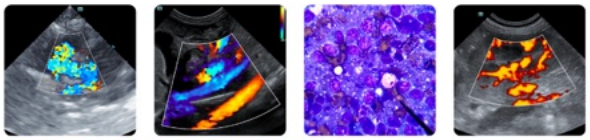

PATIENT

Pepe Irwin

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

11 years

WEIGHT

18.6 lbs

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Sara Crawford

HOSPITAL NAME

Countryside VS Champion

REFERRING VET

Dr. Crawford

INVOICE

74893

DATE

4/27/26

PRESENTING CLINICAL SIGNS

History: Patient presented for not eating hard treats. Most recently not eating/drinking or defecation for 5 days. weight loss
Elevated renal values (SDMA 25, Crea 3.4, BUN 59, normal WBC) Elevated Cystatin B >2500, concentrated urine at 1.044 with UPC 0.3 1+ calcium oxalate crystals

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** revealed a minimal amount of urine, potential calculus, yet the contrast resolution was challenging. The bladder should be reimaged at full bladder with high resolution. The proximal urethra was unremarkable.

The **left kidney** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for this age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The left kidney measured 5.5 cm with 1.0 x 1.5 cm of pyelectasia and non-obstructive calculi at the time of the sonogram.

The **right kidney** presented a relatively uniform cortical hyperechogenicity when compared to the renal medulla, spleen and liver. No overt masses were noted. Corticomedullary definition was nebulous and the ratio favored the cortex slightly. The ureters were not visible and assumed to be normal. These changes are most consistent with chronic interstitial nephritis yet infiltrative disease could not be entirely ruled out without biopsy though neoplasia is not suspected. The right kidney had poor blood flow and measured 4.2 cm in length.

Adrenal Glands

The **adrenal glands** were not visualized.

Spleen

The **spleen** in this patient was uniform, yet volume contracted. Hydration status should be assessed.

Liver

The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

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Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

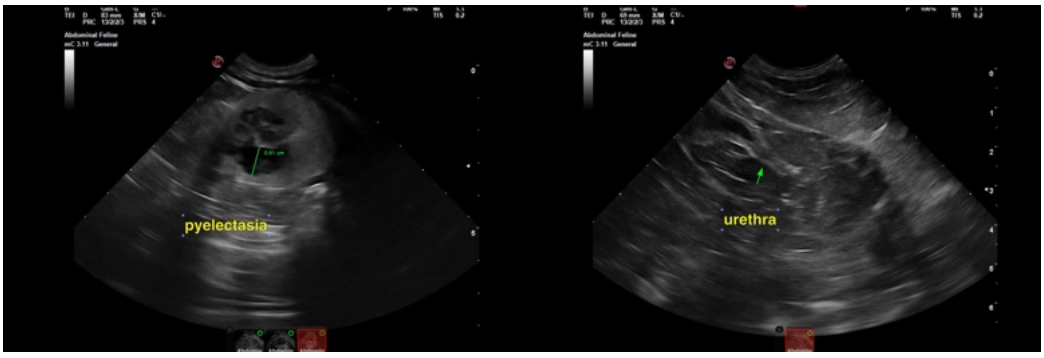
ULTRASONOGRAPHIC FINDINGS

Left nephrolithiasis with pyelectasia and pelvic scarring, possible bladder calculus.

Moderate, chronic, degenerative right renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further definition of the possible bladder calculus is recommended on further imaging at full bladder. I recommend 72-hour IV fluid protocol, blood pressure and urine culture are all indicated. Recheck sonogram is recommended after 48-72 hours of therapy. Eventual cystotomy +/- stent placement of the left kidney would be ideal.



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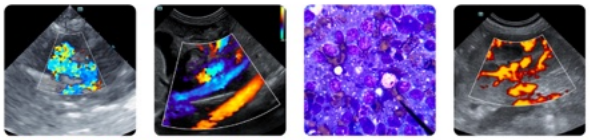

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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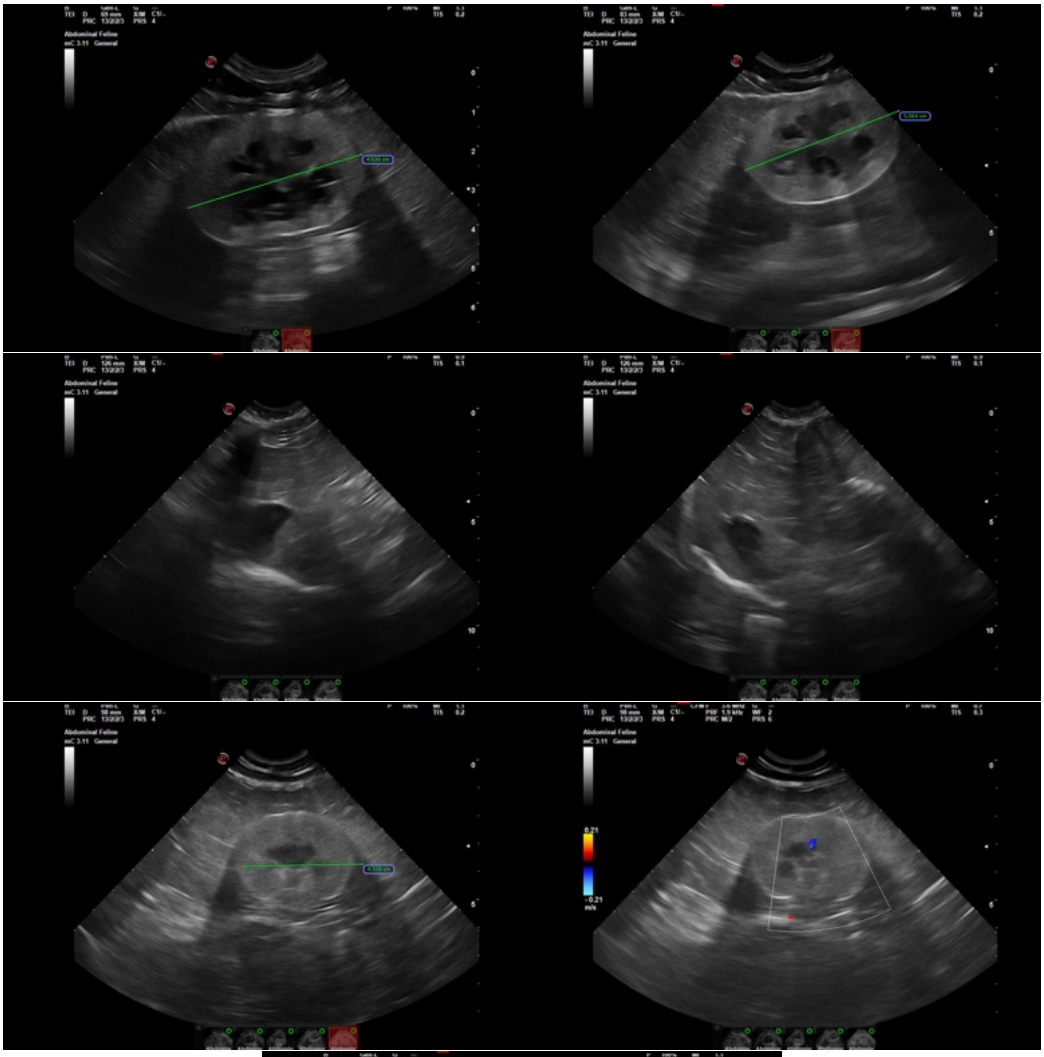
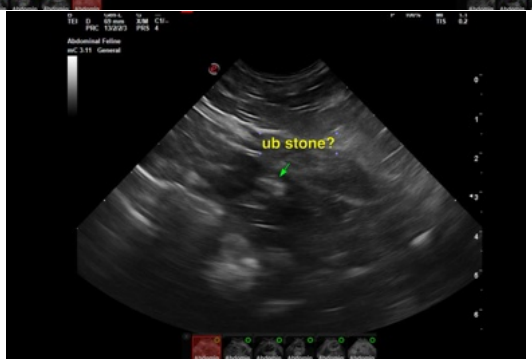
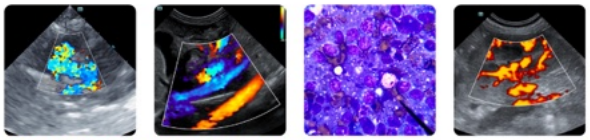




The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I



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can be of any further assistance please contact me.

Eric Lindquist, DMV, DABVP (CFM), Cert. IVUSS, CEO of SonoPath.com

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