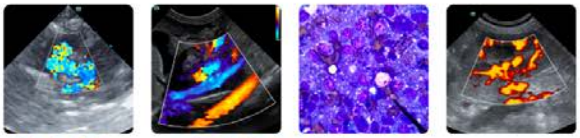




SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

**PATIENT**

Mist Kozak

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Spayed Female

**AGE**

4 Years

**WEIGHT**

3.72 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Crystal Hill

**HOSPITAL NAME**

Vetwell Rockliffe Animal Hospital

**REFERRING VET**

Dr. Guatto

**INVOICE**

73096

**DATE**

2/19/26

## PRESENTING CLINICAL SIGNS

First presented for weight loss and inappetence in Dec. Owner elected to start diet trial, Returned Feb 9 with ongoing inappetence and weight loss. Comprehensive blood panel run. Showed elevated kidney values, Hematocrit 22%, metabolic acidosis. Started renal diet and phos binder. Sent out Urine for U/A and UPCR results pending.

Abnormal PE/Chem/CBC/UA Results: Hematocrit 22% SDMA 28, Creatinine 421, Urea 31.3, Phos 3.5. Low Bicarb and high anion gap.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is mildly to 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 has a normal shape and size (3.62 cm). Overall echogenicity is significantly increased, 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 pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.34 cm). Overall echogenicity is significantly increased, 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 pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

### *Adrenal Glands*

The left adrenal gland is normal in size measuring 0.34 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 0.29 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.

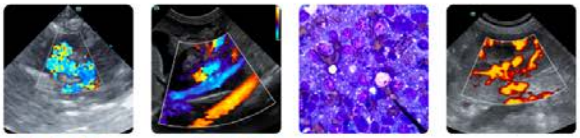
### *Spleen*

The spleen is subjectively normal in size (0.92 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.

### *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. Luminal contents are mild and likely incidental at this time. The bile duct appears slightly prominent and tortuous, measuring at 0.23 cm.





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### *Gastrointestinal*

The stomach contains mild fluid. The gastric wall appears slightly prominent, measuring at 0.43 cm with intact wall layering. 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 relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Jejunum wall measures 0.19 cm. 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 left limb of the pancreas is prominent and mottled compared to the surrounding isoechoic mesentery. 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, 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.

## ULTRASONOGRAPHIC FINDINGS

- Hyperechoic kidneys with decreased corticomedullary distinction – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.
- Prominent, hypoechoic left limb of the pancreas – Findings are most consistent with mild pancreatitis +/- pancreatic remodeling.
- Prominent/mildly thickened gastric wall – Findings could be consistent with mild gastritis.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The appearance of the kidneys is most consistent with chronic renal disease. This could be congenital, acquired secondary to renal injury, or less likely be associated with infiltrative disease such as FIP, lymphoma, etc. Recommend a blood pressure, urinalysis and culture as a baseline (+/- urine protein to creatinine ratio), and potential diuresis for an acute on chronic episode. If renal values continue to rise, consider repeat evaluation, looking for renal enlargement, irregularity, etc., which could indicate the need for a fine needle aspirate, looking for infiltrative disease to the kidneys.

The left limb of the pancreas is prominent. Correlate with PLI level and consider empirical treatment for pancreatitis.

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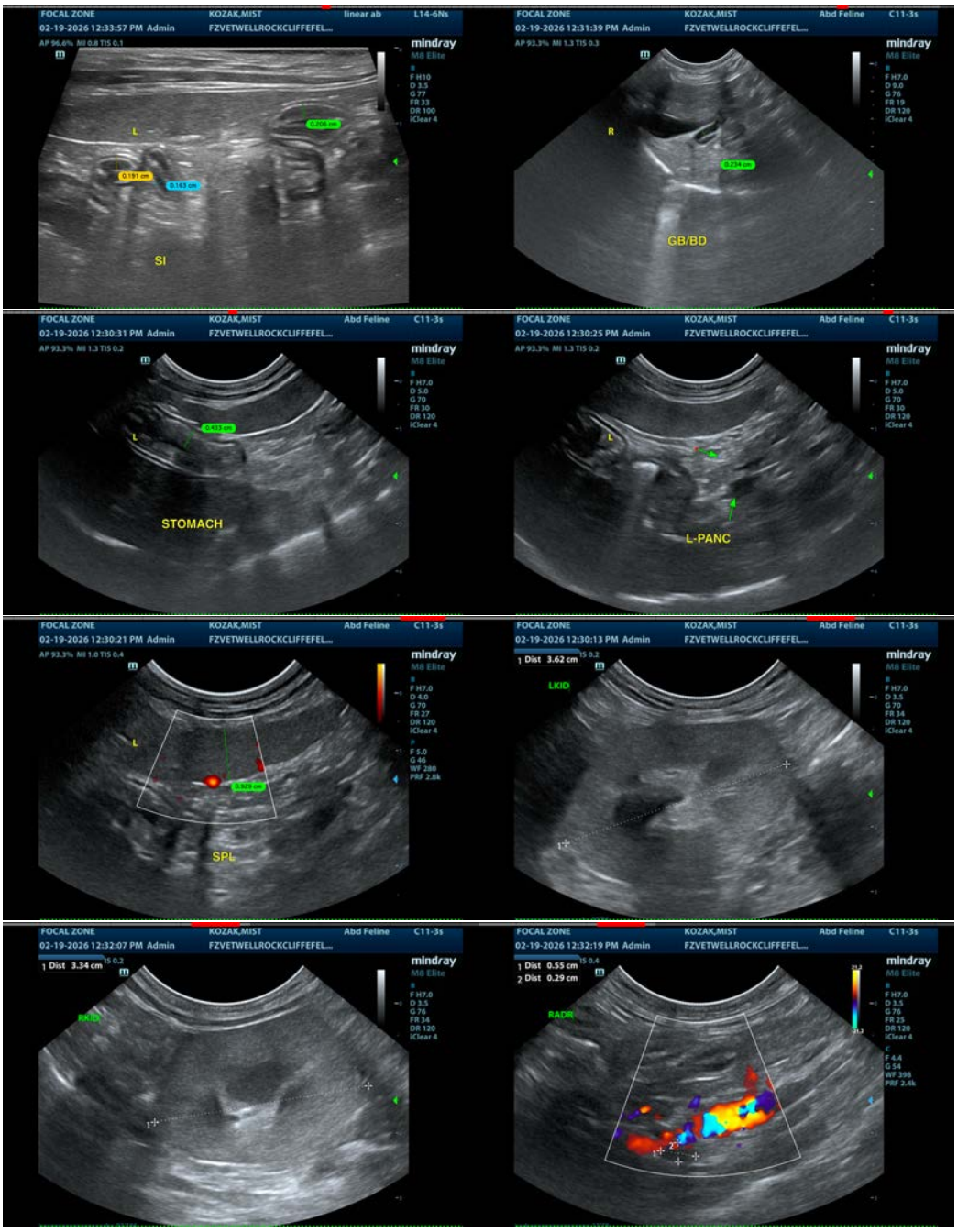
The stomach wall is somewhat prominent with intact wall layering. At this time this has the appearance most consistent with gastritis (possibly uremic gastritis). Symptomatic therapy for nausea could be considered if present, and continued monitoring of the appearance of the gastric wall.



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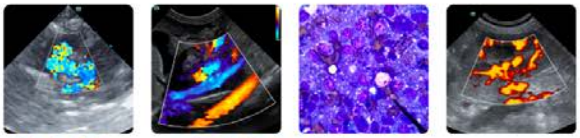

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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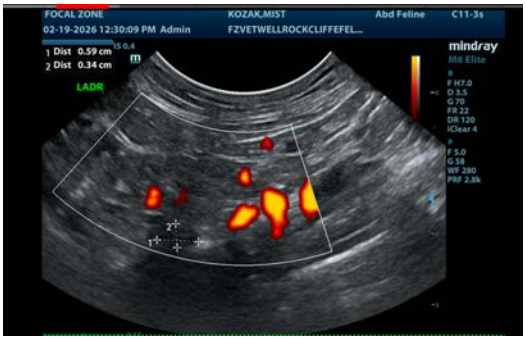


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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