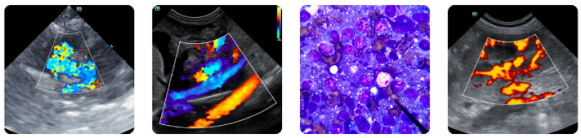


PATIENT

Joey The Red Borden

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

16 years

WEIGHT

12.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

MountainView Animal Hospital

REFERRING VET

Dr. Brown

INVOICE

11427

DATE

3/5/2026

PRESENTING CLINICAL SIGNS

- Patient has IRIS Stage III Kidney disease that was diagnosed a year ago. He also has a grade III/VI parasternal
- apical holosystolic heart murmur. He is currently on Hills k/d. Mom has been unable to do SQ fluids. Attempted
- renal supplements but he does not like them.
- He is currently on Clavamox for UTI, despite negative culture he seems to be feeling better per Mom.
- Blood pressure to be obtained today.

Abnormal PE/Chem/CBC/UA Results: Recent blood work was as follows: SDMA 18 (H) Creatinine 3.5 (H) BUN 52 (H) USG 1.015 with rods and pyuria, culture did not grow anything proBNP 1,148 (H) Thyroid normal at 1.6.

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, or masses. There are occasional pin-point hyperechoic foci along the dependent margins of the urinary bladder most consistent with small areas of sandy debris/mineralization.

The left kidney has a normal shape and size (3.72 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 a small, poorly defined infarct in the cranial pole. There is no evidence of pyelectasia, nephroliths or hydroureter. Renal vasculature is normal.

The right kidney is small in size with decreased corticomedullary distinction. There is a thick hyperechoic band separating the cortex and medulla, most consistent with a medullary band, as well as a focal mineralization/non-obstructive nephrolith visualized near the medulla. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

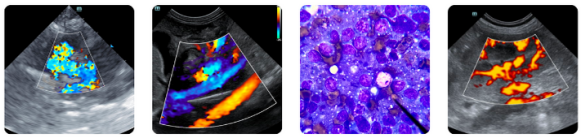
Adrenal Glands

The left adrenal gland is normal in size measuring 0.41 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 0.38 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 (0.83 cm in width at the hilus), irregular in shape, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the



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hilus and splenic parenchyma appears normal. There are numerous hyperehoic foci visualized within the spleen. Examples measure 0.34 cm, 0.25 cm. Some of these nodules deform the splenic margins, increasing concern for a more aggressive lesion.

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 cystic and common bile ducts are normal/not visible.

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 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. The duodenum measured as normal (0.29 cm in wall thickness) and the jejunum measured as normal (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. The descending colon wall is focally thickened with reduced detailed wall layering measuring 0.39 cm.

Pancreas

The pancreas is normal and isoechoic to surrounding 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 a prominent colic lymph node visualized near the ileocecal junction measuring 0.52 cm. Additionally, in the caudal abdomen cranial to the urinary bladder there is a large, hpoechoic lymph node measuring 1.18 cm x 0.85 cm. The omentum is hyperechoic in the caudal abdomen around the abdnormal lymph node.

ULTRASONOGRAPHIC FINDINGS

- Small, pinpoint mineralizations in the urinary bladder. Correlate with urinalysis and culture results.
- Decreased corticomedullary distinction in both kidneys with a small, irregular right kidney with a medullary band and non-obstructive nephrolith. Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial

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nephrosis. Changes to the right kidney are more severe than the left kidney indicating likely previous renal injury.

- Numerous hyperechoic nodules in the spleen. Some causing deviation of the splenic capsule. Generally, these have the appearance most consistent with benign myelolipoma-like lesions. Deviation of the splenic capsule is abnormal, which could increase the risk for rupture in a benign or neoplastic lesion.

- Thickened descending colon wall with reduced detailed wall layering. Findings could be consistent with severe inflammatory or early neoplastic change.

- Large, caudal abdominal lymph node. This lymph node is hypoechoic and surrounded by inflammation in the caudal abdomen near the abnormal section of colon. Findings are concerning for a metastatic lymph node although a highly reactive lymph node is possible.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Both kidneys have changes consistent with chronic renal disease. The right kidney is smaller and appears more abnormal. Management for chronic renal disease is indicated as well as continued monitoring with ultrasound. There are hyperechoic nodules visualized in the spleen, some if which the deform the splenic capsule. The general appearance trends towards a benign lesion but the deformation of the splenic capsule is slightly more aggressive behavior. Options would include continued monitoring with ultrasound or a fine needle aspirate.

The descending colon wall appears thickened with reduced detailed wall layering. There is a large, prominent, hypoechoic lymph node in the caudal abdomen in this region. If a safe window for sampling is available, you could consider a fine needle aspirate of the enlarged lymph node. Further evaluation of the colon could involve a colonoscopy and/or continued monitoring with ultrasound.

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

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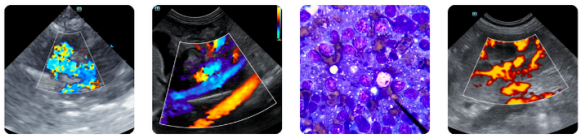

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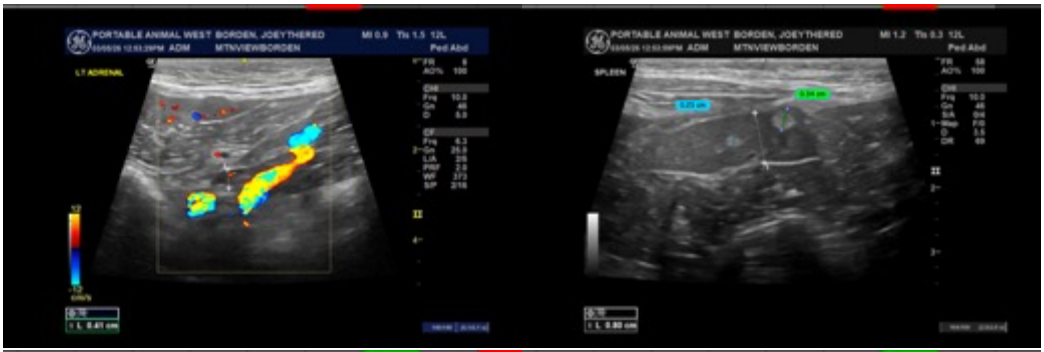

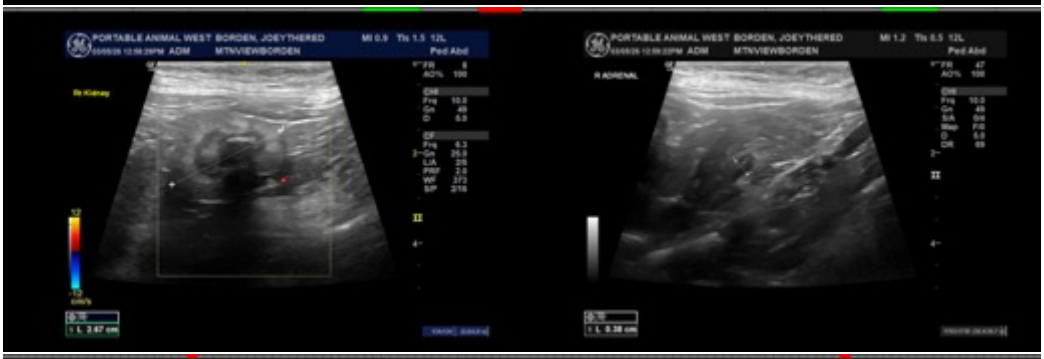

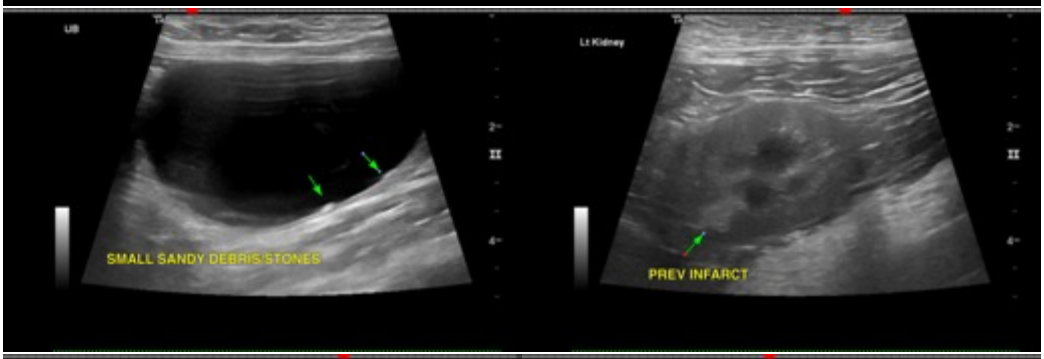

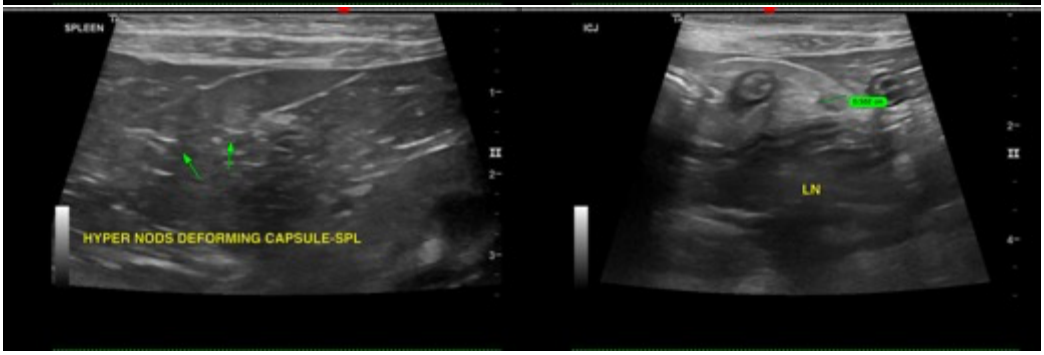

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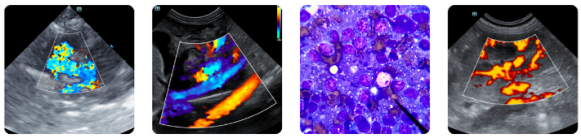

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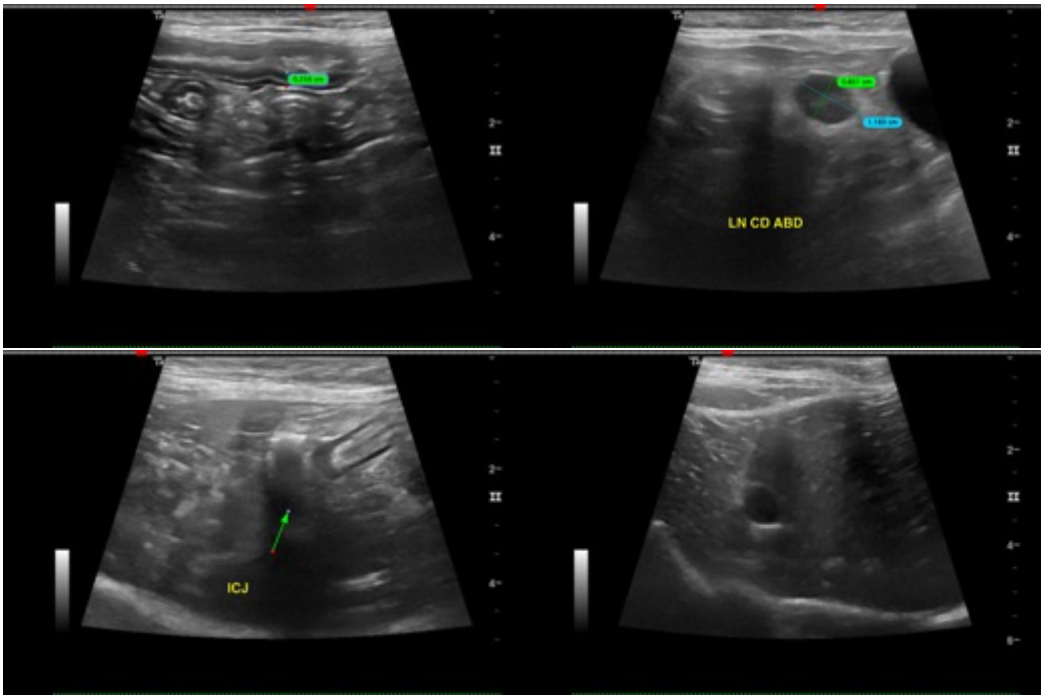

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

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