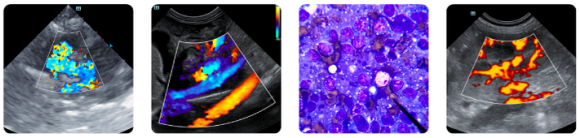

SonoPath www.thefocalzone.com
info@thefocalzone.com 289.808.2608

PATIENT

Bentley Griffith

SPECIES

Feline

BREED

DSH

SEX

Male Neutered

AGE

8y

WEIGHT

5.22 kgs

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Hamilton Emerge

REFERRING VET

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INVOICE

13060

DATE

1/12/26

PRESENTING CLINICAL SIGNS

History: initially had hypersalivation, no response to maropitant. Went to rDVM on Saturday, found severe azotemia, small R kidney, suspect dilated L renal pelvis, presumed acute on chronic kidney disease (Cr 1078, BUN 40). Patient admitted to hospital for IVF & further work-up. Urinalysis from cystocentesed sample revealed isosthenuria (USG 1014), mild hematuria, no bacteriuria or pyuria, no casts appreciated on sedivue. Urine culture & sensitivity has been sent out, patient started on ampicillin after cystocentesis sample was collected. Cr rechecked after 12h of fluids (1065), Cr remained slightly improved but static yesterday, recheck Cr due today at `1pm. Patient has been having inconsistent appetite in hospital, suspect due to selective appetite, overall demeanor BAR & comfortable

Current Medications buprenorphine 0.01mg/kg IV q8h, pantoprazole 1mg/kg IV q12h, maropitant 1mg/kg IV q24h, ampicillin 22mg/kg IV q8h, ondansetron 0.1mg/kg IV q8h, mirtazapine transdermal q24h

Abnormal PE/Chem/CBC/UA Results: ABNORMAL Lab work Values creatinine yesterday 1065, BUN yesterday 43.8 Radiographic Findings none

Primary Question to Be Answered in This Exam: does patient have pyelonephritis or obstructive ureterolith causing acute kidney injury? Does patient have concurrent chronic kidney disease?

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

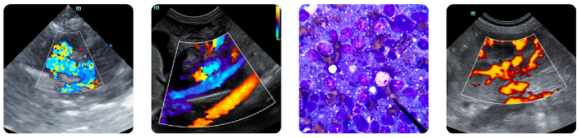
Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

The area of the aortic trifurcation was free of pathology.

The left kidney was enlarged in size with mild asymmetrical contour. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Moderate loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. Lateral sub capsular hypoechoic fluid was present with potential for emerging left kidney pseudocyst vs mild left retroperitoneal free fluid. Medullary mineral to small renoliths and mild pyelectasia was present. The left kidney measured 5.8 cm in length.

The right kidney was subnormal in size with asymmetrical contour. The renal cortex presented increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Marked loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. Areas of medullary mineral and mild pyelectasia was present. The right kidney was subnormal in size measuring 2.4 cm in length.



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Adrenal Glands

The left and right adrenal glands presented overtly normal in size, position and shape. The left adrenal gland measured 0.45 cm. The right adrenal gland measured 0.3 cm.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non distended in size with mild, echogenic, nonmineralized biliary sludge. The proximal common bile duct was dilated and mildly tortuous without overt post hepatic obstruction.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The pancreas was mildly prominent in size with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

Minor concurrent perihepatic free fluid, no visualized significant omental lymphadenopathy with overall normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Left kidney renomegaly exhibiting moderate chronic degenerative changes, medullary mineral to small renoliths, mild pyelectasia, minor left kidney sub capsular free fluid with potential for emerging pseudocyst or mild left retroperitoneal free fluid
- Subnormal right kidney exhibiting marked chronic degenerative changes, medullasry mineral and mild pyelectasia
- Remodeled pancreas with possible chronic pancreatitis
- Normal empty gastrointestinal tract
- Mild gallbladder debris with non-obstructive proximal common bile duct dilation – possible low-grade cholangitis

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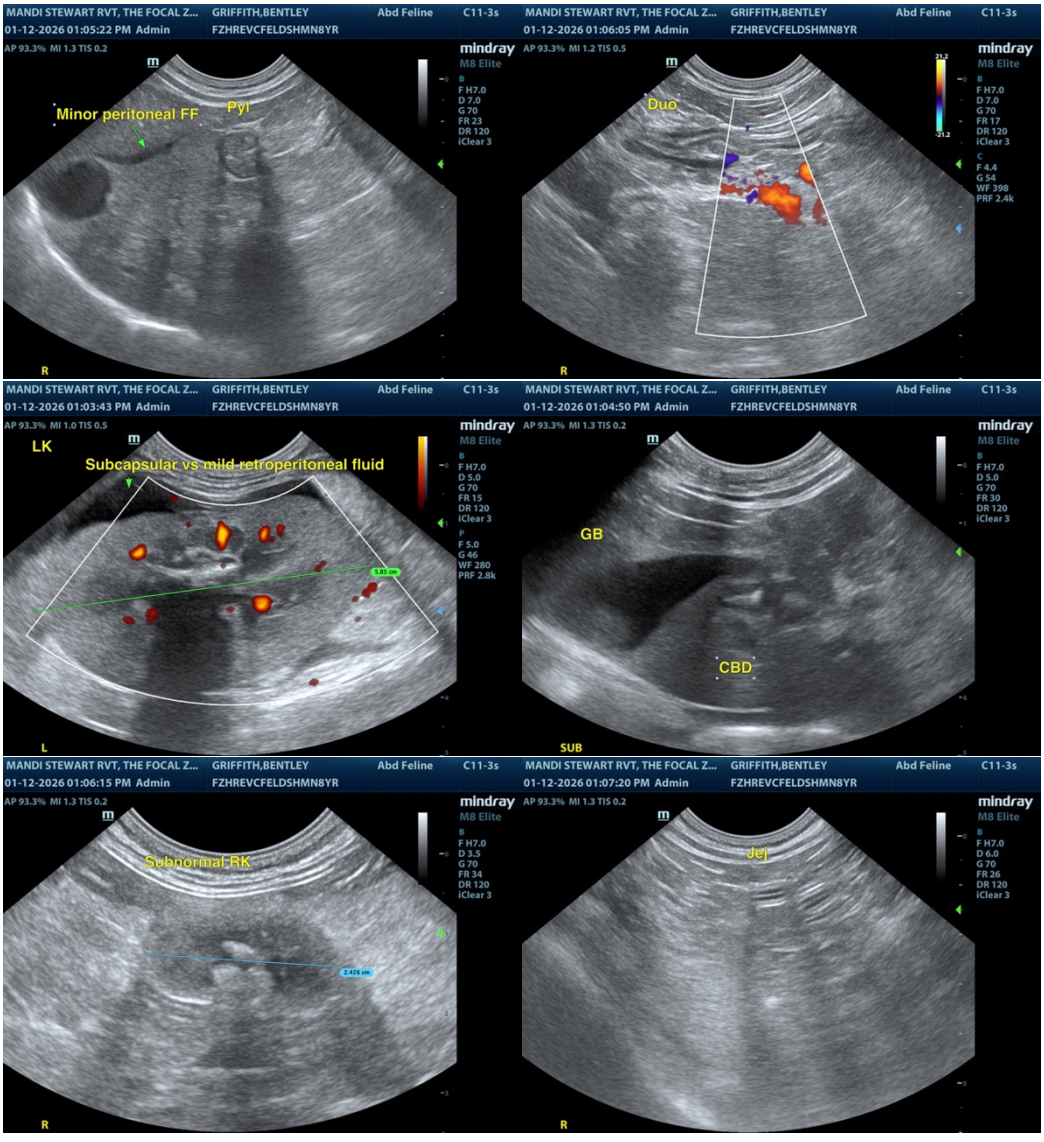
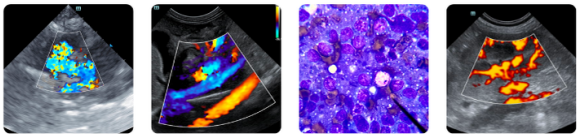
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Bilateral chronic nephropathy including left kidney compensatory hypertrophy given subnormal right kidney size is probable. Acute on chronic renal insult or underlying infection cannot be definitively excluded. Correlate with urinary workup including urine C/S is recommended. No overt evidence of renal neoplastic criteria which is thought less likely or evidence of left to right ureter obstruction. A spec fPL may be considered. Continued renal and concurrent as needed gastrointestinal support with monitoring of renal parameters, urinalysis/urine output and body weight for further assessment and prognosis is recommended.





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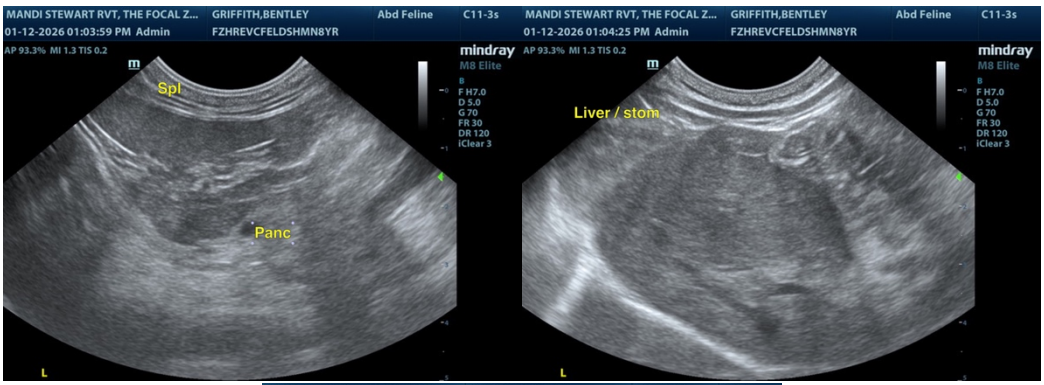

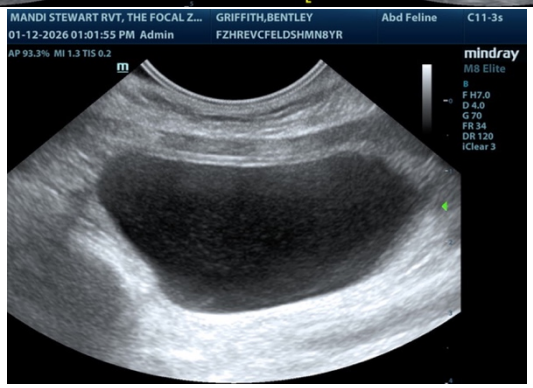

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

info@SonoPath.com