SonoPath
Clinical Sonography & Telecytology
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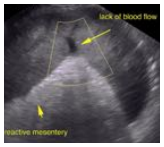
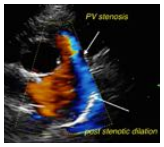
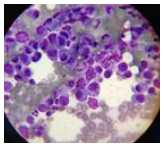
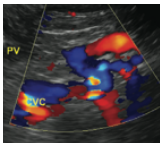

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Nemo Kastner

SPECIES
Feline

BREED
Domestic Shorthair

SEX
Neutered male

AGE
15 years

WEIGHT
8.5 lbs

INTERPRETED BY
Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY
Dr. Roche

HOSPITAL NAME
Fredon AH

REFERRING VET
Dr. Roche

INVOICE
42582

DATE
1/9/23

PRESENTING CLINICAL SIGNS

History: in and out of box, digs aggressively. maybe more urine production? no accidents noted.
Abnormal PE/Chem/CBC/UA Results: mass on palpation of bladder area

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder wall is severely thickened measuring up to 2cm with complete loss of wall layering and infiltration with hypoechoic to heterogenous tissue and irregular serosal surface. Bladder lumen is very small and mucosal surface contains mineral shadowing consistent with mineralization of the bladder lumen.

The kidneys have a smooth capsule and with complete loss of corticomedullary definition. No evidence of pelvic dilation was present. The left kidney measured 3.34 cm. The right kidney measured 3.48 cm.

Adrenal Glands

Adrenal glands were not distinctly visualized. The area of the adrenal glands and surrounding vasculature were normal.

Spleen

The spleen was normal with a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma and 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 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. No pathological hepatic lymphadenopathy observed. Gallbladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally

Gastrointestinal

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 and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed. The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed. The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. 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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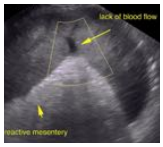
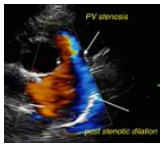
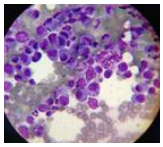
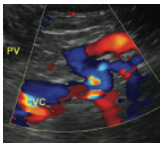

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Pancreas

The base and limbs of the pancreas were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour and parenchyma were normal. No overt evidence of active inflammatory or neoplastic disease was noted.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

No masses or free fluid were noted.

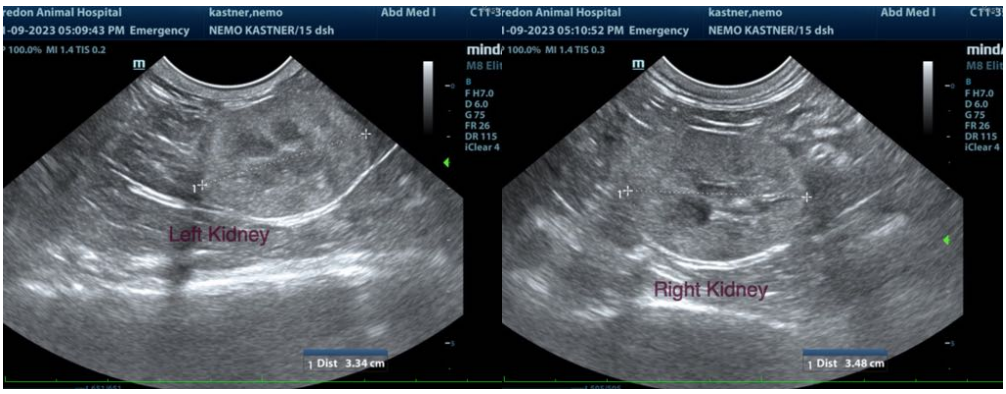
ULTRASONOGRAPHIC FINDINGS

Primary Findings

1. Urinary bladder mass with luminal mineralization
2. Degenerative renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urinary bladder mass is the likely cause of reported clinical signs and is concerning for neoplasia with transitional cell carcinoma, carcinoma, and lymphoma being top differentials. Severe hyperplasia and remodeling secondary to severe chronic cystitis or mural bacterial invasion cannot be definitively ruled out but is less likely based on appearance. Percutaneous fine needle aspirate should be considered for further differentiation. While ceding tumor cells along the path of the needle is a potential risk of this procedure, the risk is generally low. Sampling via traumatic catheterization is another option, however this runs the risk ceding the urethra with tumor cells and may be non-diagnostic as pathology appears largely within the bladder wall rather than the lumen. Renal changes are likely age related degeneration. Correlate clinical significance with blood work/urinalysis findings and clinical signs.



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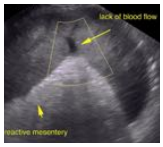
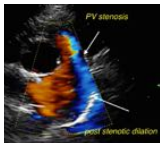
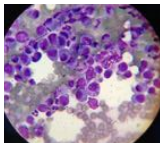
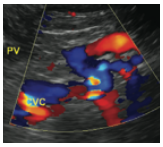

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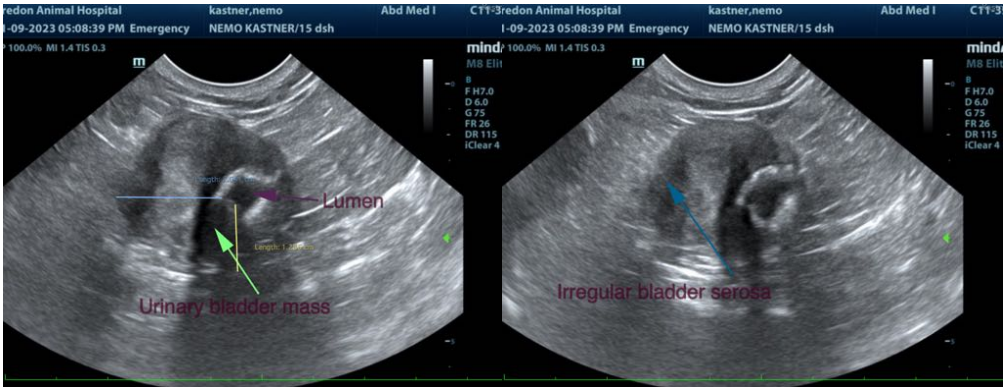

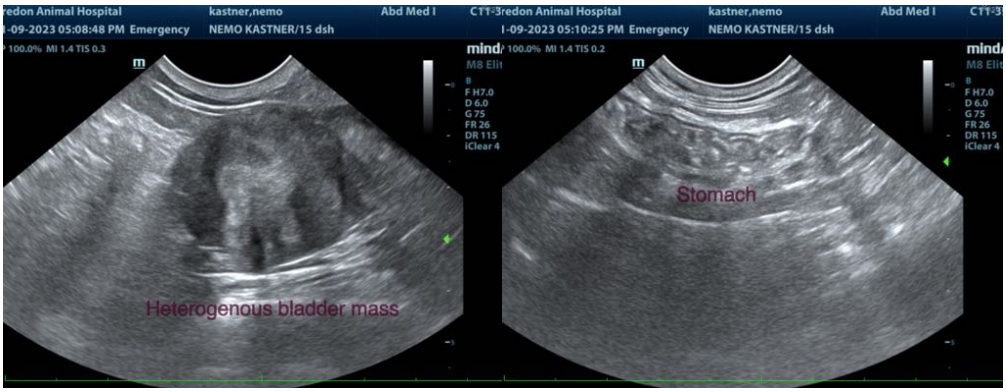

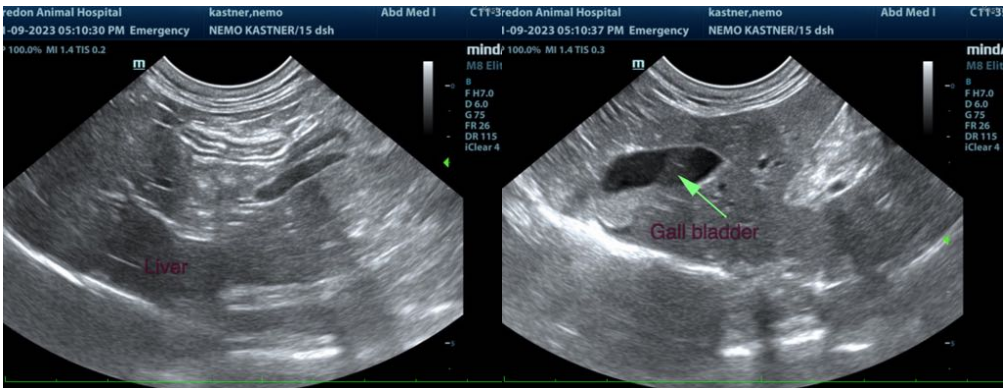

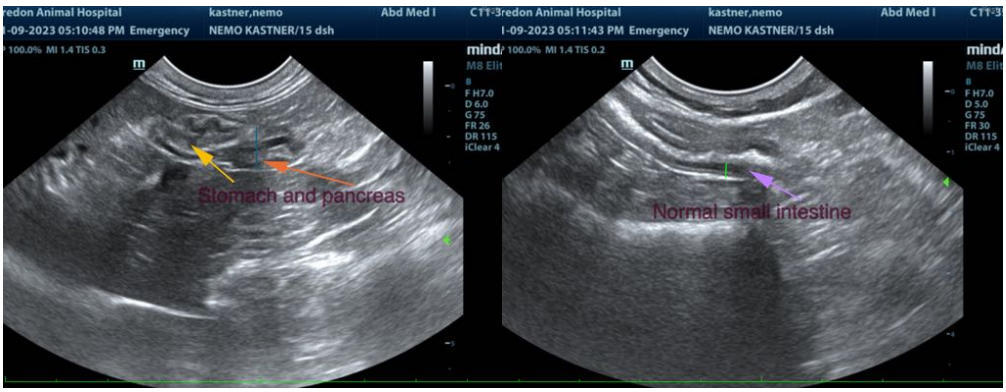

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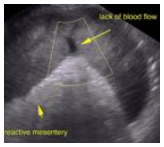

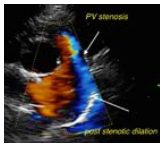

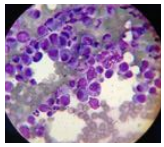
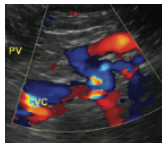

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@SonoPath.com