

**PATIENT**

Buffy Trotter

**SPECIES**

Feline

**BREED**

DLH

**SEX**

Spayed Female

**AGE**

2 Years

**WEIGHT**

4.64 pounds

**INTERPRETED BY**

Bradley Harris, DVM,  
DACVECC, DACVIM  
(cardiology)

**IMAGING PERFORMED BY**

Rebecca Hamilton

**HOSPITAL NAME**

Santa Clara Animal  
Hospital

**REFERRING VET**

Dr. Maki

**INVOICE**

13076

**DATE**

01/10/26

**PRESENTING CLINICAL SIGNS**

Patient presented 1-6-26 for evaluation of inappropriate urination. Patient was found to be underweight with a weight loss of 2 lbs. She was also mildly dehydrated. Meds: Just starting Mirataz and Cerenia Working up kidney failure cause

BM: 01-08-26 at 9:13a: \*Test Results\* \*CBC\* - RBC: 4.36 - HCT: 20.7% - HGB: 6.6 - WBC: 22,200 - Lymphocytes: 6,949 \*Chemistries\* - SDMA: 30 - CREA: 3.9 - BUN: 178 - PHOS: 9.2 - Cl: 107 - TCO2: 24 - Anion Gap: 28 \*Urinalysis\* (cystocentesis sample) - USG: 1.013 - pH: 5.5 - Protein: 2+ - RBC: 10-15/hpf \*Endocrine/Infectious Disease\* - T4: 1.9 (normal) - FeLV/FIV/HW test: Negative \*Fecal Test\* - O&P: Negative - Fecal antigen panel: Negative

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is minimally distended with anechoic urine and contains a mild amount of suspended echogenic debris. The bladder mucosa is irregular and hyperechoic with no overt shadowing urolithiasis noted. The trigone and proximal urethra appear patent and free of obstruction.

The kidneys are normal in size and structure. The cortices are hyperechoic with a decreased corticomedullary definition. There are rare cortical cystic changes and mild capsular irregularity. The cortex to medulla ratio is slightly skewed in favor of the cortex. There is mild pyelectasis noted bilaterally with proximal ureteral dilation. The distal ureter is not visualized. The left kidney measures 3.5 cm. The right kidney measures 3.88 cm.

**Adrenal Glands**

Both adrenal glands are visualized and have normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measures 0.52 cm. The right adrenal gland measures 0.54 cm.

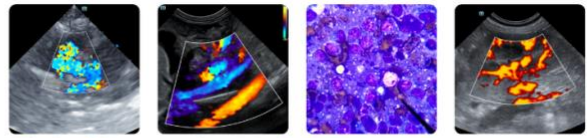
**Spleen**

The spleen is smooth with homogeneous parenchyma and hyperechoic to liver and renal cortical parenchyma. The capsule is without noticeable irregularity or deformation. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis. No evidence of acute or chronic inflammatory, neoplastic, or infarct are documented. The spleen measures 0.56 cm at the hilus.

**Liver**

The liver is subjectively normal liver size, contour, and structure. Parenchymal echogenicity is naturally coarse and hypoechoic to the spleen. Vasculature is within normal limits with no evidence of congestion. The gallbladder has thin walls which contain anechoic bile. There is no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal. No hepatic lymphadenopathy is documented. There is no overt structural evidence of inflammatory, infiltrative or regenerative pathology evident.

**Gastrointestinal**



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The stomach is non-distended with no evidence of pyloric outflow obstruction. There are focal regions of small intestine with a mildly prominent or thickened muscularis layer that mildly distorts the normal 1:3 muscularis to mucosal ratio. The overall wall thickness appears normal. There's no significant small intestinal dilation or shadowing material that would be concerning for mechanical small intestinal obstruction. The colon contains normal shadowing feces.

***Pancreas***

The pancreas is slightly prominent and hypoechoic, but there is no overt hyperechoic mesentery or omental fat consistent with active steatitis or peritonitis.

***Free Abdomen***

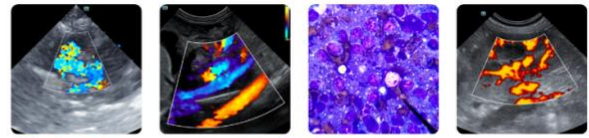
There is no significant lymphadenopathy or free fluid.

**ULTRASONOGRAPHIC FINDINGS**

- There is thickening of the cranioventral and craniodorsal urinary bladder wall with mucosal changes and echogenicity consistent with suspended debris. This is most consistent with chronic cystitis. Technically transitional cell carcinoma cannot be ruled out without histopathology but is not overtly suspected based on this pattern.
- The bilateral renal changes are discordant with this patient's age and likely represent a form of renal dysplasia, however, chronic glomerulonephritis or ascending pyelonephritis can't be definitively excluded.
- The thickened regions of small intestine likely represent early infiltrative disease such as inflammatory bowel disease or other chronic enteropathy, however, infiltrative neoplastic disease cannot be definitively ruled out despite the patient's young age.
- The changes to the pancreas may be an incidental finding, however, earlier occult pancreatic inflammation or pancreatitis can't be definitively excluded.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

A urinalysis and urine culture via cystocentesis are recommended to evaluate the urinary tract changes for potential urinary tract infection. A gastrointestinal panel (TLI, PLI, B12, folate) via Texas A&M gastrointestinal laboratory is indicated to further evaluate for potential chronic enteropathy. Ultimately, gastrointestinal biopsies may be required for a definitive diagnosis. Consider a spec fPLI to further evaluate the pancreas for active pancreatitis or inflammation. Consider empiric antibiotic therapy pending additional diagnostics to ensure coverage of potential ascending pyelonephritis.



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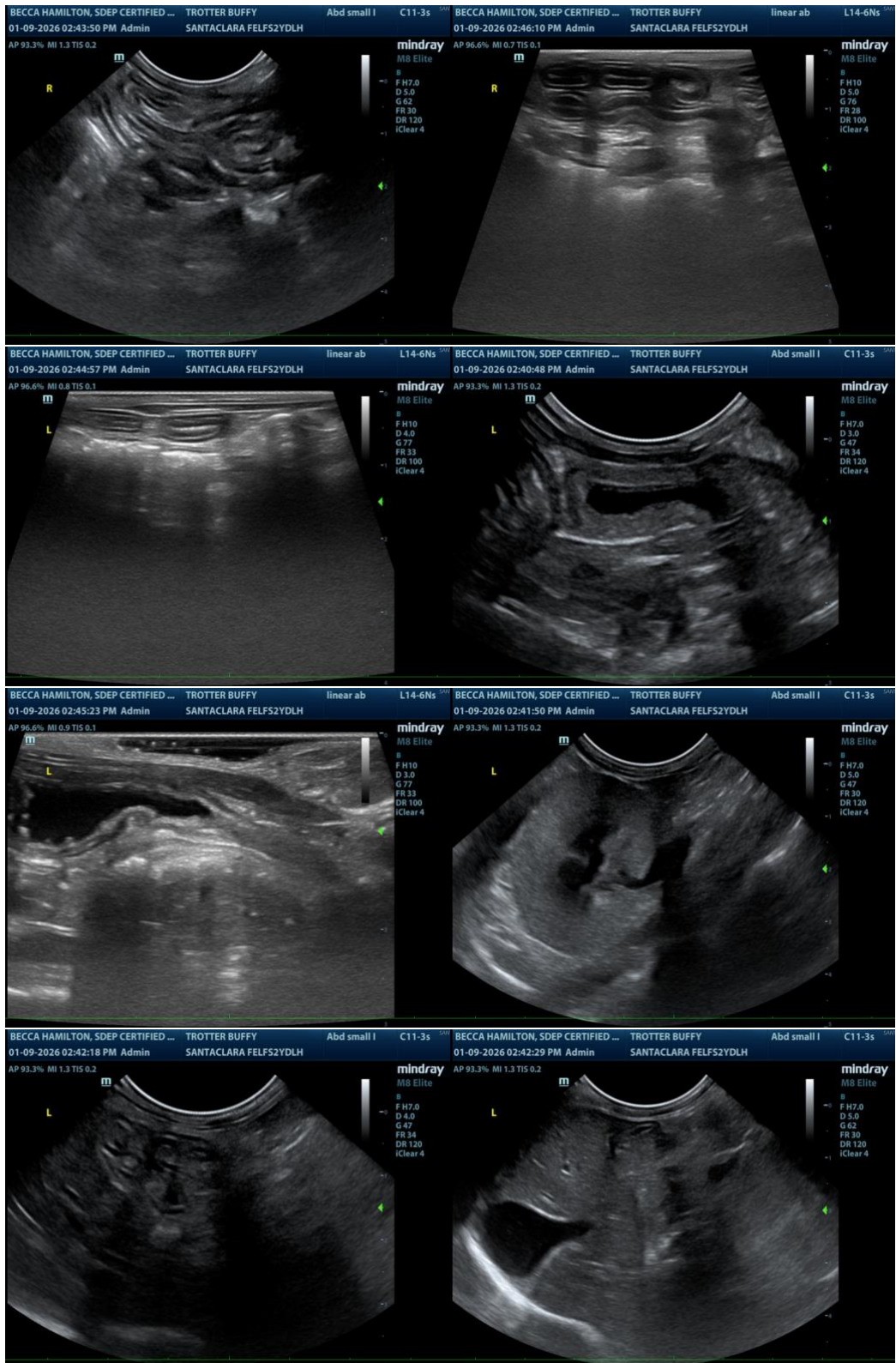
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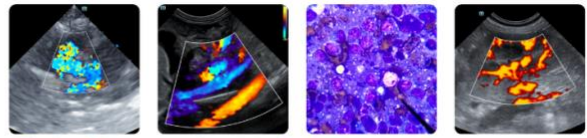
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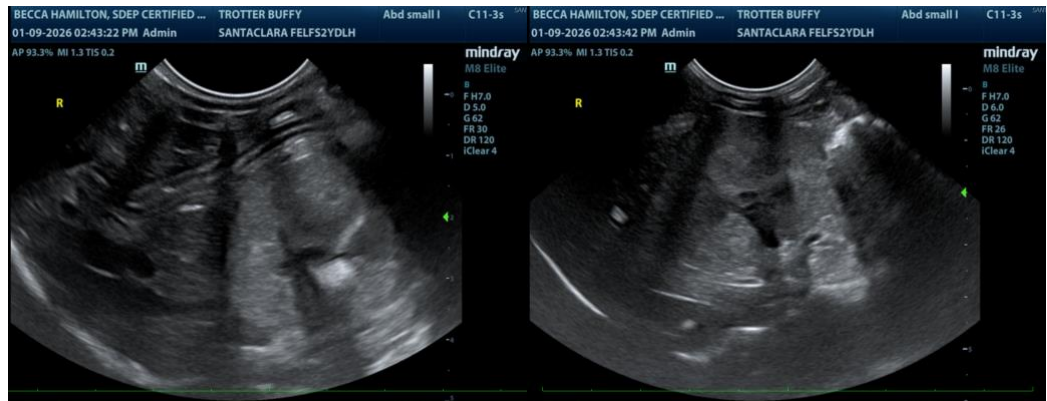
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**Bradley Harris, DVM, DACVECC, DACVIM (cardiology)**

[info@SonoPath.com](mailto:info@SonoPath.com)