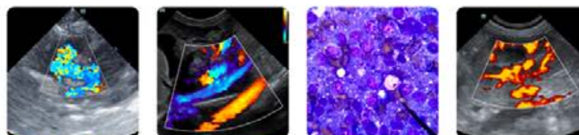


PATIENT
Baby Ritter

SPECIES
Feline

BREED
DSH

SEX
Spayed Female

AGE
14 Years

WEIGHT
9.2 lbs

INTERPRETED BY
Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY
Dr. Jennifer Todd

HOSPITAL NAME
Lambs Gap Animal Hospital

REFERRING VET
Dr. Lindsey Knouse

INVOICE
75967

DATE
6/17/26

PRESENTING CLINICAL SIGNS

Baby is a 14 year old FS DSH. She presented 5/18/26 for a new spot of alopecia. on her neck that was pruritic. At that time, Baby was reportedly eating well but had lost a few ounces of weight. No vomiting or diarrhea reported. She was visibly jaundiced on exam 5/18, and also had a new Grade II/VI systolic heart murmur. Baby has a history of elevated liver values and is currently managed with Denamarin and Denosyl, along with Phosbind powder (0.25 teaspoon twice daily, separated by 2-4 hours). She previously required lactulose for constipation but has not needed it recently.
Owner believes Baby has a history of urinary stones requiring surgical intervention in the past after presenting with hematuria to a previous vet. She is currently fed Royal Canin urinary diet along with Fancy Feast. Owner was under impression that previous vet- Country side clinic did an ultrasound, but I did not find this in records. Recheck bloodwork was performed 5/18/26: Newly anemic (non-regenerative) HCT 25%, mild monocytosis was found T4 wnl, proBNP =176, Stress hyperglycemia 222, Mild azotemia creat 1.5, SDMA 18, BUN 38, Liver enzymes elevated with ALT, ALP around the same as in April: ALT 494, AST 143, ALP 332, Bilirubin is higher- 2.7, with conjugated and unconjugated levels high.

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.

Kidneys are normal in size but bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. No mineral is observed. The left kidney measures 3.8 cm. The right kidney measures 3.8 cm with mild renal pelvic dilation of 0.60 mm.

Adrenal Glands

The right adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The cranial pole measures 2.4 mm in width.

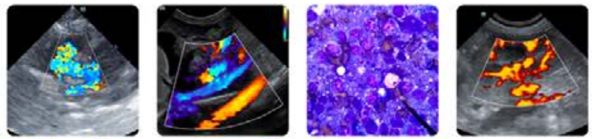
The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The left adrenal gland measured 2.5 mm in width.

Spleen

Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged (swollen contour) with a diffusely mildly coarse architecture and subtly increased portal markings. Mildly mixed echogenic changes are noted diffusely. Within the ventral aspect of the left liver there is a 1.2 cm in diameter cystic lesion present. The cystic lesion has areas that appear mass-like. The cystic fluid is hypoechoic without significant echogenic debris present within the fluid, and the outer rim of the ventral aspect of this cystic lesion does appear to be a mass lesion. It has the tissue of a mass lesion and is heterochoic. No other lesions seen throughout the liver. Visible



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vasculature and biliary tree appear normal without distension or congestion.

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. Diffusely, the small bowel is normal in thickness at 2.4 mm in width with normal layering. Subjectively the muscularis layer is mildly thickened. Colon contains normal contents with normal wall thickness.

Pancreas

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

Free Abdomen

Multiple moderately enlarged mesenteric lymph nodes are present. A representative node measures 3.3 mm x 9.7 mm. The nodes are hypoechoic and mildly rounded.

No free abdominal fluid is seen.

ULTRASONOGRAPHIC FINDINGS

- Chronic kidney disease changes.
- Hyperechoic splenic nodules.
- Cystic liver lesion.
- Subjectively mildly thickened muscularis layer of the small intestine.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The appearance of both kidneys is consistent with chronic kidney disease, which correlates with patient's recent lab work. Recommend full staging, monitoring and managing per IRIS guidelines. The mild renal pelvic dilation of the right kidney is most likely due to chronic kidney disease. However, pyelonephritis cannot be ruled out. Therefore, as part of the IRIS staging workup, recommend urine culture to rule out urinary tract infection and possible pyelonephritis.

The appearance of the liver is consistent with a chronic hepatopathy, possibly due to infiltrative neoplastic disease such as lymphoma. Recommend fine needle aspirate of the liver for cytology to rule out infiltrative disease. If infiltrative disease is ruled out as cause for the non-specific hepatopathy, consider a liver biopsy.

Regarding the cystic hepatic lesion, suspect possible malignant neoplasia such as biliary cystadenocarcinoma or possibly benign lesion such as biliary cystadenoma. Recommend a fine needle aspirate of the lesion, both the cystic fluid and mass portions, and submit for cytology to further characterize the lesion. If FNA is non-diagnostic, consider CT scan of the abdomen for pre-surgical planning to determine if mass resection is feasible. If surgery is performed, submit mass for histopathology and also recommend biopsy of the liver at that time for histopathology to help determine the underlying cause of elevated liver values.

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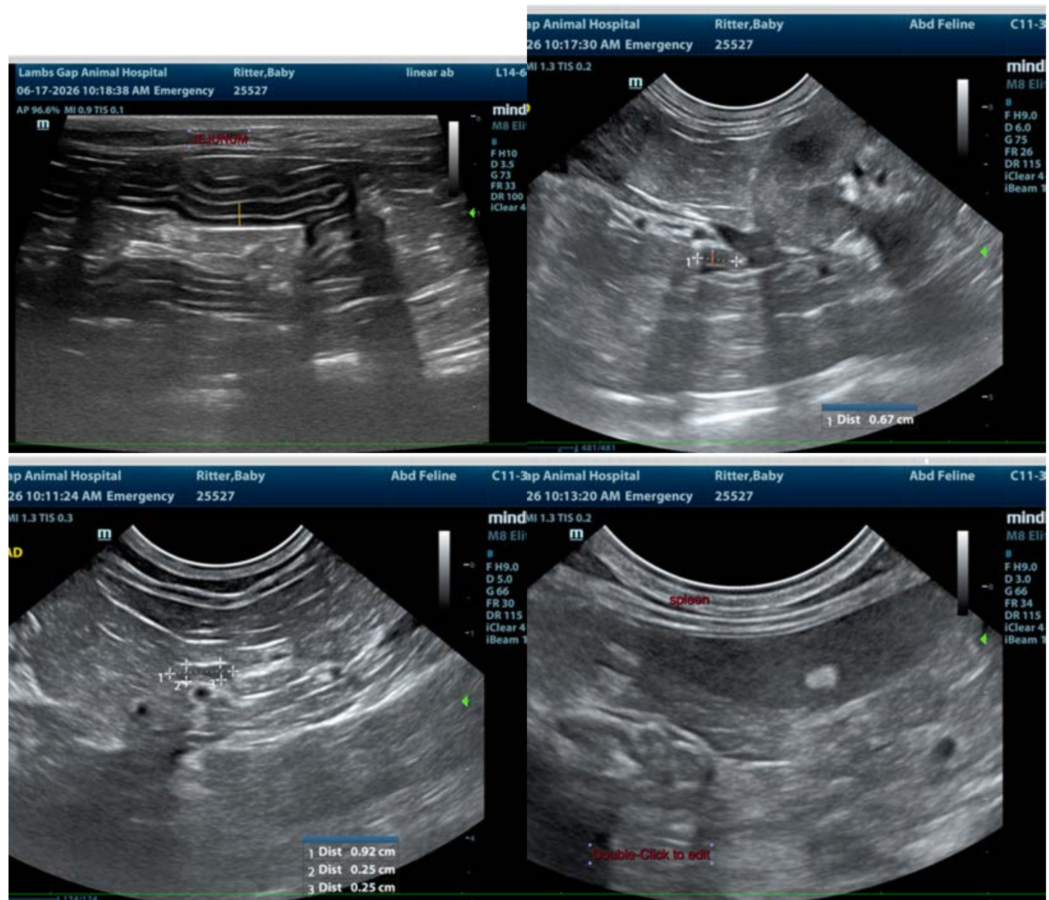
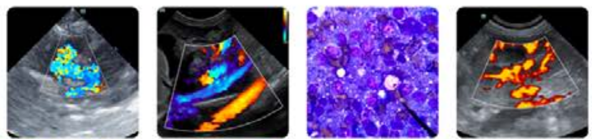
Recommend submitting a GI panel to screen the patient further for possible chronic enteropathy. If chronic enteropathy is identified and if appropriate for patient's other medical condition, consider a hydrolyzed diet trial. Recheck the appearance of the small bowel via ultrasound in 6-8 weeks. If muscularis layer remains subjectively thickened, consider GI biopsies. If the patient has surgery to remove the cystic liver mass, also recommend obtaining GI biopsies at the same time.

Recommend 3-view chest radiographs prior to any surgical procedure to screen for possible pulmonary metastatic disease.

The enlarged mesenteric lymph nodes may be reactive or may be enlarged due to infiltrative or metastatic neoplasia. They are most likely reacting to patient's suspected gastrointestinal disease. If possible recommend fine needle aspirate of mesenteric lymph nodes to further characterize the cause of their enlargement.





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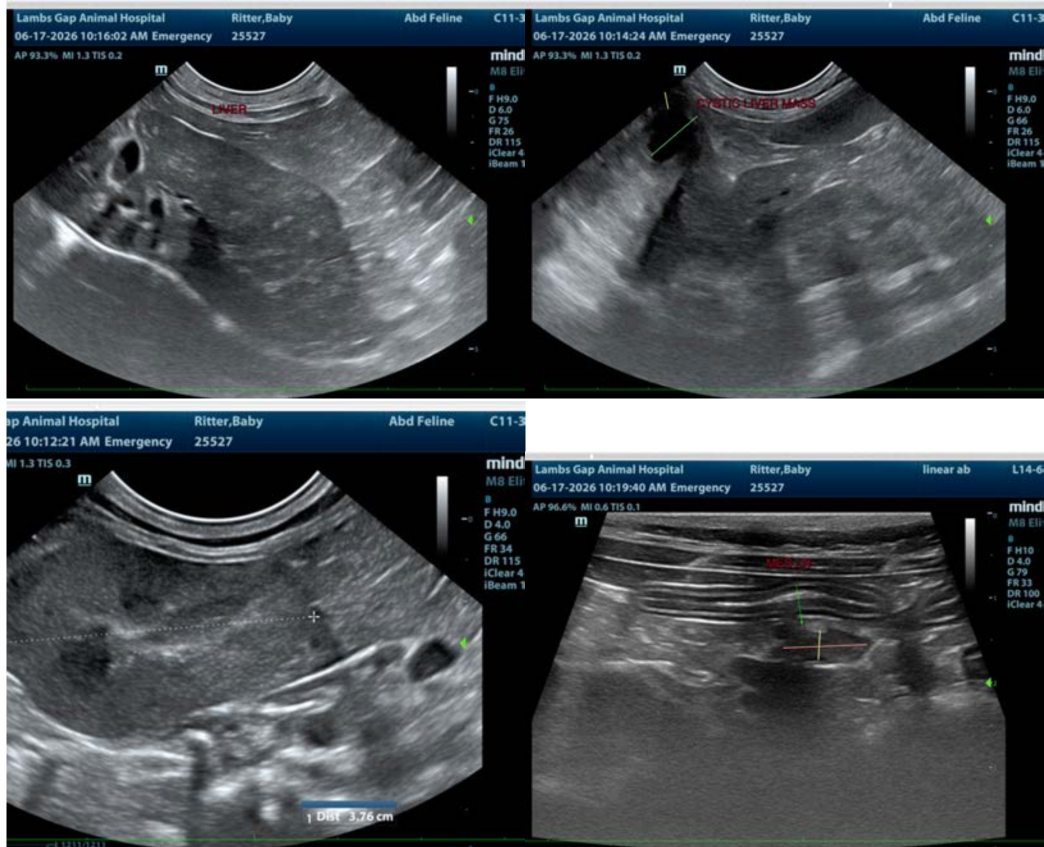

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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