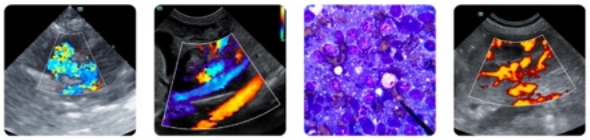


PATIENT

Sassy Gordon

SPECIES

Feline

BREED

Domestic Longhair

SEX

Spayed female

AGE

15 years

WEIGHT

3.7 kg

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Woodside

HOSPITAL NAME

Cat and Dog Hospital of Portland

REFERRING VET

Dr. Woodside

INVOICE

69750

DATE

12/31/25

PRESENTING CLINICAL SIGNS

History: Starting in Sept 2025, intermittent episodes of hematuria associated with stressful events (grooming, etc). In first week of October, UTI diagnosed with culture and treated based on sensitivity. November 11, presented for hematuria. UA showed hematuria and bacteria. On ultrasound guided cystocentesis, soft tissue density (7mm diameter) noted along gravity dependent aspect of bladder, in caudal 1/3 of bladder. Cat too fractious to determine if location changed when cat was standing vs being in dorsal recumbency. Rule outs for soft tissue density included blood clot, bacterial mat, neoplasia, other. Hematuria resolved with antimicrobial treatment of UTI and Gabapentin for suspected FIC. 12/27/2025 - Presented for inappropriate urination and visible hematuria. On ultrasound guided cystocentesis, large, irregular soft tissue density noted in bladder, prompting recommendation for AUS. Abnormal PE/Chem/CBC/UA Results: BCS 3/9, heavy calculus, mild gingivitis, firm texture to bladder on abdominal palpation. UA USG 1.020, protein 100mg/dL, WBC 20/hpf, RBC >50/hpf, non-squamous epithelial cells 3-5/hpf, no bacteria, crystals, or casts seen. CBC normal. CHEM Creatinine 1.3, BUN 25. In house urine culture - no growth.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** revealed an apical mass with ventral polyp. The mass measured 1.4 x 1.8 cm with ventral wall polyp measuring 0.86 x 0.5 cm. The cystourethral junction and proximal urethra appeared unremarkable. The pathology may be resectable with aggressive bladder wall resection. However, there is a minor cystourethral junction polyp. This may be related to metastatic seeding process.

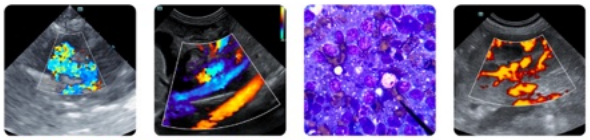
The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for this age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. Slight cortical infarct in the dorsal cortex of the left kidney. The left kidney measured 3.4 cm. The right kidney measured 2.72 cm.

Adrenal Glands

Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The right adrenal gland measured 0.36 cm and the left adrenal gland measured 0.4 cm.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes was noted. The spleen measured 0.9 cm.



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Liver

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some age-related parenchymal remodeling was noted but likely not clinically significant at this time. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable.

Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxiphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

ULTRASONOGRAPHIC FINDINGS

Bladder mass and ventral polyp and cystourethral junction polyp.

Slight cortical infarct in the dorsal cortex of the left kidney.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Exploratory bladder surgery could be considered with potential resection. However, special attention should be paid towards to the cystourethral junction polypoid change. Likely carcinoma and less likely bladder lymphoma, non-neoplastic granulomatous disease is possible, yet less likely. Cytospin and free catch urine sample with immediate slide preparation may allow for a definitive diagnosis from a cytological sample.

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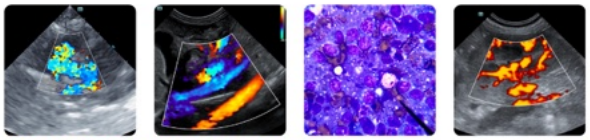

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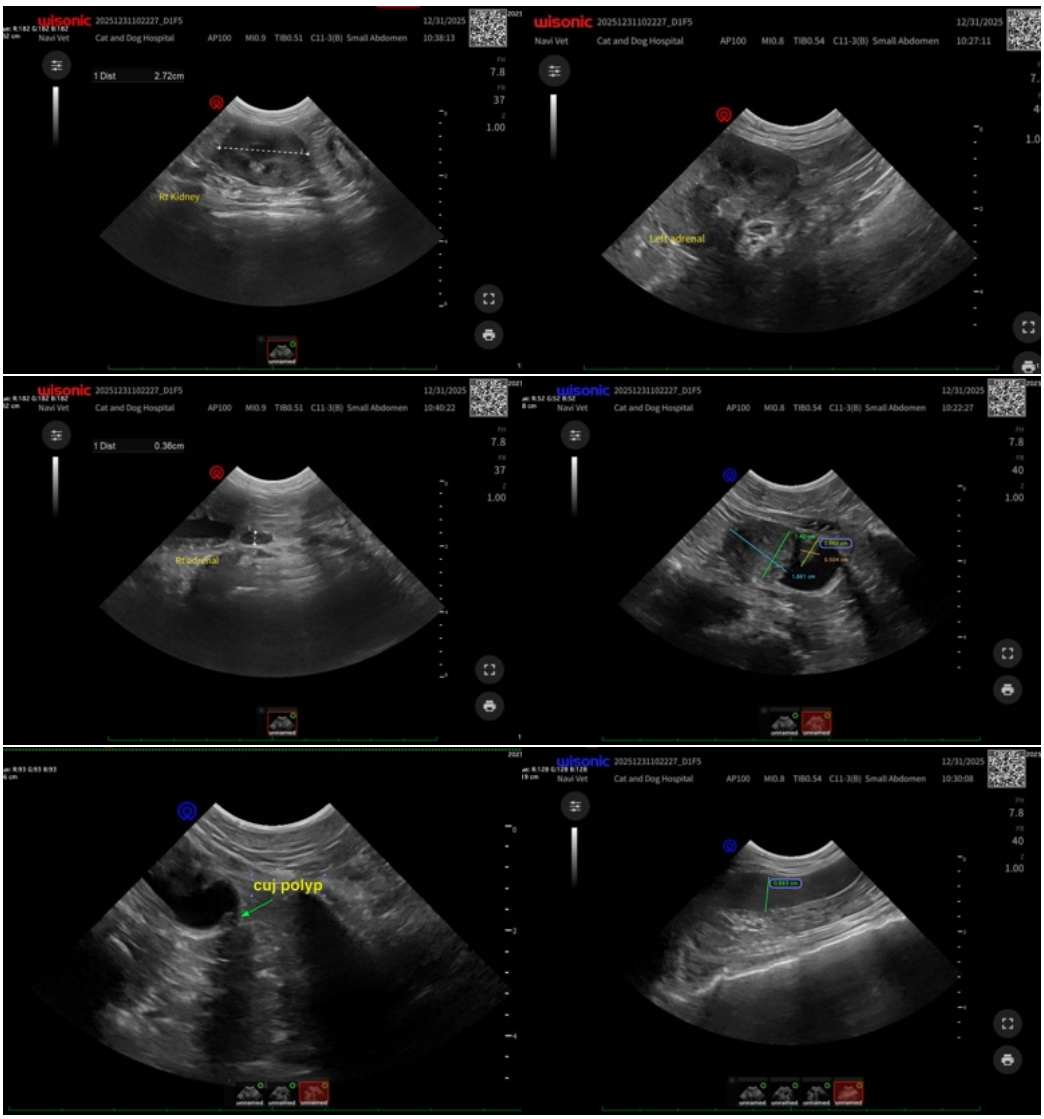

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP (CFM), Cert. IVUSS, CEO of SonoPath.com

info@SonoPath.com