



**PATIENT**

Kanza Riehl

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Spayed Female

**AGE**

12 Years

**WEIGHT**

4.83 kg

**INTERPRETED BY**

Dr Brittany Sinclair,  
BVSc(hons),  
DACVECC

**IMAGING PERFORMED BY**

Amanda Stewart

**HOSPITAL NAME**

Hawkins Animal  
Hospital

**REFERRING VET**

Dr. Da Costa

**INVOICE**

74796

**DATE**

4/29/26

**PRESENTING CLINICAL SIGNS**

Clinical exam done on April 9th, 2026. Subjective: Presented for making weird noises when urinating, also after using the litter box, meows at the door to outside afterwards, never used to do this, recently also is sneezing frequently. HR - 148.00 BCS - 2.25/5 CRT - 1.0 sec. Abdomen - Painful over kidneys & bladder. Repro/urogenital - Medium-sized soft bladder. Oral - m3 tartar premolars & molars. Goal was to r/o urolith, nephrolith, UTI, etc.. Concern being that either ureter could be obstructed.

Abnormal PE/Chem/CBC/UA Results: Bloodwork (April 9th 2026): PLT 663 (125-618) CA 2.96 (2-2.95) K+ 6.1 (3.7-5.8) Urinalysis (April 9th 2026): SG > 1.050 Leu 3+, pH 7.5, Pro 2+, Hb 4+, RBC >200/HPF, WBC 0-2/HPF, Cocci 4+, Squamous cells 1+, Transitional cells 1+, Debris 1+. Urinalysis (April 23rd 2026) SG > 1.050 LEU 3+ pH 5.5 PRO 1+ Hb 4++, RBC >200/HPF, WBC 1-3/HPF, Squamous cells 1+, Cocci 1+, debris 1+. Radiographic Findings Small nephroliths/calcification seen in kidneys, but not sure if they are causing any obstruction of outflow into ureters; Medium sized bladder; No uroliths seen; Ingesta, feces and gas seen in GI tract. Primary Question to Be Answered in This Exam Are either ureters obstructed? Is there an explanation for the hematuria? See attached files

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys have a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present. Hyperechoic, shadowing foci present in renal parenchyma and calyces bilaterally, consistent with nephrocalcinosis. Left kidney measures 4.16 cm. Right kidney measures 3.92 cm.

**Adrenal Glands**

Adrenal glands were visualized on still images only. They appear to have normal shape, size, position and echogenicity for this breed and age though this could not be confirmed on cine loops. Left measures 0.27 cm in thickness. Right measures 0.24 cm in thickness.

**Spleen**

The spleen was normal with age appropriate homogeneous parenchyma and a smooth capsule with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

**Liver**

The liver is subjectively normal in size with normal contours and structure. There is age appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

Gall bladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.

**Gastrointestinal**



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The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.

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The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is diffusely increased and wall layering is distinct with a prominent muscularis layer. There were no focal lesions consistent with obstruction or a mass effect observed.

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The mesentery around the ICJ is hyperechoic with slightly prominent lymph nodes. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

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***Pancreas***

The visible pancreas was observed to be largely isoechoic to surrounding omental fat.

***Free Abdomen***

No clinically significant lymphadenopathy or abnormalities noted. No free fluid noted.

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**ULTRASONOGRAPHIC FINDINGS**

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- Mild nephrocalcinosis. No pelvic dilation or ureteral distention.
- Normal urinary bladder.
- Thickened small intestine with inflammation at the ICJ.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Urinary bladder is normal in this patient. The kidneys have some age related degeneration and mild nephrocalcinosis, but no signs of ureteral obstruction. This patient likely suffers from feline lower urinary tract syndrome. Urine culture and sensitivity is warranted to treat any underlying infection properly, with repeat culture at the end of antibiotic treatment to ensure clearance. Ultimately FLUS is most often a sterile process which can be difficult to control. Stress reduction is important and pheromone therapy (Feliway) or anxiolytic medications (gabapentin, fluoxetine, etc) may be of use. Promotion of increased water intake with canned food and access to water fountains and urinary health diets (hills c/d, royal canin urinary S/O, purina proplan UR, etc) may be useful but must be fed exclusively to be effective. Increasing the number of litter boxes and being fastidious about changing the litter, as well as placing litter boxes in stress free areas, away from other pets, high traffic areas or noisy appliances can be helpful.

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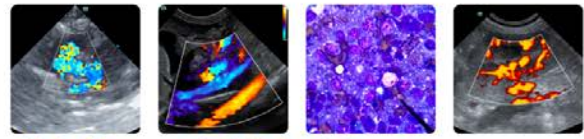
The patient does not have GI signs. This may be an incidental finding. Small intestinal changes are most consistent with infiltrative disease of the small intestine with inflammatory bowel disease or GI lymphoma being the top differentials. No overt neoplastic criteria present in the bowel given that curvilinear layering is still intact. Ultrasound cannot differentiate between small cell lymphoma and inflammatory bowel disease and GI biopsies are recommended for definitive diagnosis, especially if there is a poor response to empirical efforts or recurrence of clinical signs after initial control. Endoscopic biopsy is less invasive but may miss lesions due to inability to obtain samples from all sections of the GI tract, especially the jejunum which is the most common site of development of disease. Surgical biopsies are more likely to be diagnostic but are more invasive. A GI panel (TLI/PLI/cobalamin/folate) will help determine the severity of SI dysfunction, and need for vitamin supplementation.

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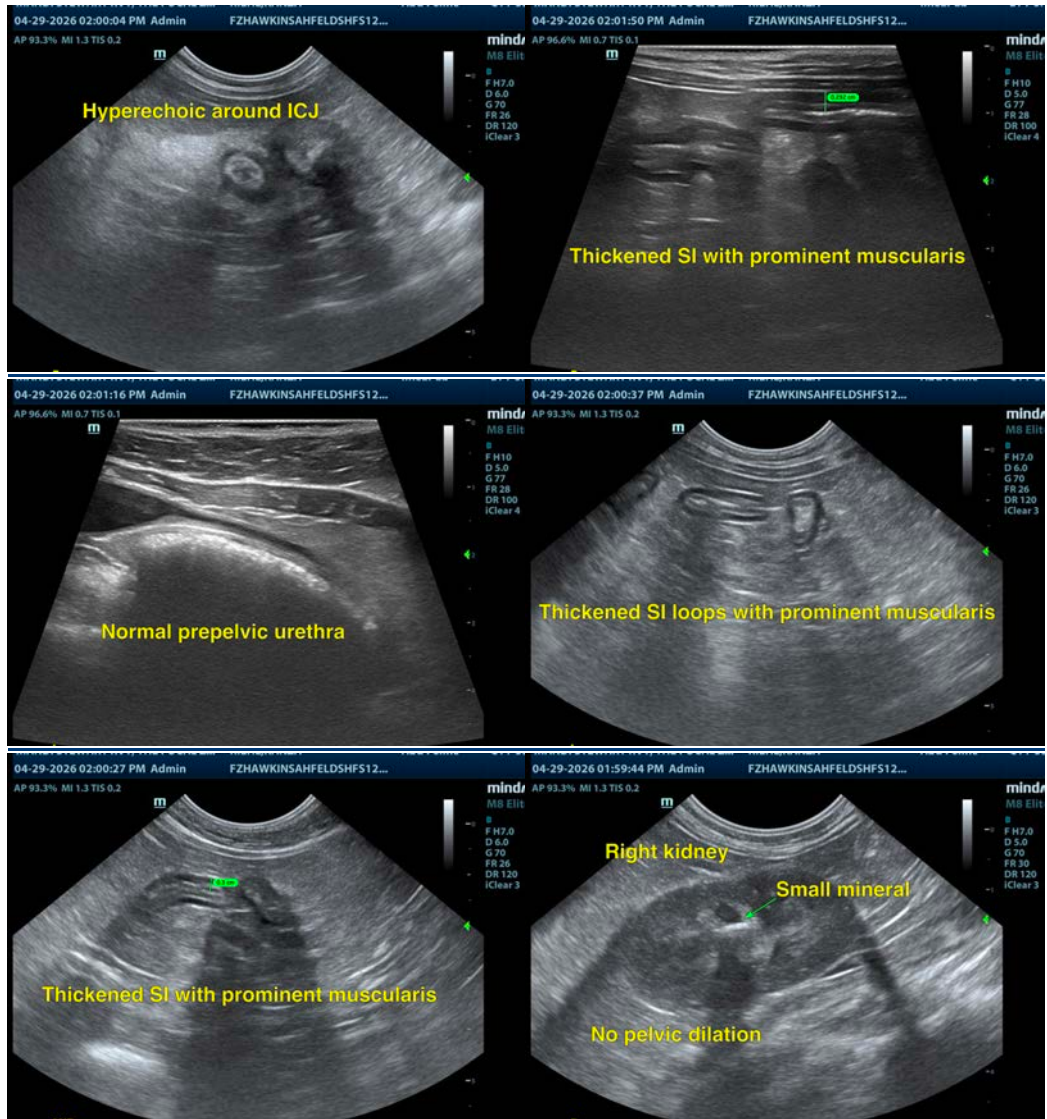
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Empiric treatment for IBD includes diet trial with either hydrolyzed or select protein diet, vitamin b-12 supplementation, GI support as needed (anti-nausea, appetite stimulant). Treatment with steroids (budesonide vs prednisolone) is often required – biopsies should be acquired prior to treatment with steroids. Steroids may ultimately be tapered to the lowest effective dose or discontinued in some cases.



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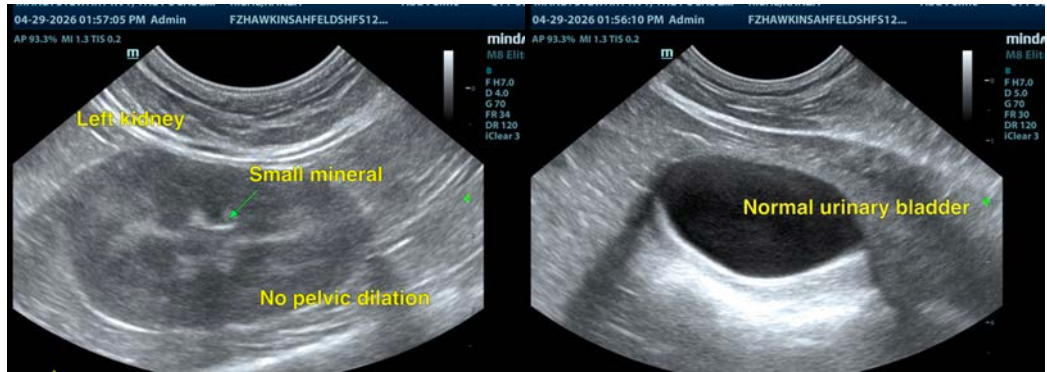
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

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