PATIENT

Charlie Busam

SPECIES

Feline

BREED

Siberian

SEX

Neutered Male

AGE

12 Years 3 Months

WEIGHT

Not Provided

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Kerri Becker

HOSPITAL NAME

Farview Animal Clinic

REFERRING VET

Dr. Mosaad

INVOICE

14750

DATE

03/30/26

PRESENTING CLINICAL SIGNS

- PU/PD rads show osteophyte formations, rest wnl

Abnormal PE/Chem/CBC/UA Results: mchc-29 mono-5 eos-19 abs eos-1159

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder is moderately distended with anechoic urine. No uroliths are seen. The bladder wall is normal in appearance and thickness. No masses are seen.

The left kidney presents normal size with normal shape and architecture. Moderate loss of corticomedullary distinction with renal pelvic dilation measuring 4.6 mm x 8.2 mm. The left kidney measured 4.0 cm in length.

The right kidney presents normal size with normal shape and architecture. Moderate loss of corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis. The right kidney measured 4.2 cm in length.

Adrenal Glands

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The left adrenal gland measured 3.7 mm.

The right adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The right adrenal gland measured 3.6 mm.

Spleen

The spleen has multifocal variable sized hyperechoic lesions throughout. Largest of these lesions measures 9 by 8.4 mm in size and is capsule displacing causing a shadowing effect.

Liver

The liver presents normal size and shape with smooth lobar margins. The parenchyma has normal echogenicity with normal echotexture. No focal lesions are seen. Intrahepatic bile ducts are normal. Normal vascular pattern.

The gallbladder presents normal size with anechoic contents. Normal gallbladder wall. No evidence of bile duct distention or obstruction.

Gastrointestinal

The stomach has normal wall layering and thickness. Colon contains normal contents with normal wall thickness.

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,

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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.

Pancreas

The visible pancreas is normal in size with normal echogenic parenchyma and surrounded by normal peri-pancreatic mesentery.

Free Abdomen

There are no enlarged abdominal lymph nodes seen on this exam. No free abdominal fluid is seen.

ULTRASONOGRAPHIC FINDINGS

- Bilateral chronic kidney disease.
- Splenic lesions.
- Possible inflammatory bowel disease.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The patient appears to have bilateral chronic kidney disease. Recommend full staging, monitoring and managing chronic kidney disease per international renal interest society guidelines. Left kidney pyelectasia differentials include pyelonephritis versus obstructive nephropathy. No obvious obstruction is identified on this exam. Recommend urine culture and antibiotic sensitivity to decrease suspicion of pyelonephritis.

Recommend fine needle aspirate of one or several of the splenic lesions. Differentials include round cell neoplasia such as lymphoma, mast cell or other malignant neoplasia. Less likely but possibly these lesions are benign myelolipomas. Other differentials would include an infectious etiology although an infectious etiology seems unlikely. If fine needle aspirate rules out round cell neoplasia, recommend rechecking these lesions ultrasonographically in six to eight weeks. If there appears to be progression of these lesions, then at that time consider splenectomy for histopathology.

The appearance of the small bowel is consistent with possible inflammatory bowel disease versus small cell lymphoma versus mast cell disease. Less likely an infectious etiology should be considered for the appearance of the small bowel. Consider histoplasmosis of geographically relevant. No specific cause for the patient's polyuria polydipsia is seen.

If pyelonephritis is ruled out, then recommend periodic monitoring of left kidney via ultrasound to determine if renal pelvic dilation persists. If it does, there may be a possible obstructive process occurring within the ureter. CT scan would be recommended if renal pelvic dilation persists to rule out an obstructive nephropathy.

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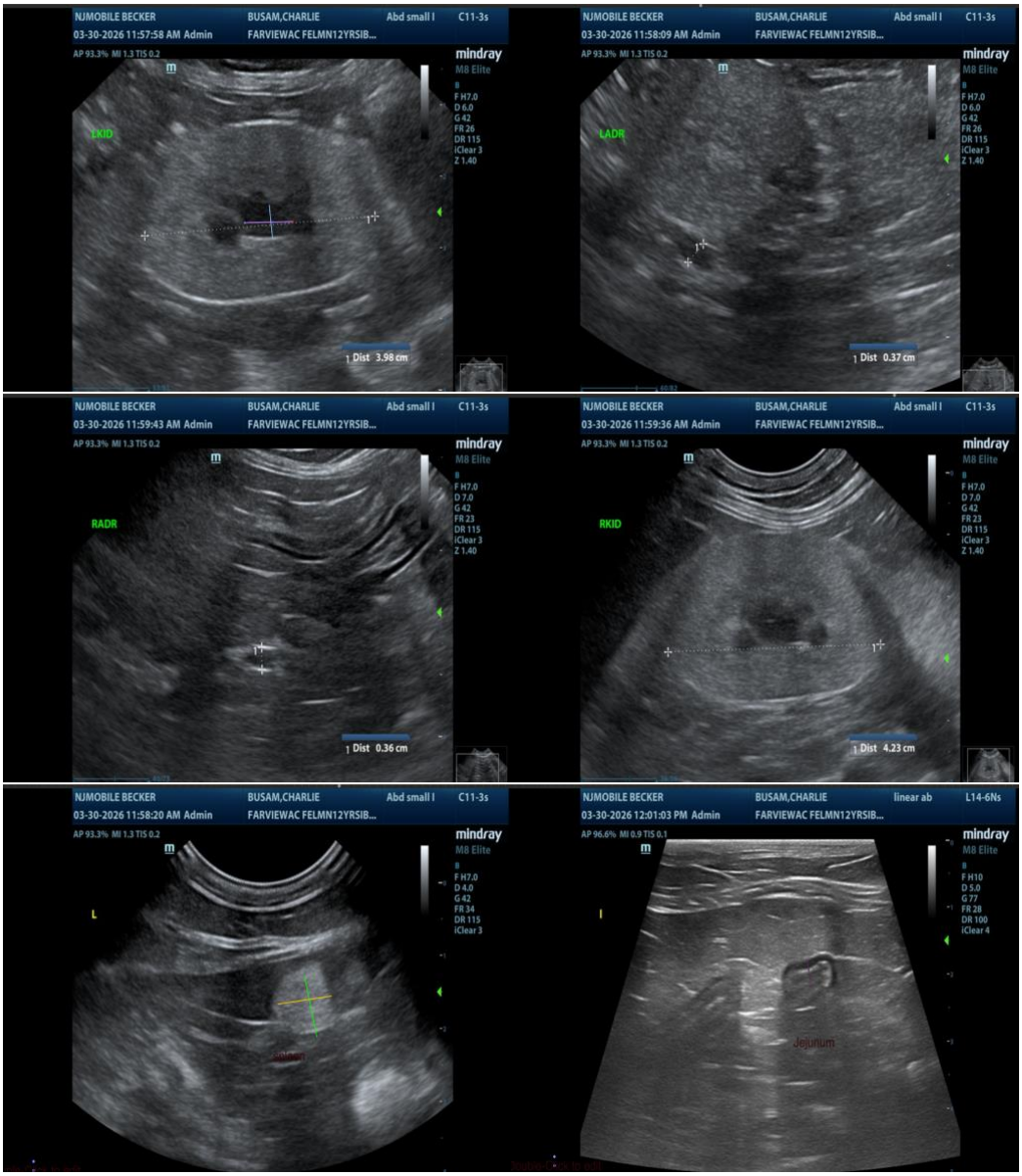

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Greg Kuhlman, DVM, DACVIM (SAIM)
Veterinary Internal Medicine Specialist
info@SonoPath.com