



**PATIENT**

BugBug Bahnick

**SPECIES**

Feline

**BREED**

DUH

**SEX**

Neutered Male

**AGE**

7 Years

**WEIGHT**

12 Lbs.

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Dr. Reyes

**HOSPITAL NAME**

Mobile Vet  
Ultrasound

**REFERRING VET**

Dr. Beltran

**INVOICE**

14244

**DATE**

3/10/22

**PRESENTING CLINICAL SIGNS**

History: Pet presented on 1/28 for hematuria and inappropriate urination. Urinalysis was done and pet received a Convenia injection at the clinic. On January 31st, pet was also prescribed Clavamox. Radiographs were done and nothing abnormal was seen. On 2/4 pet presented for recheck. Urinalysis that was done that day showed possible Capillaria plica so Panacur was added to treatment. On 02/09 owner reported that pet was doing better and urine was not as bloody. On 02/17, owner noticed hematuria again, urine culture was done and Enterococcus faecalis was isolated, sensitive to Doxycycline. Pet was treated for 14 days. Pet continues to have blood in urine.  
Abnormal PE/Chem/CBC/UA Results: UA: SG: 1.056 Blood: 4+ Prot: 3+ Leuk: 3+ pH: 6.0

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

Urinary bladder is not fully distended in these images. It has a normal uniform wall thickness (<0.2 cm). Contents include primarily anechoic fluid combined with suspended echogenic non-shadowing debris within the fluid. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are normal in size, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. The left kidney measures 3.6 cm. The right kidney measures 3.0 cm. \*Note: hyperechoic wedge-shaped cortical indentations create abnormal shape of the caudal pole bilaterally.

**Adrenal Glands**

Left adrenal gland is normal in size (0.28 cm thick), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.34 cm thick), shape and contour. Corticomedullary structure is unremarkable. 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 homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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.

**Gastrointestinal**



<b>PATIENT</b>	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.
BugBug Bahnick	
<b>SPECIES</b>	The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.
Feline	
<b>BREED</b>	The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.
DUH	
<b>SEX</b>	<b>Pancreas</b> 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.
Neutered Male	
<b>AGE</b>	<b>Free Abdomen</b> There is no appreciable lymphadenopathy or free fluid in these images.
7 Years	
<b>WEIGHT</b>	<b>ULTRASONOGRAPHIC FINDINGS</b>
12 Lbs.	<ul style="list-style-type: none"> <li>• Urinary bladder sediment/debris, consistent with the reported urinalysis results</li> <li>• This appearance of the kidneys is consistent with chronic kidney disease with chronic infarcts such as chronic glomerular or interstitial nephritis, chronic pyelonephritis, etc.</li> </ul>
<b>INTERPRETED BY</b>	<b>INTERPRETATION OF THE FINDINGS &amp; FURTHER RECOMMENDATIONS</b>
Beth Johnson, DVM DACVIM	Enterococcus bacteria can be the primary pathogen causing a urinary tract infection; however, it is also often a contaminant, subclinical or present as a secondary agent on top of a primary pathogen. Therefore, recommendations include a CBC/serum chemistry panel (if not recently evaluated) for assessment of metabolic health and to look for any evidence of diseases that might be resulting in immunosuppression. Additionally, given the reported capillaria, improvement with treatment, and now return of the same clinical signs, my suspicion is capillaria is the primary problem and treatment for the capillaria should be repeated and potentially a longer course should be considered. If enterococcus is also contributing to clinical signs, a recheck culture while on antibiotics could be helpful if clinical signs aren't resolving as the antibiotic sensitivity can change mid treatment. Adequate hydration is important during the treatment. Finally, transition to a urinary health diet could be considered given the combination of pathogens reported.
<b>IMAGING PERFORMED BY</b>	
Dr. Reyes	
<b>HOSPITAL NAME</b>	
Mobile Vet Ultrasound	
<b>REFERRING VET</b>	
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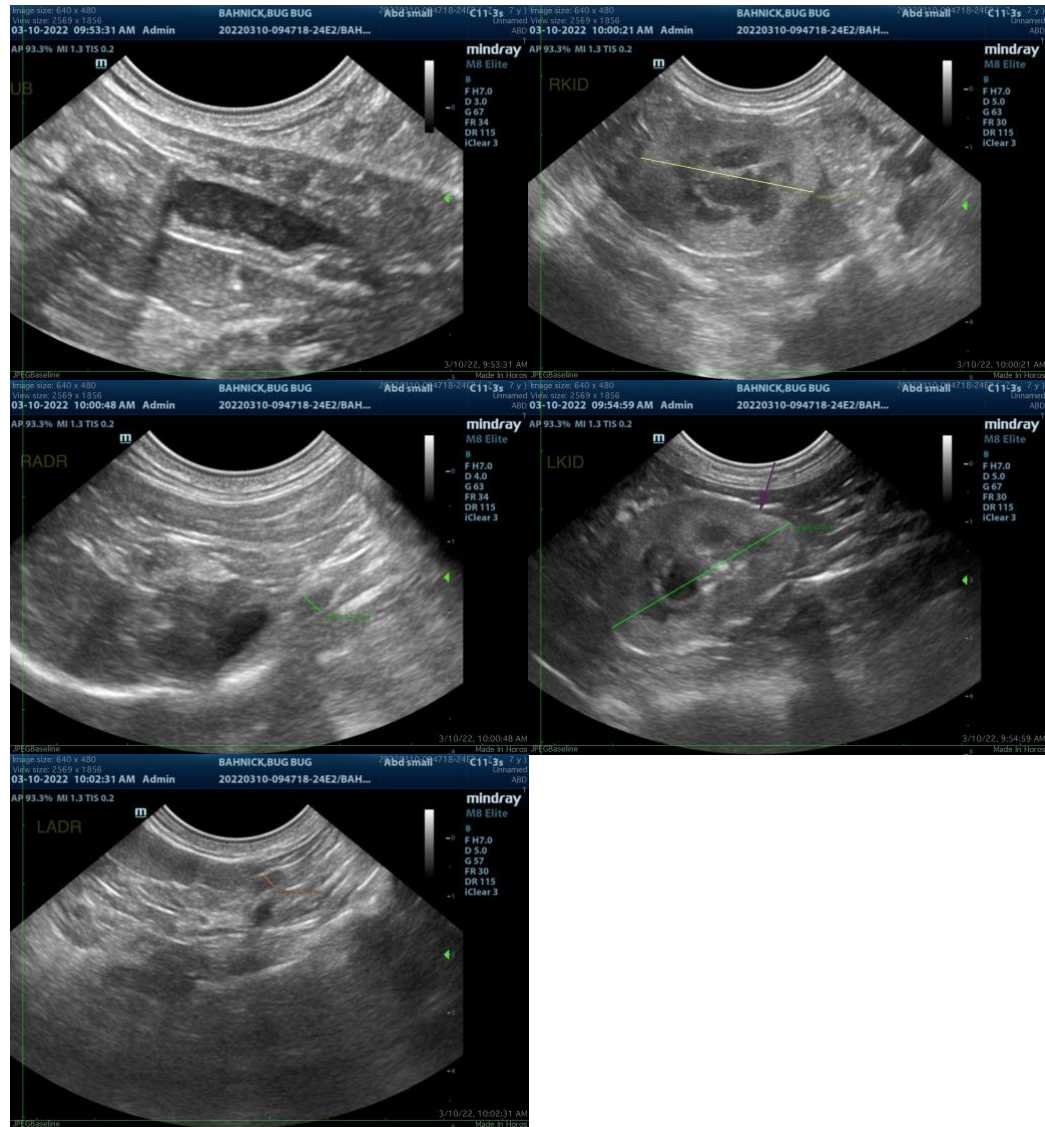
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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**

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