



<b>PATIENT</b>	<b>PRESENTING CLINICAL SIGNS</b>
Pepper Brechbill	Presented at our hospital for recheck, urinating blood, NE or drinking much. Presented with UR blockage 10/20/22 and was hospitalized, was doing better and sent home 10/22/22. Previous Health Concerns: None Current Medications: Gabapentin (O having difficulty getting pill into FEL; has been dissolving in H2O) and Buprenorphine; both last doses @ 12midnight. Appetite/When did they eat last: sm amts
<b>SPECIES</b>	
Feline	
<b>BREED</b>	Abnormal PE/Chem/CBC/UA Results: 10/20/22:Chemistry: BUN 88.1 H, Creat 5.3 H, Glucose 256 H CBC: WBC 20.63 H, PMN 18.98 H, stress leukogram, RBC 11.76 H, HGB 18.5 H, HCT 50.6 H, MCHC 36.5 H; EPOC: K+ 6 H, Ca 0.76 L, Lactate 3.96 H, BUN 82 H, Creat 5.86 H, Glucose 240 H, HCT 57% H; Urinalysis: USG 1.034, 3+ protein, 2-3 WBC/hpf, TNTC RBC/hpf, 2+ struvite crystals, 1+ cocci/hpf; Radiograph post unblocking: no radio-opaque stones noted
DSH	
<b>SEX</b>	<b>ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN</b>
Neutered Male	<b>Urinary System</b>
<b>AGE</b>	Urinary bladder is only mildly distended (empty). Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. Mineral densities/foci are present within the partially visualized lumen as well as suspected to be embedded within the mucosa throughout the urinary bladder, most consistent with small cystoliths or mineral sand/debris.
7 Years	
<b>WEIGHT</b>	The right kidney is normal in size (3.97 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.
7.3 kg	
<b>INTERPRETED BY</b>	The left kidney is normal in size (3.9 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.
Beth Johnson, DVM DACVIM	<b>Adrenal Glands</b>
<b>IMAGING PERFORMED BY</b>	The right adrenal gland is normal in size (0.61 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.
Erin Wicks	The left adrenal gland is normal in size (0.49 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.
<b>HOSPITAL NAME</b>	<b>Spleen</b>
Shores VEC	The 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.
<b>REFERRING VET</b>	<b>Liver</b>
Dr. Christian	The 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 homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.
<b>INVOICE</b>	
42381	
<b>DATE</b>	The 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.
10/27/22	



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DSH

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Beth Johnson, DVM  
DACVIM

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**Gastrointestinal**

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

**Pancreas**

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

**Free Abdomen**

There is no evidence of free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

**ULTRASONOGRAPHIC FINDINGS**

- Mineral/sand urinary bladder debris – Small cystoliths cannot be definitively ruled out.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

If recheck lab work was not performed after the presenting lab work provided in today's history, revealing marked azotemia, recheck CBC/Chem panel and electrolytes is recommended. Additionally, a urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

In the meantime, given the mineral debris, a urinary bladder flush could be considered.

Following the bladder flush, recommendations include maximizing water consumption (water fountains, canned food, etc) as well as reducing stress (recommendations can be found at Indoor Cat Initiative out of The Ohio State University CVM). Transition to a urinary health diet such as Royal Canin Urinary SO (or similar) could also be considered at home.



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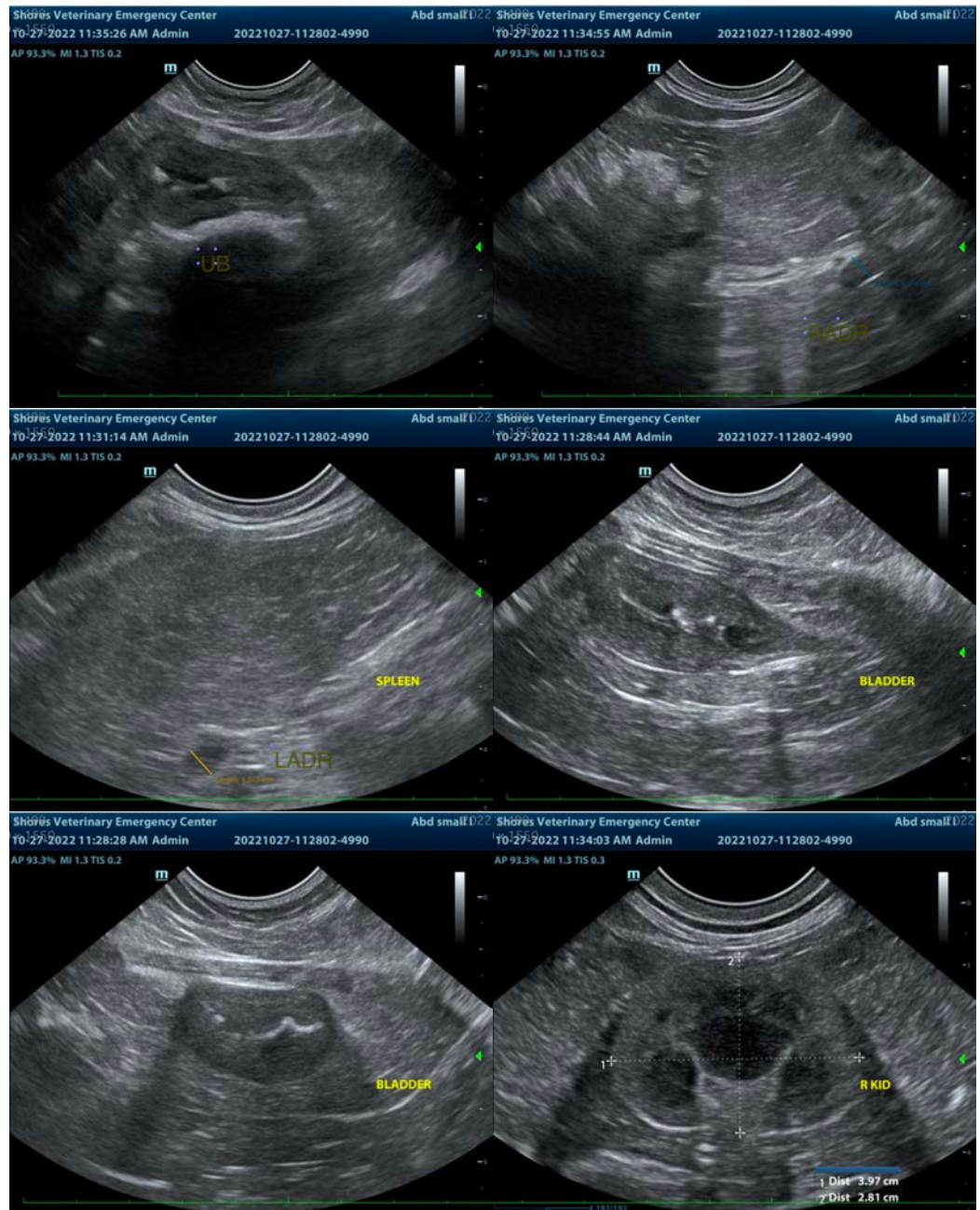
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM  
Beth.Johnson@sonopath.com