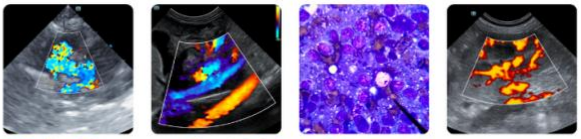


PATIENT

Luna Goldberg

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

5.5 Years

WEIGHT

3.89 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary Emergency Center

REFERRING VET

Dr. Logan Law

INVOICE

14405

DATE

03/18/26

PRESENTING CLINICAL SIGNS

- P diagnosed CKD years ago, kidney values have always been elevated, no treatment needed per RDVM. Has been on K/D diet. 4 months ago, P was seen at RDVM - BW WNL at that time, tooth infection discovered and given antibiotics. Did well and has done well since. Seem at RDVM last week - tooth looked good, BW WNL. P then started to decline over the past 4 days. Stopped eating K/D diet and would only eat other cat's food (ravenously). P began urinating outside of litter box and then would enter litter box and urinate more. PU/PD. O noted P drastically declined within past 24 hours. Very lethargic, unable to jump on furniture or move around like she normally would. P laying in water dish and not wanting to eat. P feels cold to the touch. Seen at RDVM today where BW was performed and kidney values were severely elevated; P transferred here for supportive care/hospitalization. admitted for supportive care iv fluids with KCL, emeprev, Unasyn, ondansetron, pantoprazole. P did eat overnight and at 6 am this morning.
- concern for worsening CKD; congenital/dysplasia; other

PE: Temp at triage 96.3; dull/depressed; pain 3/4, painful on palpation of the colon; 4/4 dental disease; kidneys difficult to palpate, feel small T4 11/2025 2.2; SDMA 11/2025 21 rDVM 3/17: CBC Neu 10.72 H, Eos 0.01 L; Chem Creat 7.5 H, BUN >130 H, Phosphorus 13 H, TP: 9.8 H Glob 6.1 H, Chol 259 H, Sodium: 174 H Shores u/a USG: 1.020; ++blood, +protein, +++ leukocytes, pH 6.0 Shores 3/18 epoc: TCO2 10.3 L, pH 7.119 L, chloride > 140 H, ica ++ 0.88 L, BUN >120 H, creat 5.92 H

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Echogenic to particulate nondependent mild sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

The area of the aortic trifurcation was free of pathology.

The left kidney was borderline subnormal in size while the right kidney was subnormal in size. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Moderate pyelectasia was present bilaterally without overt visualized evidence of left/right hydroureter. The left kidney measured 3.1 cm in length. The right kidney measured 2.4 cm in length.

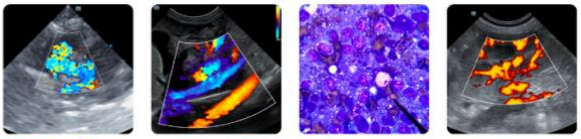
Adrenal Glands

The left adrenal gland was overtly normal in size, position and shape. The left adrenal gland subjectively measured 0.36 cm width.

No obvious pathology in the area of the right adrenal gland.

Spleen

The spleen was mildly subnormal in size and exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and



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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. The spleen measured 0.60 cm width level of the mid spleen.

Liver & Gallbladder

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 mildly subnormal in size (likely owing to the presence of gastric ingesta) with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained echogenic, mild nonshadowing ingesta without signs of obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Segmental nonshadowing intestinal ingesta was present.

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

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Nonspecific chronic nephropathy exhibiting bilateral pyelectasia.
- Normal gastrointestinal tract with gastrointestinal ingesta (most consistent with food echogenicity).
- Normal area of the pancreas.
- Mild volume contracted spleen.
- Mild urine sediment.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The bilateral kidneys are consistent with chronic to progressive nephropathy with considerations including dysplasia given patient's age, nonspecific nephritis or potential combination. No evidence of neoplastic criteria. The renal pyelectasia may be secondary to chronic renal changes, pelvic scarring with underlying bilateral pyelonephritis not definitively excluded.

Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered. Hospitalization with planned renal support with concurrent gastrointestinal support if clinically indicated with monitoring of renal parameters, urinalysis, urine output, body weight and

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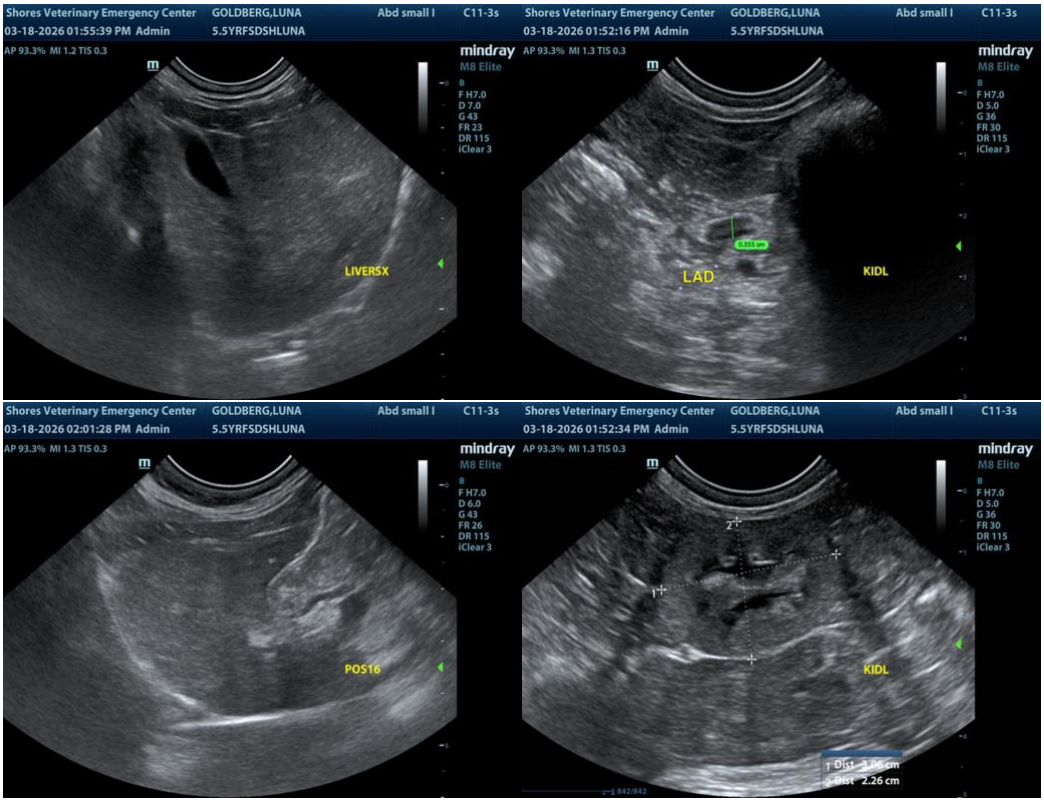
systemic BP is recommended for further prognosis. Guarded prognosis is indicated given renal presentation and degree of azotemia.



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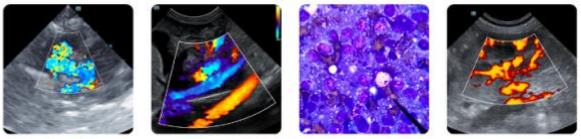

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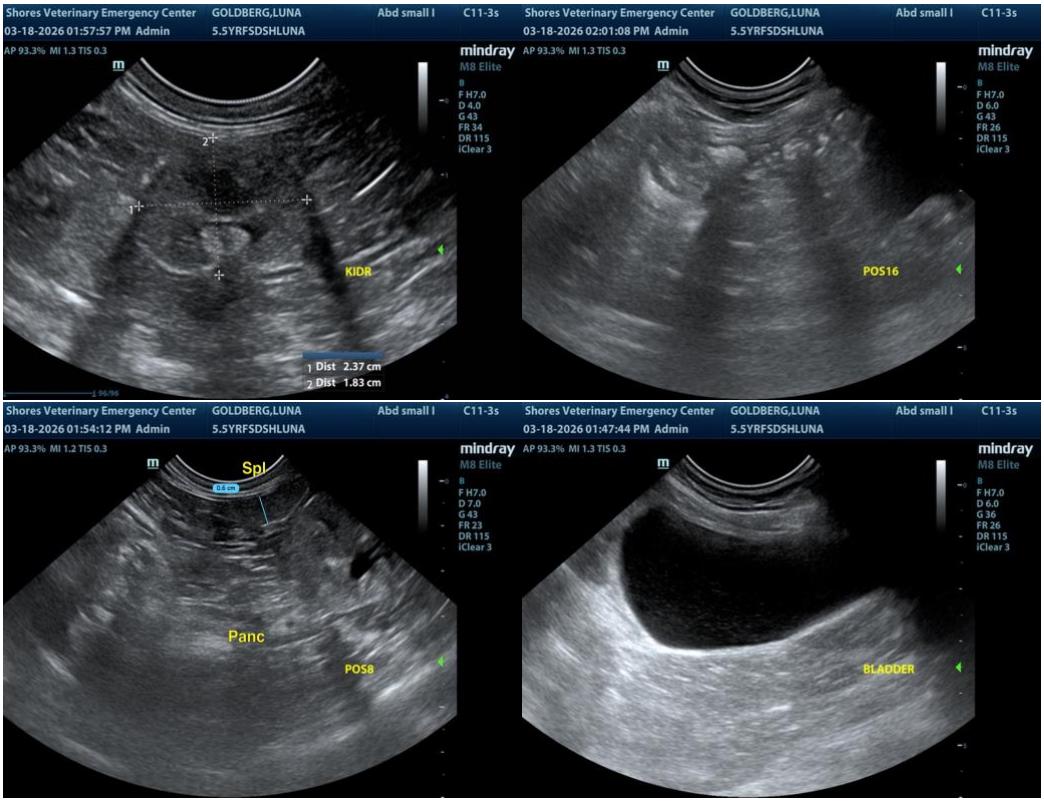

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@SonoPath.com