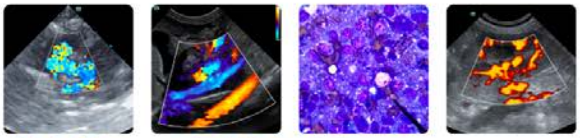


SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Gunner Meyers

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

3 Years

WEIGHT

9 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

BPH Stoney Creek

REFERRING VET

Dr. Beckstead

INVOICE

73210

DATE

2/24/26

PRESENTING CLINICAL SIGNS

Last few days P has been urinating small frequent amounts and over grooming in the inguinal area. Medications started over night: Buprenorphine SR, Metacam, Prazosin, Gabapentin

Abnormal PE/Chem/CBC/UA Results: UA - 3+ RBCs, SG <1.050, 3+ protein, 3+ RBCs, 1-5 HPF struvite crystals and 1+ unclassified crystals Primary Question to Be Answered in This Exam - cause for hematuria

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly under distended, potentially partially exacerbating the appearance of the thick wall. However, apical urinary bladder wall is diffusely mildly thick, measuring 0.25 cm thick. Contents are primarily anechoic with some suspended echogenic debris as well as moderate amount of mineral/sand debris, both suspended. Some appeared be embedded within the apical wall, and some settled along the inner dependent wall in a pile. Within the pile of mineral, a more distinct cystolith up to 0.60 cm in diameter can't be definitively ruled out. No masses are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal is size (4.5 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.

The left kidney is normal is size (4.6 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

The right adrenal gland is normal in size (0.27 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.29 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

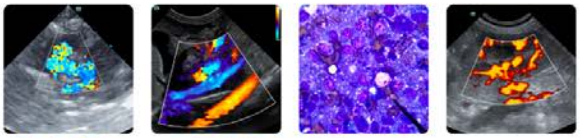
Spleen

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.

Liver

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.

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.



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Gastrointestinal

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.

The visible small intestine demonstrates areas of moderately 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.

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

Pancreas

The pancreas that is observed 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.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Chronic Cystitis - Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes.
- A moderate amount of mineral/sand debris within the urinary bladder is present, and a more discrete sizable cystolith can't be definitively ruled out.
- Minor 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 loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urine culture is recommended if not recently evaluated.

A heavily sedated/anesthetized voiding urohydropropulsion/bladder flush could be considered, both as a therapeutic intervention to remove debris as well as a diagnostic to obtain some of the mineral debris for analysis, which will further guide treatment and prevention, i.e., indicate if dissolution may be an option.

Further workup of the bowel changes are largely dependent on any clinical history of gastrointestinal disease, including unintentional weight loss, but could be begin with a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory for further evaluation of GI and pancreatic function.

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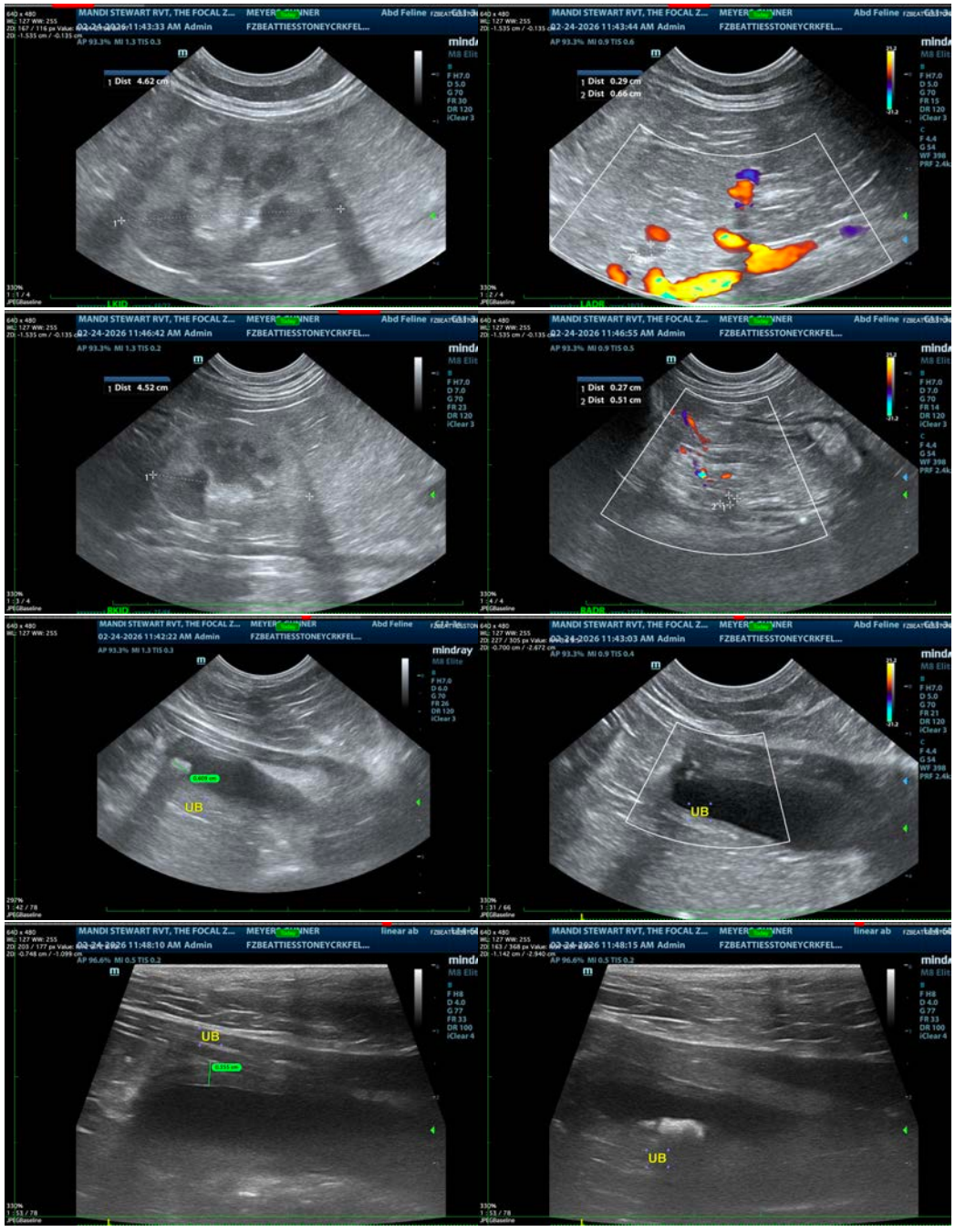

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@sonopath.com