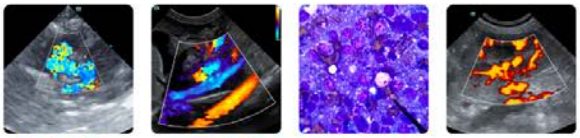


SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Paddy Hawkins

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

14 Years

WEIGHT

4 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Hawkins Animal Hospital

REFERRING VET

Dr. Hawkins

INVOICE

74795

DATE

4/29/26

PRESENTING CLINICAL SIGNS

Chronic intermittent vomiting, weight loss over past few years. Current Medications: 8mg cerenia Q 3 days.

Abnormal PE/Chem/CBC/UA Results: Urinalysis : Sample via cysto SG 1.030, pH 6.0, Protein 1+, Blood 4+, Leuk 2+, RBC >200/HPF, WBC 6-8/HPF, Cocci 3+, Transitional cells 1+, Debris 1+ blood and x-rays being sent See attached BW and rads

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 borderline large at 4.9 cm with numerous small, non-obstructive cortical mineralizations/nephroliths. Overall echogenicity is slightly hyperechoic with reduced 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, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is small and irregular in shape, measuring 2.12 cm. Corticomedullary distinction is significantly decreased, with reduced/absent normal architecture. There are numerous non-obstructive nephroliths visualized.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.30 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 0.34 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.

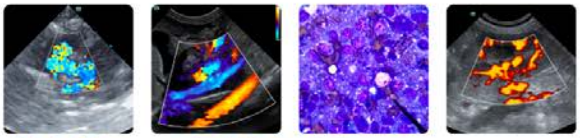
Spleen

The spleen is subjectively normal in size (0.84 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 normal/borderline large in size, and hyperechoic in echogenicity with smooth peripheral margins. The parenchyma is subjectively normal in echotexture with subtle, indistinct focal mottling. 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 dilated and tortuous, measuring at 0.34 cm.



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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. Duodenum wall measures 0.23 cm. Jejunum wall measures 0.23 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 pancreas is prominent, hypoechoic and mottled in the left 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. No significant lymphadenopathy noted. The omentum is mildly diffusely hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- Decreased corticomedullary distinction in both kidneys with a large left kidney and a shrunken right kidney with significantly reduced normal architecture. Both kidneys have cortical mineralizations/nephroliths.
- Pancreatic changes most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.
- Subjectively mildly hyperechoic/large liver – Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- Dilated/tortuous bile duct – Dilation of the common bile duct could be consistent with a functional obstruction (i.e. primary hepatic disease resulting in hepatocellular swelling) or with an extrahepatic bile duct obstruction (ie. choledocholith, bile duct tumor, pancreatic disease, other).
- Diffusely “ropey” 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There are bilateral renal changes with a large left kidney and a small shrunken right kidney. Both kidneys have decreased corticomedullary distinction and there are cortical mineralizations most

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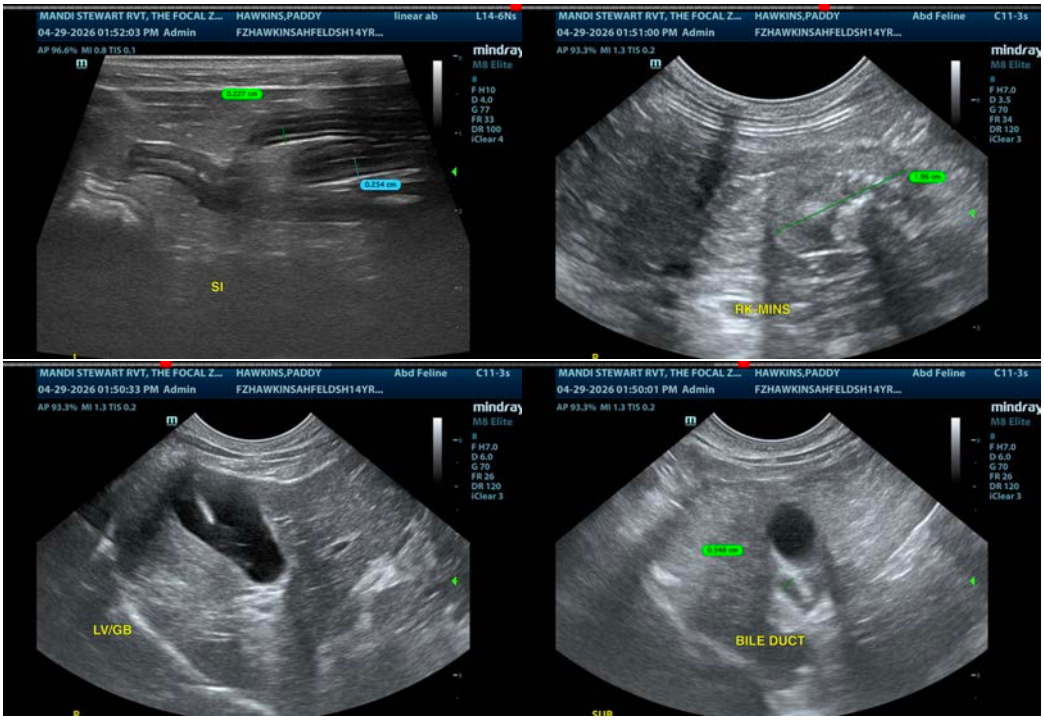
consistent with non-obstructive nephroliths. Changes are consistent with chronic renal disease. Recommend a urine culture and blood pressure for initial evaluation.

The left limb of the pancreas is very prominent, hypoechoic and mottled. With a normal PLI this is possibly consistent with significant pancreatic remodeling, although chronic mild pancreatitis is also possible.

No focal lesions were clearly visualized in the liver, although subjectively it appears somewhat large and hyperechoic. Additionally, the bile duct is dilated and tortuous. This cannot be clearly followed to the termination, but no focal lesion/obstruction is observed.

Recommend a fine needle aspirate of the liver (provided coagulation parameters are normal) to look for evidence of lipidosis, round cell neoplasia, etc. Additionally consider concurrent treatment for cholangiohepatitis with supportive care (IV fluids, nausea meds, etc.), Ursodiol, Denamarin, and a course of antibiotics. If liver values continue to rise and cytology is not diagnostic. Repeat imaging of the gallbladder and bile duct could be considered looking for progressive dilation etc.. +/- a contrast CT scan, looking for a focal obstruction or similar.

Subjectively, the small intestine appears somewhat “ropey”. These changes are most consistent with mild inflammatory type changes. Given the chronic vomiting reported, a concurrent enteropathy is possible. You could consider a hydrolyzed protein prescription diet and/or a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate. If a primary enteropathy is strongly suspected and/or surgery (biopsies etc..) is pursued for the liver/bile duct, then biopsies of the small intestine should be considered.



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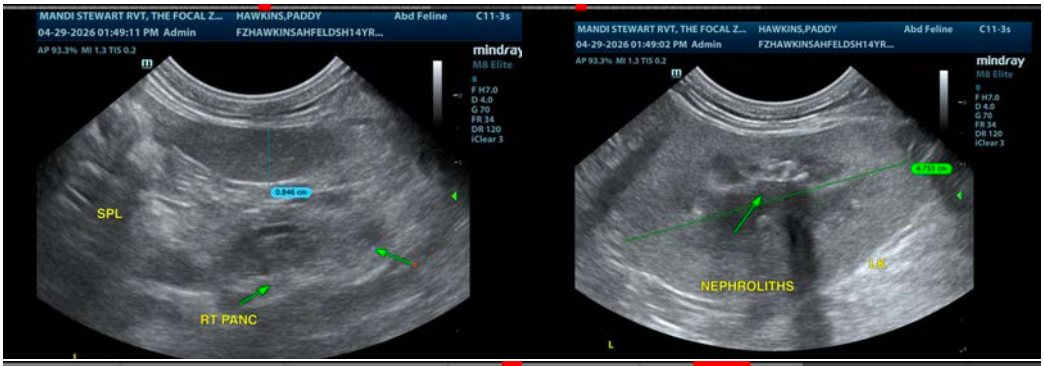

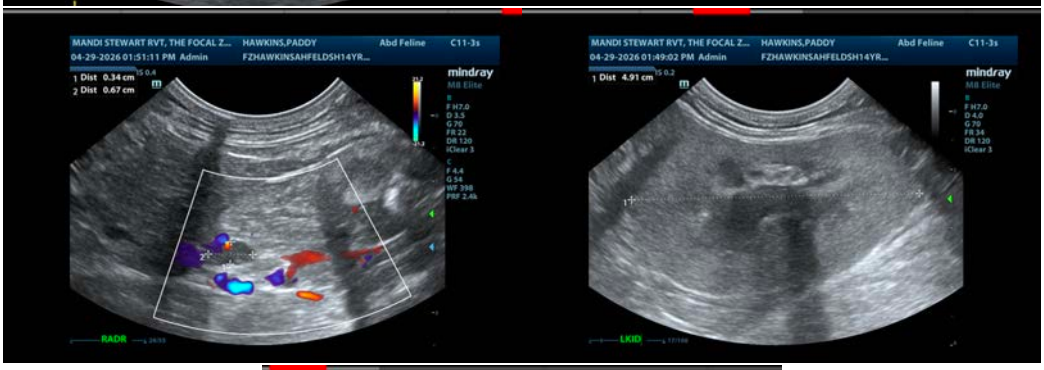

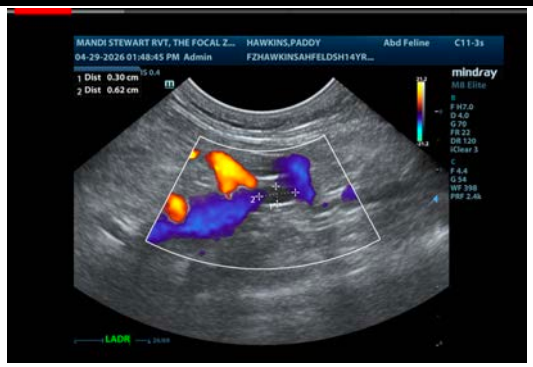

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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