective dose or discontinued in some cases.

Renal changes are likely age related degenerative changes. Correlate clinical significance with blood work/urinalysis findings and clinical signs. Nephroliths may act as a nidus of infection and predispose to urinary tract infections. They can also cause sterile inflammation leading to renal hematuria. They have the potential to move into the ureters or bladder causing obstructive uropathy.

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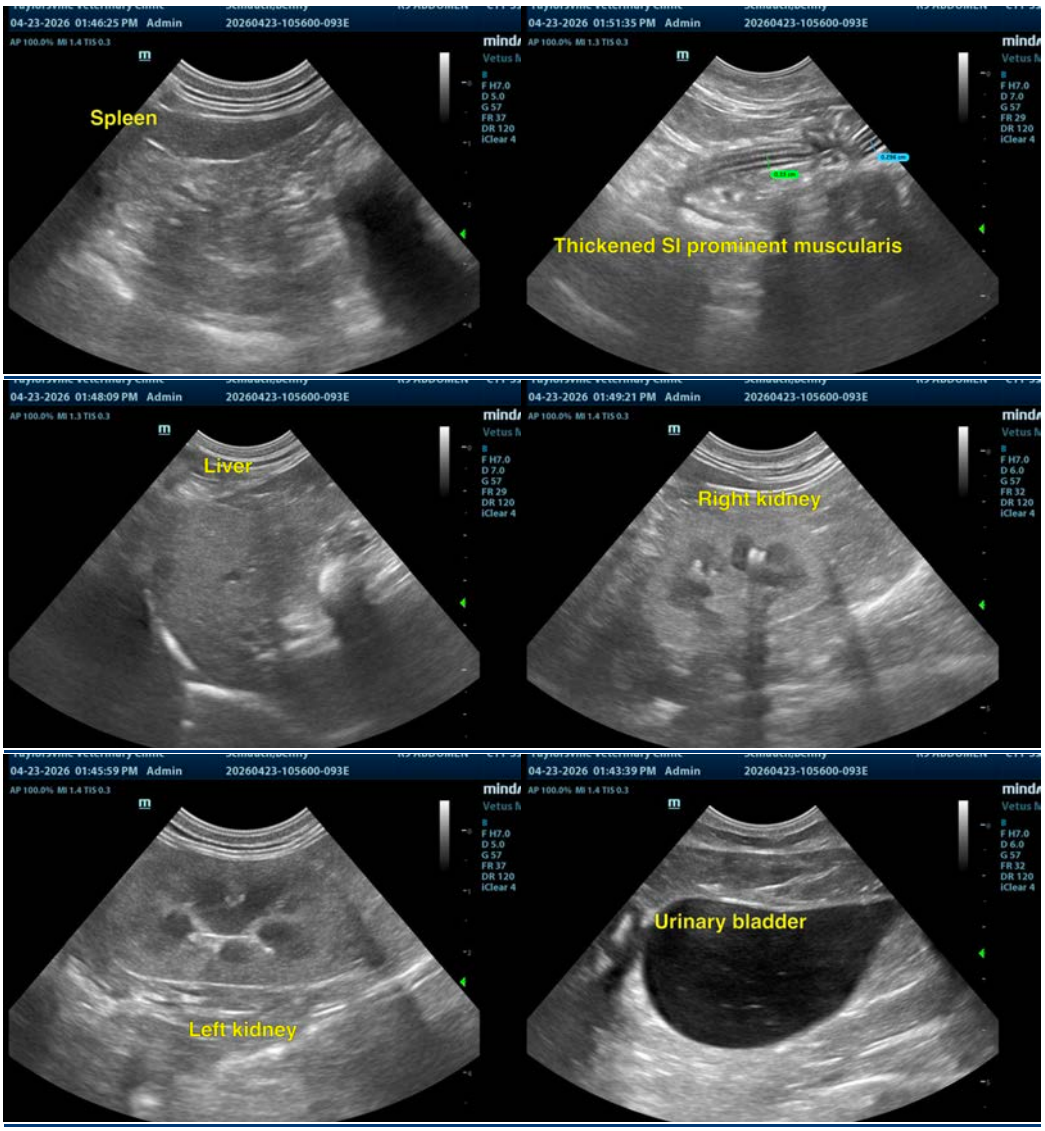

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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