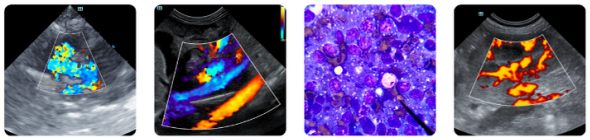


PATIENT

Ellie Smith

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

12 years

WEIGHT

3.43 kg

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Lindsay Powell, CVT

HOSPITAL NAME

Hershey Animal Emergency Center

REFERRING VET

Dr. Cara Sinopoli

INVOICE

11763

DATE

4/22/2026

PRESENTING CLINICAL SIGNS

Ellie presented to HAEC on 4/21/26 at 8pm for a three-day history of lethargy, decreased appetite and holding her head down. She has a history of being bullied at the food dish and her owners are unsure if she is eating her proper daily caloric intake. No known vomiting or diarrhea. Did eat small amount today in hospital.

Abnormal PE/Chem/CBC/UA Results: 6-8% dehydrated cervical ventroflexion, generalized weakness unable to ambulate well, mild generalized muscle atrophy Intake: CBC: WBC 18.21 (H), Neutrophils 14.65 (H) Chem: Glucose 203 (H), Globulin 5.5 (H), ALT 152 (H) EPOC: Potassium 1.9, Lactate 5, Glucose 185 T4: 2.2 (normal; possible grey zone) Radiographs: unable to stretch forelimbs forward due to pain/discomfort/behavior; Thorax: increased sternal contact of cardiac silhouette, mild globoid appearance on VD Abdomen: stomach appears empty, SI NSF, large urinary bladder (patient urinated large volume in room post-diagnostics) 4/22 Day: Lytes: 8am K 2.4 L; 2pm K 2.5 L PCV/TS: 37%/8.2 Lactate: 3.6 H.

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 mild 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.

The left kidney is overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measures 3.8 cm in length.

The right kidney was not visualized in these images.

Adrenal Glands

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The caudal pole measures 2.6 mm in width. A mass is noted in the cranial pole measuring 5.6 mm x 2.8 mm in size.

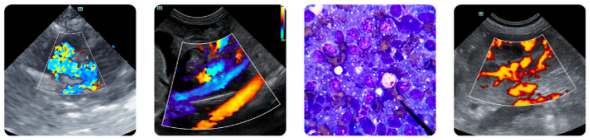
The right adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The right adrenal measures 3.2 mm.

Spleen

The spleen is enlarged in size with scalloped margins and is diffusely hypoechoic. Normal blood flow.

Liver

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal



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lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out.

If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

Small intestines have normal wall layering and thickness (2.1 mm). The lumen is diffusely moderately to markedly distended with fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal chyme.

Colon contains normal contents with normal wall thickness.

Pancreas

The visible pancreas appears mildly hypoechoic with mild surrounding hyperechoic fat.

Free Abdomen

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

ULTRASONOGRAPHIC FINDINGS

- A mild amount of urinary bladder debris.
- Age related changes in the left kidney.
- Splenomegaly with scalloped margins. Possibly normal patient variant or the appearance may be due to infiltrative process such as lymphoma, mast cell disease, or less likely an infectious etiology.
- Mildly hypoechoic pancreas with mild surrounding hyperechoic fat. Possibly consistent with pancreatitis.
- Moderate gallbladder debris – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness, however, it can also be associated with hepatobiliary disease in cats and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.
- Hyperechoic hepatomegaly – This appearance is most consistent with benign hepatic lipidosis or endocrine/DM hepatopathy. Infiltrative disease such as amyloidosis or round cell neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.

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- Hyperechoic adrenal mass on the cranial pole of the left adrenal – Differentials include primary adrenal cortical adenoma or adenocarcinoma, pheochromocytoma, myelolipoma, adrenal hyperplasia secondary to pituitary disease or metastatic disease. Ultrasound alone cannot differentiate between functional and non-functional nodules and/or between benign and malignant disease. Small nodules without other evidence of abdominal disease (to suggest metastatic disease) and/or clinical signs (to suggest adrenal disease) are most often incidental and should be monitored.
- Given the appearance of the stomach and small bowel, the patient appears to have functional ileus. No mechanical lesion is seen within the GI tract on this exam.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Consider a fine needle aspirate of the spleen and the liver with submission for cytology to rule out infiltrative neoplasia, and hepatic lipidosis.

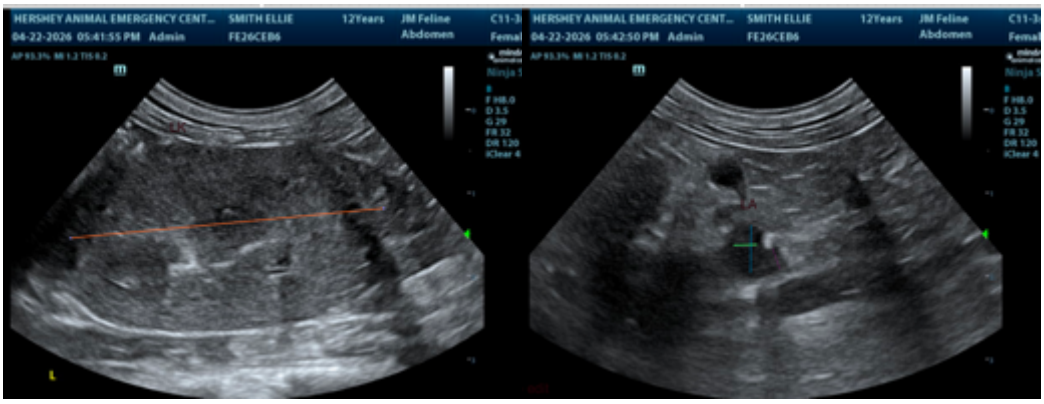
Recommending submitting fPLI to screen further for pancreatitis.

Given that there is an apparent mass on the cranial pole of the left adrenal gland, the patient's potassium is reportedly 1.9 and is showing signs of ventroflexion (due to low potassium), I suspect the patient's low potassium is due to hyperaldosteronism possibly caused by the mass on the left adrenal. Recommend submitting aldosterone level to determine if it's elevated and starting oral potassium supplementation. If aldosterone is elevated, consider starting spironolactone at a dose of 1.0-2.0 mgs/kg, by mouth every 12-24 hours as needed to achieve normal potassium levels.

Given that patients with hyperaldosteronism are most often found to be hypertensive, recommend evaluating blood pressure.

Functional ileus is most likely due to the hypokalemia. Recommend treating the patient supportively.

Given the appearance of the left kidney, I recommend full staging, monitoring, and managing this patient per International Renal Interest Society (IRIS) Guidelines.



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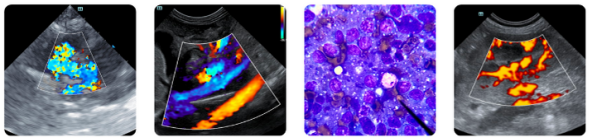

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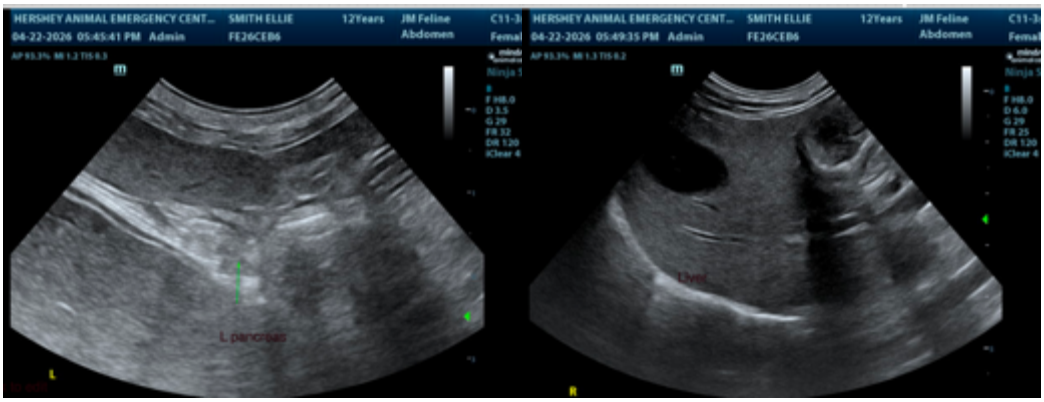

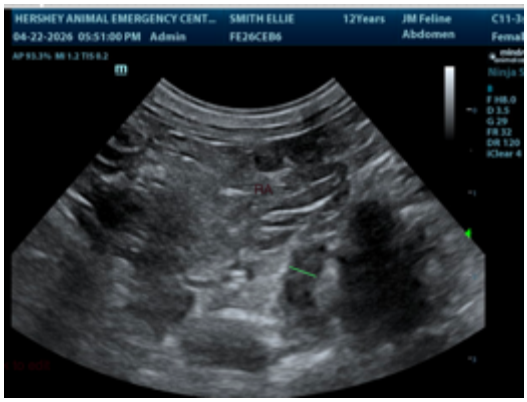

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Greg Kuhlman, DVM, DACVIM (SAIM)

Veterinary Internal Medicine Specialist
info@SonoPath.com