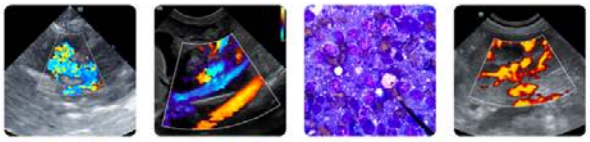


PATIENT

Thunder Beitzel

SPECIES

Feline

BREED

Calico

SEX

Neutered Male

AGE

18 Years 3 Months

WEIGHT

5.8 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Mariusz Chmielinski, DVM

HOSPITAL NAME

Apex Veterinary Services, Ltd.

REFERRING VET

Alpine 24/7 ER

INVOICE

71751

DATE

11/12/25

PRESENTING CLINICAL SIGNS

Vomiting and lethargy; transferred for abdominal ultrasound History Diagnosed with chronic kidney disease (CKD) in August 2025. Owner reports intermittent vomiting and periods of lethargy.

Abnormal PE/Chem/CBC/UA Results: Temperature: 37.0 °C, Heart Rate: 180 bpm (pulse ratio 1:1), Respiratory Rate: 28/min, non-labored, Mucous Membranes: Pink, moist, CRT <2 s, Mentation: Bright, alert, responsive (BAR), BP: 176/138 mmHg (MAP 148 mmHg) CBC Mild, stable non-regenerative anemia (HCT 0.311 L/L; reticulocytes low 9 K/µL). Platelets: 103 × 10^9/L (low-normal, adequate mass per analyzer). Chemistry Creatinine: 319 µmol/L (↑; previously 403), BUN: 16.6 mmol/L (↑), SDMA: 21 µg/dL Sodium: 166 mmol/L (slightly ↑), Amylase: Mildly elevated, Urinalysis Specific Gravity: 1.014 Protein: Trace No glucose, ketones, or blood detected Sediment: <1 WBC/RBC per HPF, no bacteria or casts

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mild primarily suspended echogenic debris present. 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 calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (3.84 cm) with occasional small cortical cysts and mild pyelectasia at 0.22 cm. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.89 cm) with occasional small cortical cysts and pyelectasia at 0.25 cm. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

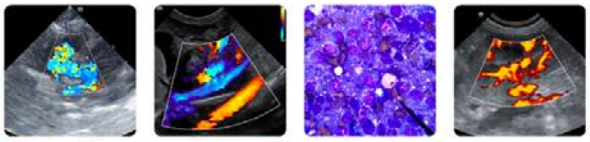
Adrenal Glands

The left adrenal gland is normal in size measuring 0.39 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 normal in size measuring 0.32 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 borderline large. The spleen echotexture is heterogenous and mottled, 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 normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There are occasional small hyperechoic foci visualized within the gallbladder, most consistent with small choleliths. An example measures 0.26 cm. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains moderate/large shadowing ingesta. 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. Duodenum wall measures 0.25 cm. Jejunum wall measures 0.22 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. 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 left limb of the pancreas is large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild/moderate pancreatitis.

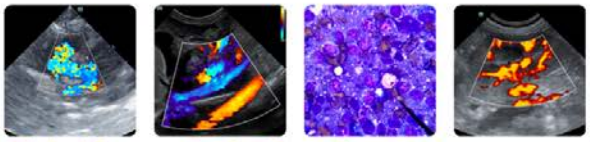
Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

PRIMARY FINDINGS

- Bilateral renal changes most consistent with chronic renal disease and bilateral pyelectasia – Pyelectasia of the kidney(s)could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.

- Borderline large, mottled spleen – The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.



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- Pancreatic changes most consistent with mild/moderate pancreatitis in the left limb.
- Large, shadowing ingesta visualized within the gastric lumen – Correlate with feeding history. If the patient was appropriately fasted, then this could be consistent with delayed gastric emptying or partial outflow tract obstruction (none observed).
- Diffusely "ropey" small intestine with some areas exhibiting a mildly 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.

SECONDARY FINDINGS

- Mild suspended echogenic debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.
- Small mineralizations/choleliths visualized within the gallbladder. No evidence of an obstruction or inflammation noted.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach is significantly distended with shadowing ingesta. Correlate with the feeding history. If the patient was adequately fasted, this could represent delayed gastric emptying. The left limb of the pancreas appears prominent with some surrounding inflammation, most consistent with pancreatitis. Correlate with a PLI level and consider empirical treatment for pancreatitis. Additionally, some of the small intestine appears somewhat "ropey" with a mildly prominent muscularis layer, possibly consistent with an underlying inflammatory enteropathy. If there is no response to treatment for pancreatitis, consider the following:

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.

Both kidneys have changes consistent with chronic renal disease and pyelectasia. Recommend a urinalysis, culture and a blood pressure evaluation as a baseline.

The spleen is prominent and somewhat mottled. Options moving forward would include a fine needle aspirate or continued monitoring with ultrasound.

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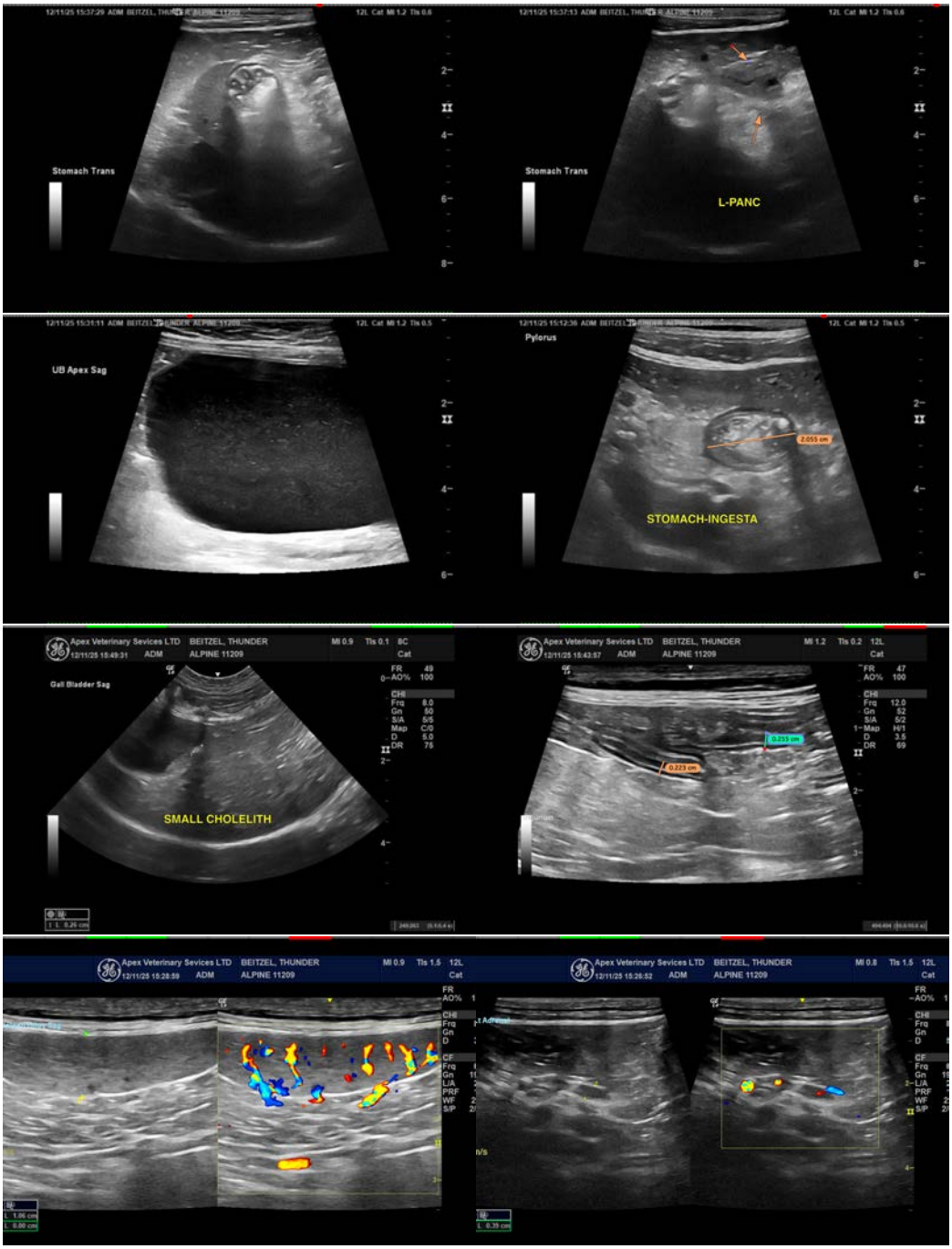

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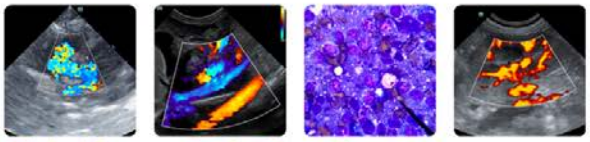

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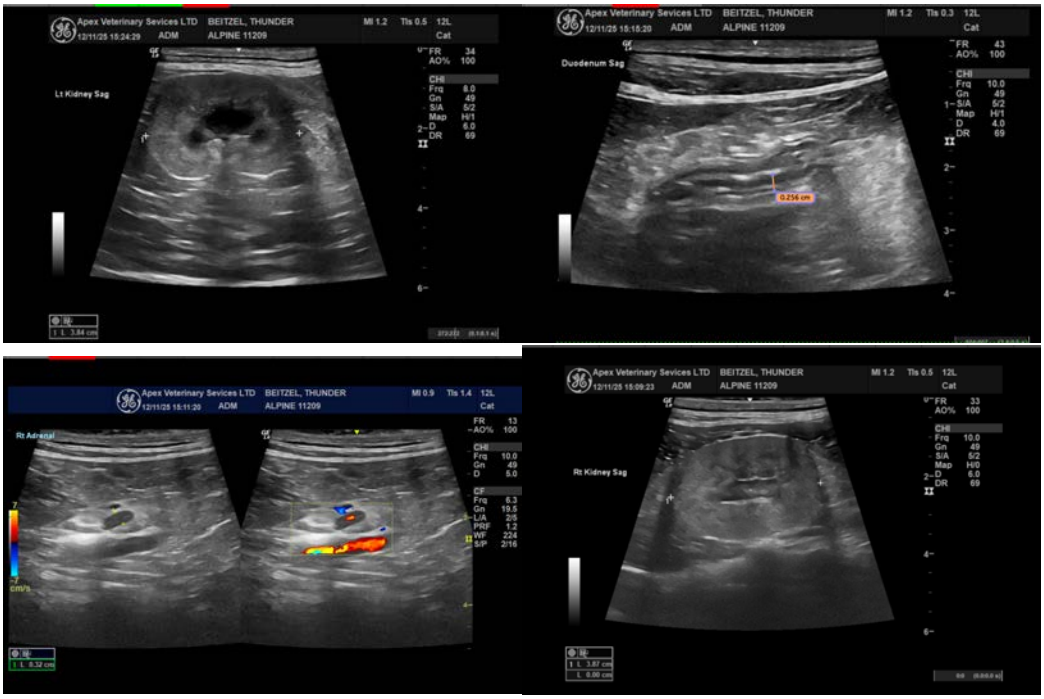

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@sonopath.com