



PATIENT

Jager Zasadny

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

17 Years

WEIGHT

9.25 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VET

Kimball AH

INVOICE

20341

DATE

1/2/23

PRESENTING CLINICAL SIGNS

History: Chronic idiopathic cystitis. Painful abd. Urinating blood intermitted x 1-2 months. Neg/low bacteria (Abx - convenia Nov 8, 2022) No crystals/stones visible in UA/Xray. Hyperthyroid - controlled Meds - Felimazole 5mg BID, Duralactin, Aminos/Cosiquin, Multivitamin supplement (Vetriscience), Occ Meloxicam, Prozac 4mg SID (Behavioral urination/hyper groomer issues). E/D well (renal canned/urinary canned and other random wet foods) Dry = SD Senior. No d/c/s. Occ V+ (eats dumb things like fake Christmas tree) Indoor only.

Abnormal PE/Chem/CBC/UA Results: Dec 5th (Chem/CBC) WNL: Besides TCO₂ (BICARBONATE) 24 (Range) 12 - 22 mmol/L HIGH No stones/masses seen in lat Xray Nov but still painful COLLECTION METHOD CYSTOCENTESIS COLOR Yellow CLARITY CLOUDY SPECIFIC GRAVITY 1.015 GLUCOSE NEGATIVE BILIRUBIN NEGATIVE KETONES NEGATIVE BLOOD 3+ PH 6.0 PROTEIN 2+ UROBILINOGEN NORMAL WBC 0-2 0 - 5 HPF RBC 75-100 HPF BACTERIA NONE SEEN EPI CELL 1+ (1-2)/HPF MUCUS NONE SEEN CASTS NONE SEEN CRYSTALS NONE SEEN 950 - UPC IF INDICATED UPC IF INDICATED A urine protein: creatinine ratio (UPC) has been ordered as indicated by a positive urine protein with an inactive urine sediment. 9970 - SPECIAL URINE PRO/CREAT RATIO URINE CREATININE 81.4 mg/dL URINE PROTEIN 130.1 mg/dL URINE PRO/CREAT RATIO 1.6 COLOR YELLOW

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal is size (3.58 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Right kidney is normal is size (3.69 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

Left adrenal gland is normal in size (0.52 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.47 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and



PATIENT

homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

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Gastrointestinal

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The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

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The visible small intestine demonstrates areas of thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

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The colon is subjectively mildly overdistended with very firm formed stool.

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Pancreas

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The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

WEIGHT

Free Abdomen

9.25 Pounds

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

INTERPRETED BY

ULTRASONOGRAPHIC FINDINGS

Beth Johnson, DVM
DACVIM

- Inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No aggressive lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.

IMAGING PERFORMED BY

- Subjectively firm stool in the colon.

Amy Mayhew, LVT

HOSPITAL NAME

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

SVS Imaging MI

There is no ultrasonographically visible explanation for this patients hematuria or painful urination, however, given the patients history, idiopathic cystitis or feline lower urinary tract disease are likely, as they can be present without visible pathology. If that is the case, increased hydration, pain management +/- empirical antibiotics, etc., as are all currently in place, are recommended.

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Given this patients subjectively distended colon with very firm stool, concurrent constipation is also a consideration, and if clinically indicated, medical management of constipation may be warranted, including hydration, stool softeners, potentially a transition to a higher fiber or colitis diet, etc.

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Without other gastrointestinal signs, including decreased appetite, weight loss, vomiting, diarrhea, etc., the small bowel changes are less significant, however, they may suggest concurrent infiltrative small bowel disease and further investigation could be considered in the form of a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory, and ultimately biopsies of the gastrointestinal tract.

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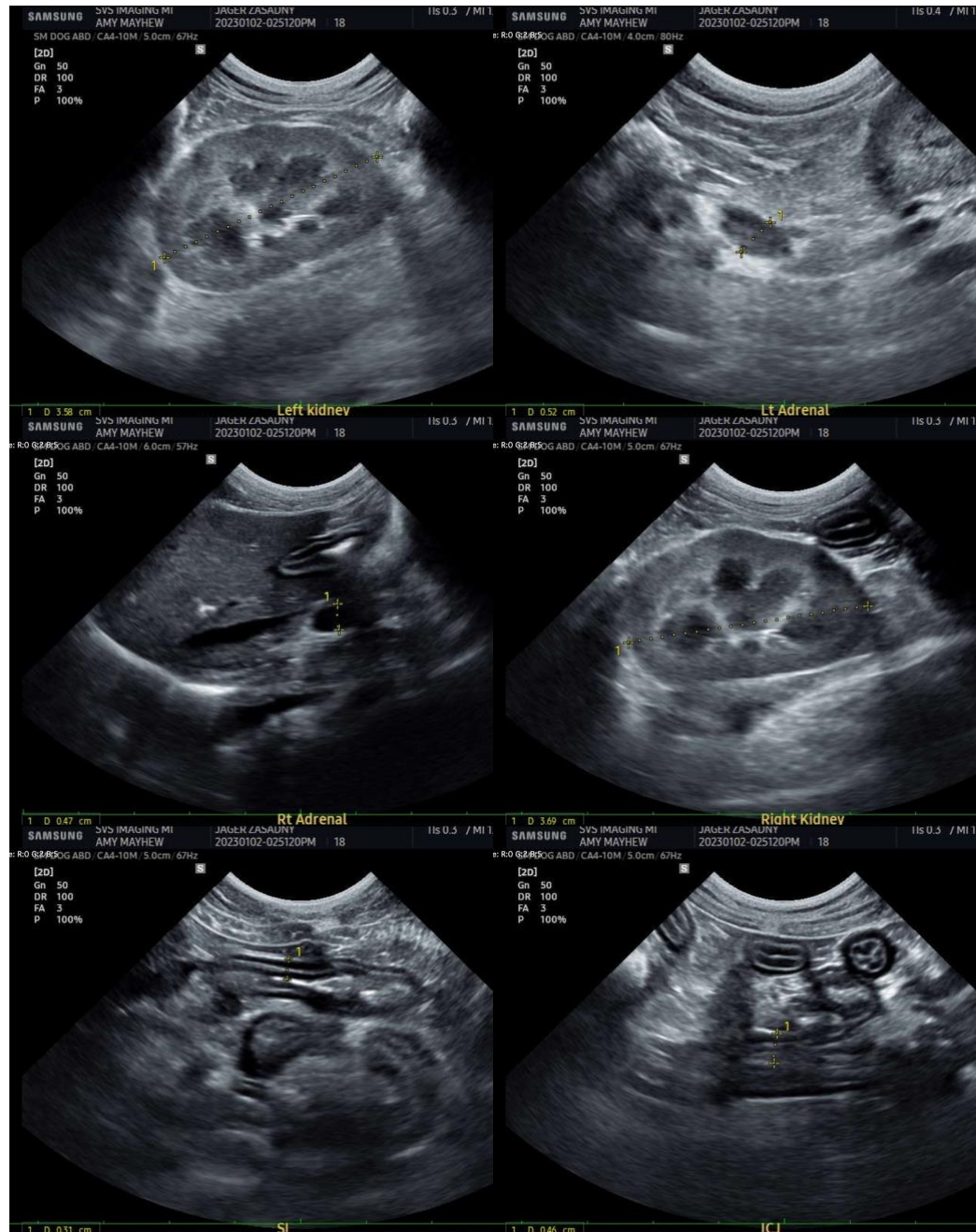
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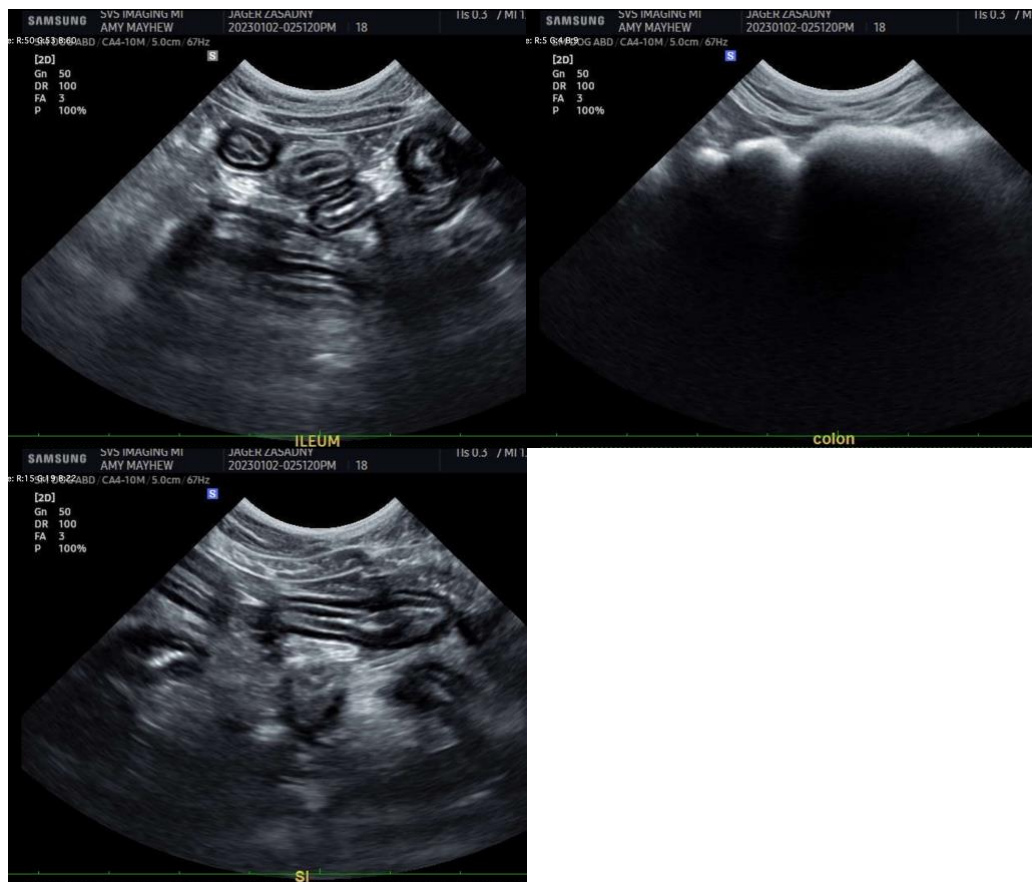
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM DACVIM

Beth.Johnson@SonoPath.com