PATIENT

Juneau Minetto

SPECIES

Feline

BREED

DLH

SEX

MN

AGE

16 years 7 months

WEIGHT

2.9 kg

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Truckee Meadows Veterinary Hospital

REFERRING VET

Dr. Rachel Kuester

INVOICE

11064

DATE

1/7/2026

PRESENTING CLINICAL SIGNS

Hypertension (12/2025) - started Amlodipine Hematuria - recurrent - DDx cystitis, other Upper Respiratory Infection - Chronic, recurrent rhinitis Severe Periodontal Disease Chronic kidney disease and proteinuria (IRIS stage 3) - currently managed with Rx PHOSBIND, SQF EOD Hyperthyroid disease - Managed with Methimazole Sarcopenia – Moderate generalized muscle atrophy is present, consistent with age and chronic conditions. Osteoarthritis - Managed with Solensia 2/2025 - Highly PD - Highly water seeking. Vomits if drinks a lot of water. Stranguria, hematuria, lethargy. Still eating, but decreased. Concern for UTI, pyelonephritis after performing POCUS 2/2025 - Pancreatitis 1-2/6 heart murmur (3/2023) patient has had recurrent bouts of hematuria, recent fast scan of urinary bladder (12/24/25) showed a thickened, slightly edematous bladder wall. Urine culture was negative for growth. BloodPressure- 12/24/25 Avg 227 - that was with Amlodipine 6.25 mg on board, just started Telmisartan Medication -include dosage & frequency Telmisartan 20 mg tablets 1/4 T PO SID, Amlodipine 2.5 mg 1/2 T PO SID, Methimazole 5 mg tablets 1.5 T PO AM and 1 T PO PM, Solensia - last given 12/8/25, Convenia last given 12/24/25.

Abnormal PE/Chem/CBC/UA Results: UMIC performed 12/24/25 - negative for growth, HyperT4 panel performed 12/8/25 - BUN 49 (14-36) CREA 4 (0.6-2.4) SDMA 21 (<15) T4 2.1 (0.8-4)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney is large in size (3.96 cm), irregular in shape (likely due to previous infarcts particularly at the caudal pole). There is decreased corticomedullar distinction. There is focal perinephric effusion and mild pyelectasia at 0.2 cm. There are multiple, irregular cortical mineralizations visualized. Renal vasculature is normal.

The right kidney is borderline small (3.17 cm), normal in shape but very abnormal in appearance. The parenchyma is mottled and there is minimal normal architecture noted. There is a dilated fluid filled space cranial pole, possibly consistent with focal pelvic dilation or a cystic area. Occasional mineralizations and there is focal perinephric effusion. There is pyelectasia at 0.29 cm.

Adrenal Glands

The left adrenal gland is borderline large in size measuring 0.55 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is borderline large in size measuring 0.7 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (0.87 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

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Liver

The liver is subjectively large in size with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in echotexture. The visible portions of the vasculature and biliary tract appear normal. Theres a small hypoechoic nodule in the right side of the liver measuring 0.73 cm x 0.83 cm.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and likely incidental at this time. The proximal bile duct is not clearly visualized but distally at the level of the duodenal papillae it is mildly dilated, measuring at 0.25 cm.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. Bowel loops follow a typical curvilinear path with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis:mucosa layer ratio. The duodenum measured 0.31 cm in diameter and the jejunum measured 0.27 cm in diameter. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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 pancreas is prominent and hypoechoic in the right limb. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is no evidence of a significant diffuse lymphadenopathy. The iliac lymph node is prominent measuring 0.33 cm. The omentum is mildly diffusely hyperechoic.

Other

In the mid caudal abdomen, there is an irregular shadowing mineralized structure/mass effect measuring 3.11 cm x 1.66 cm. A definitive source for this structure is not identified.

ULTRASONOGRAPHIC FINDINGS

- Large, irregular left kidney with significantly decreased corticomedullary distinction. Expected previous infarcts and perinephric effusion. With a much small right kidney with no normal renal architecture and a cystic/dilated region and perinephric effusion. Findings are concerning for chronic renal disease. Possibly, neoplastic disease? and chronic pyelonephritis with infarcts and nephroliths.

- Pancreatic changes most consistent with chronic active pancreatitis.

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- Large, hyperechoic liver with a hypoechoic nodule. Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy. The hypoechoic nodule could represent a benign or a neoplastic process.
- Mildly diffusely thickened small intestine with some areas exhibiting a prominent muscularis layer. The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.
- Focal mid-abdominal mineralization/mineralized mass effect. The source of this lesion is not clear. Consider a mineralized lymph node, bowel mass, etc.
- Borderline large adrenals. The adrenal glands are both large with no significant structural abnormalities. This is most likely a benign-age related change. This can be caused by chronic stress/concurrent illness etc... If signs of cushings disease are present (diabetes, thin skin etc..) pituitary dependent cushings could be considered but is much less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Both kidneys are very abnormal. The left kidney is large with perinephric effusion, likely previous infarcts and pyelectasia. The right kidney is small with a somewhat shrunken appearance, devoid of normal architecture and an echogenic cystic region as well as pyelonephritis. These changes could be due to chronic disease (pyelonephritis with infectious insult, fibrosis infarcts, etc.) Additionally, an underlying neoplastic process is possible. You could consider a fine needle aspirate of the right kidney but there could be some concern for increased risk with the severe hypertension reported.

Both adrenals are plump. This could be consistent with hyperadrenocorticism or chronic stress induced enlargement. Based on the history provided there is minimal support for pursuing a diagnosis of Cushing's disease.

The liver is large and hyperechoic. This could be due to mild lipidomic type change or even infiltrative neoplasia.

There are chronic pancreatic changes consistent with chronic pancreatic remodeling and chronic active pancreatitis. Consider empirical treatment for chronic pancreatitis.

Some sections of small intestine have focal thickening in the muscularis layer, most consistent with a chronic inflammatory condition. An early neoplastic change cannot be ruled out.

There's a focal, irregular shadowing mid abdominal lesion concerning for a calcified mass effect. A fine needle aspirate of this lesion could be considered.

Consider initial IV diuresis and therapy to see if this patient can improve clinically with more aggressive supportive care. Further evaluation would likely involve aspirates or advanced imaging to further evaluate the mineralized mass effect.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.

Imaging performed by

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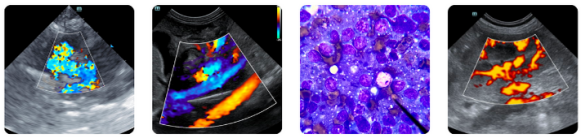

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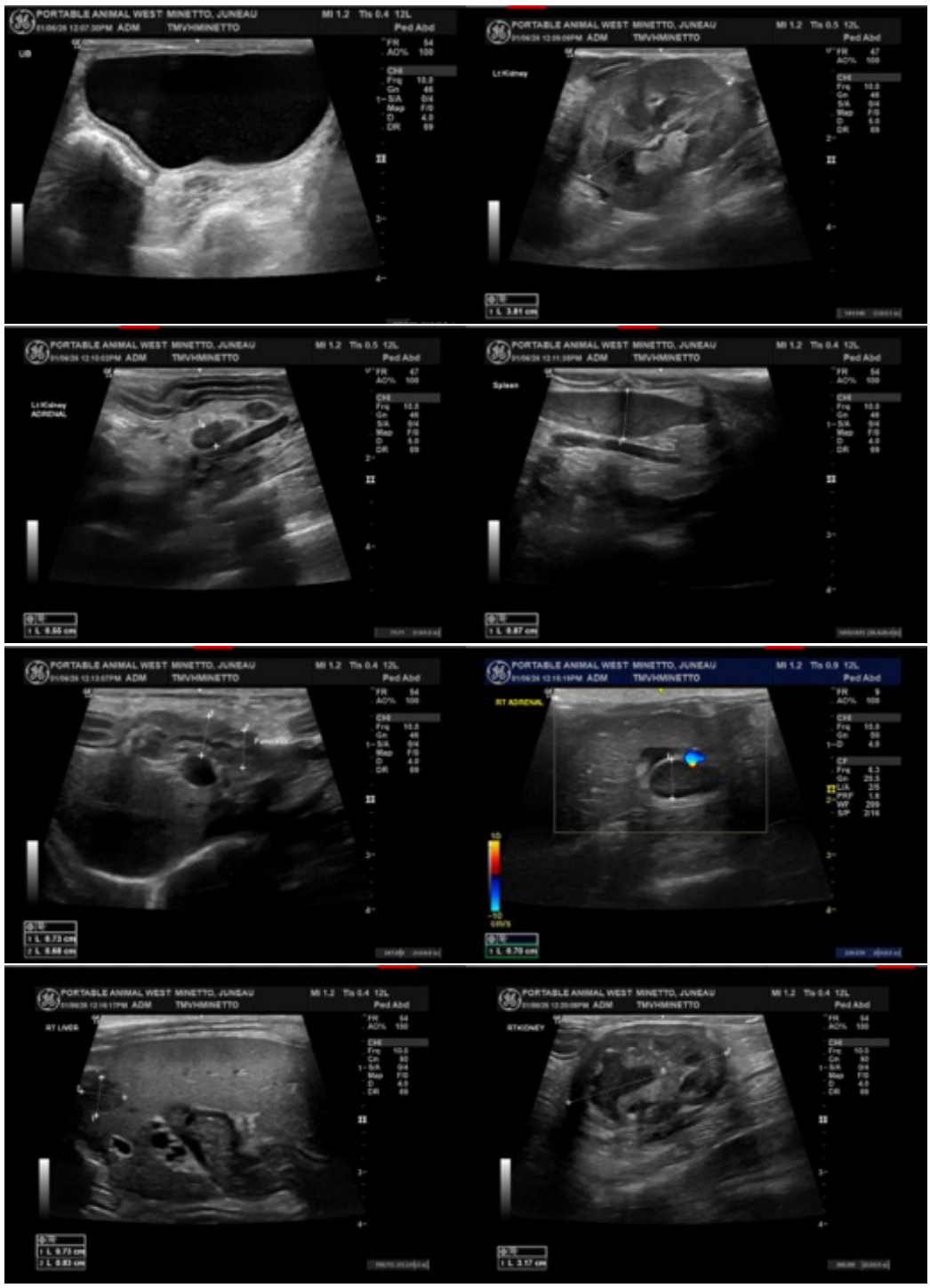

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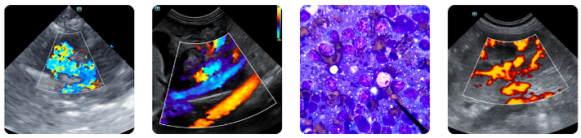

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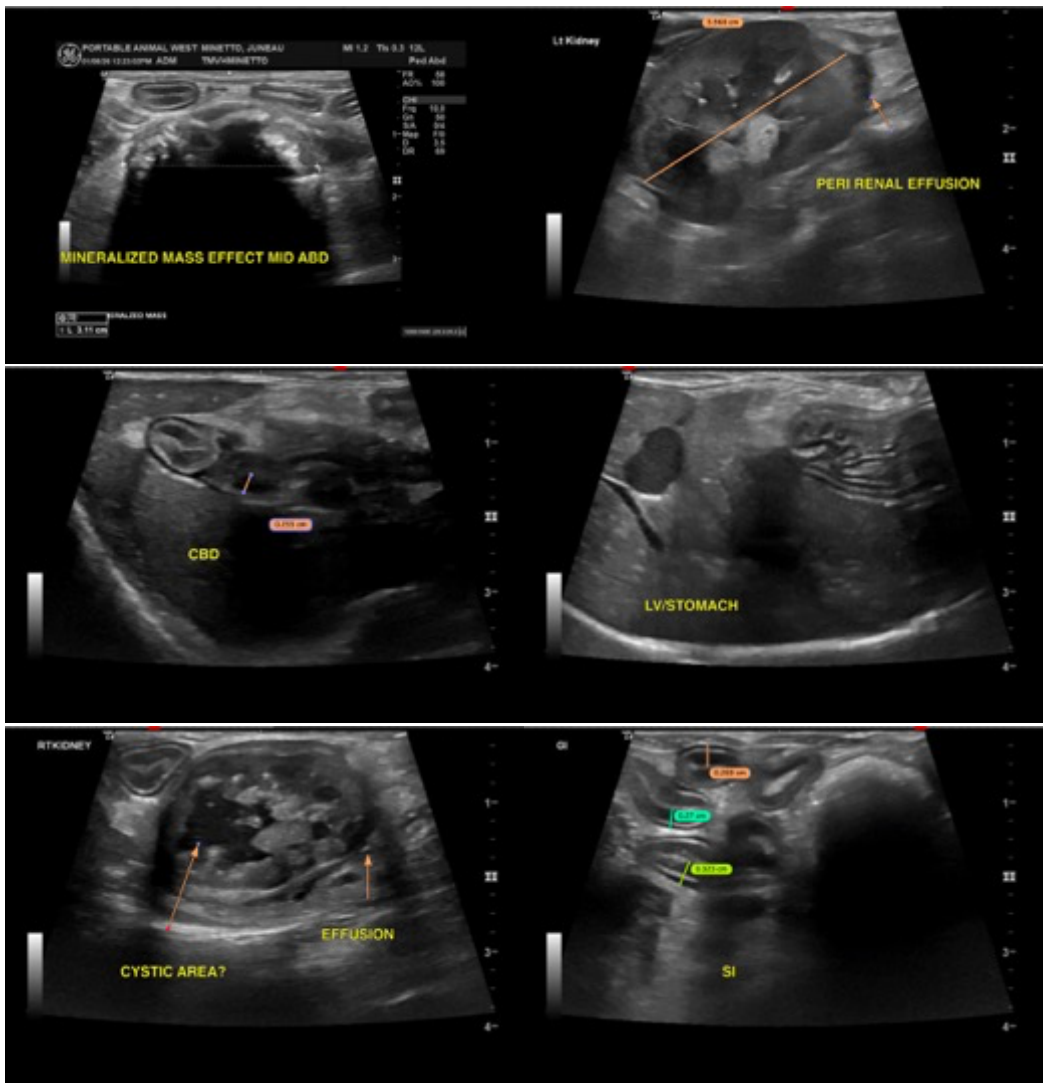

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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