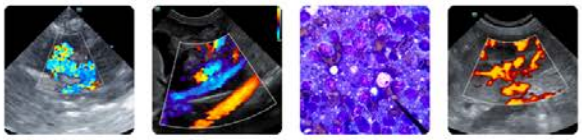

PATIENT

Buffalo Schultz

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

13 Years

WEIGHT

4.8 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Alpine Animal Hospital

REFERRING VET

Dr. Burbank

INVOICE

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DATE

3/3/26

PRESENTING CLINICAL SIGNS

Patient presented on 2/17/2026 for weight loss over the last month. Patient was 5.65kg on 7/3/24 and weighs 3.8kg today. Eating, but a lesser amount. Client feels he is eating better since switching to smaller kibble. Occasionally vomits. 3.5/9 body condition score. Palpate a nodule in the throat - suspect the thyroid. Only 4-5 teeth remain in the oral cavity. They appear healthy. 2/6 parasternal murmur. Abdomen palpates normally. Working diagnosis - Suspected hyperthyroidism, but labwork does not support. R/O pyelonephritis.

Abnormal PE/Chem/CBC/UA Results: 2/17/2026 CBC: Neutrophils 11139 /mL (2500 - 8500) Chem: BUN 44 mg/dL (14 - 36) CREATININE 1.7 mg/dL (0.6 - 2.4) SDMA 27.5 UG/dL (<15.0) PHOSPHORUS 8.3 mg/dL (2.4 - 8.2) PrecisionPSL 39 U/L (8 - 26) T4 3.3 mg/dL (0.8 - 4.0) UA: USG 1.017 Protein 2+ UPC 1.8 (<0.5) Urine Culture: Negative

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 normal in size but irregular in shape (likely due to previous infarcts?), measuring 3.42 cm, with numerous nephroliths, some of which are visualized within the renal pelvis, which is slightly dilated measuring 0.48 cm. Overall echogenicity is normal with adequate 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 hydroureter. Renal vasculature is normal.

The right kidney is normal in size but irregular in shape (likely due to previous infarcts?), measuring 2.89 cm, with occasional nephroliths, one of which is visualized within the renal pelvis, which is mildly dilated measuring 0.28 cm. Overall echogenicity is normal with adequate 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 hydroureter. Renal vasculature is normal.

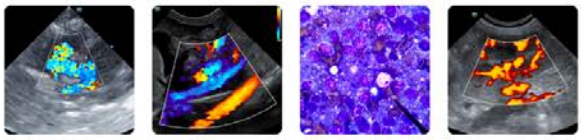
Adrenal Glands

The left adrenal gland is normal in size measuring 0.45 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 0.49 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 (0.70 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 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. There is a hyperechoic discrete mass effect visualized in the region generally craniomedial to the gallbladder, measuring 1.74 cm x 2.36 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 common bile duct is prominent distally but normal in size measuring 0.22 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.

Some of 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. Duodenum wall measures 0.21 cm. Jejunum wall measures 0.17 cm. Visualized peristalsis appears appropriate. The duodenum appears significantly corrugated and hyper motile, with no evidence of an obstruction or similar. The more distal small intestine has some mild gas and fluid, and there is a section of what appears to be jejunum with intraluminal shadowing ingesta without a significant obstructive pattern, most consistent with passing ingesta, although ingested foreign material cannot be ruled out.

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 prominent and hypoechoic as 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. There is no significant lymphadenopathy. Occasional prominent mesenteric lymph nodes are visualized measuring 0.43 cm and 0.27 cm.

ULTRASONOGRAPHIC FINDINGS

- Irregular kidneys with decreased corticomedullary distinction, nephroliths, and pyelectasia, with some of the stones visualized within the renal pelvises – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. There are stones visualized within the renal pelvis of both kidneys. This could be resulting in mild irritation/obstruction. No evidence of a significant obstruction is visualized.

- Pancreatic changes consistent with chronic pancreatic remodeling +/- chronic pancreatitis.

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- Hyperechoic mass effect in the cranial liver – Findings generally have the appearance most consistent with a primary hepatic mass lesion (adenoma, carcinoma, other), although other differentials are possible.

- Areas of bowel corrugation and shadowing intraluminal material – Findings are most consistent with enteritis and a non-fasted patient, although an underlying enteropathy or even non-obstructive/partially obstructive foreign material cannot be definitively ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

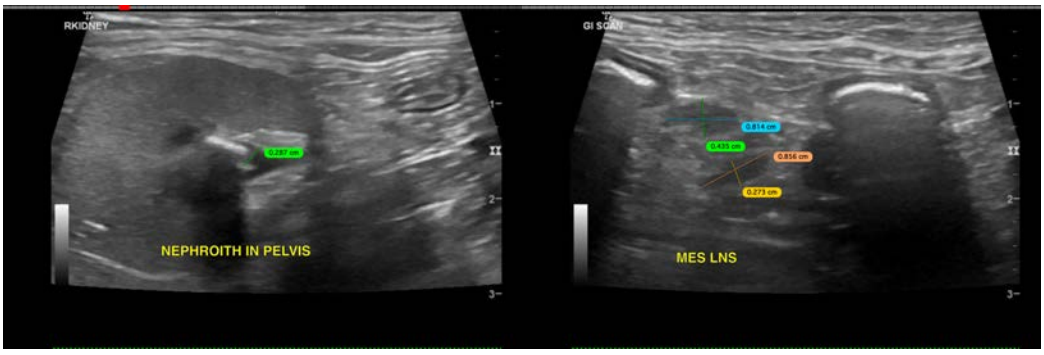
Both kidneys are significantly abnormal with abnormal shape and renal pelvic dilation in addition to numerous nephroliths. Recommend a blood pressure, urinalysis and culture as a baseline, initial treatment for chronic renal disease, and continued monitoring of the nephroliths described. Consider radiographs to better determine the number and size of nephroliths present.

The pancreas is prominent and hypoechoic. Consider a PLI level. If this is significantly elevated, you could consider empirical treatment for mild chronic pancreatitis.

There is a hyperechoic discrete mass effect visualized in the cranial aspect of the liver. I suspect this location would be very challenging to sample. Options moving forward would include a contrast CT scan for further evaluation for possible surgical planning for mass removal. If this is not an option, then continued monitoring could be considered.

There are changes visualized associated with the small intestine including areas of significant corrugation, mild intraluminal shadowing material, etc. Correlate these findings with patient's current GI status. No definitive focal lesions are visualized but an underlying enteropathy or even partially obstructive foreign material cannot be definitively ruled out. If underlying gastrointestinal disease is suspected, further workup may be warranted.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement (disregard if this has already been done).



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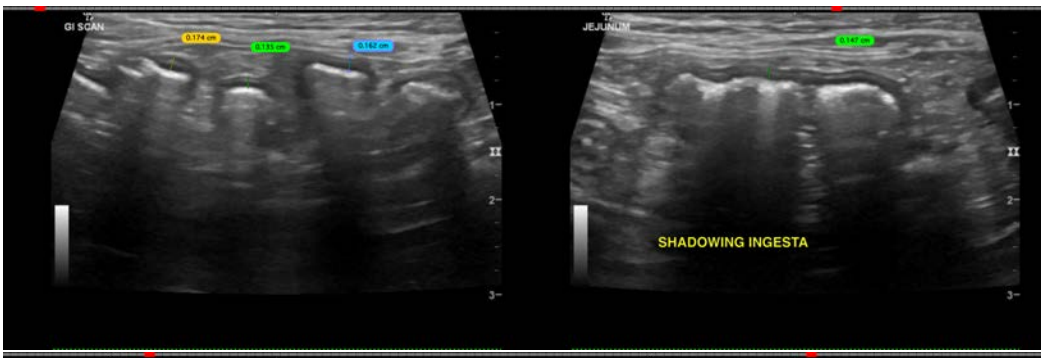

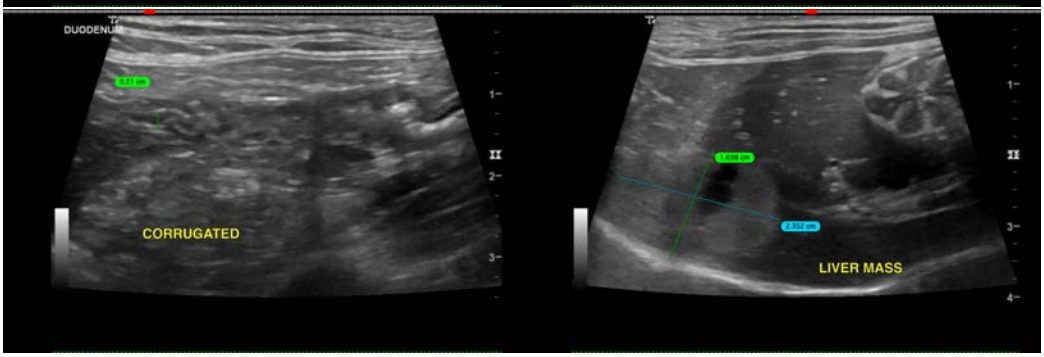

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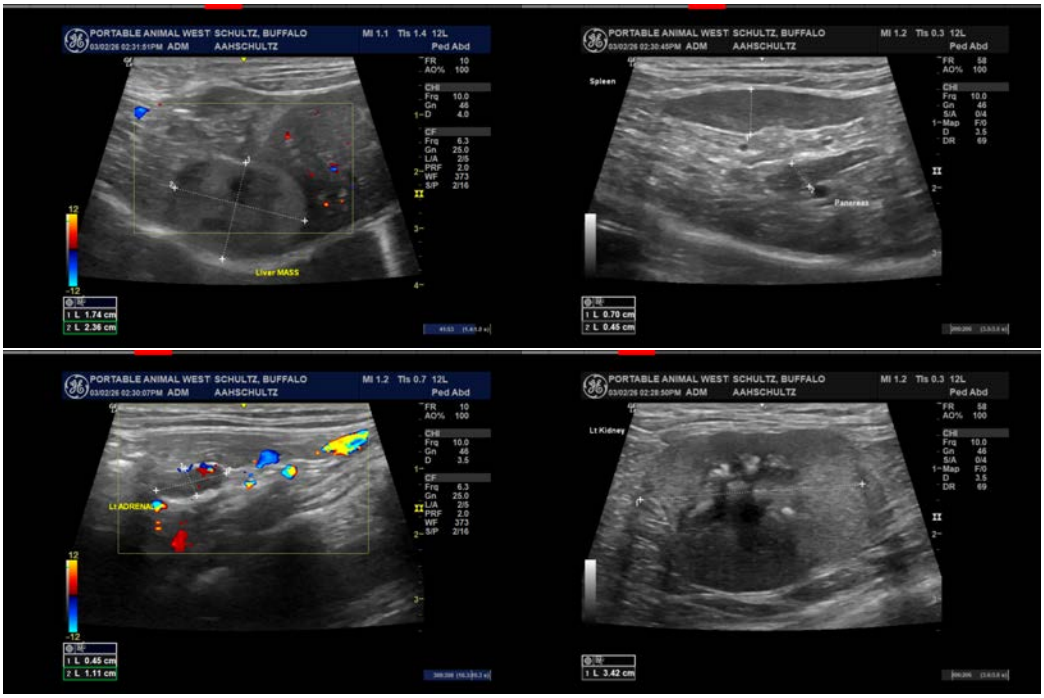

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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