



PATIENT

Kamir Stout

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

8 Years

WEIGHT

9.8 Pounds

INTERPRETED BY

Kathleen Sennello DVM,
MS, Diplomate ACVIM
(Small Animal Internal
Medicine)

**IMAGING
PERFORMED BY**

Dr. Tam Mengine

HOSPITAL NAME

Stoney Creek VH

REFERRING VET

Dr. Tam Mengine

INVOICE

34213

DATE

1/13/22

PRESENTING CLINICAL SIGNS

1 month history of profound hematuria (straining and passing clots), also 0.5 pound weight loss over that time. No prior hx of lower urinary tract disease. Urinalysis was performed on voided drops of urine previously, showing only RBCs. No response to amoxicillin, onsior, gabapentin, pred (tried sequentially). Samples obtained today for CBC / Chem / T4 / cysto U/A and culture- results pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended with mildly echogenic urine. The Bladder wall is diffusely thickened and irregular, measuring 0.36 cm. There is shadowing sandy debris and likely tissue mineralization, possibly with some small stones. The area of the proximal urethra appears free of thickening, masses or calculi. Findings are most consistent with diffuse cystitis and mineralization/sandy debris, but it is possible that there are some larger stones present. Findings are most consistent with diffuse cystitis, but underlying neoplasia cannot be completely ruled out.

The left kidney has a normal shape and size (3.61 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.0 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.25 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.28 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (0.91 cm in width at the level of the hilus), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.



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Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36cm 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. Duodenum wall measured 0.26 cm. Jejunum wall measured 0.22, 0.24 cm. 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. Colon wall measures 0.13 cm. 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.

Pancreas

The pancreas is prominent and hypoechoic as compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a single prominent mesenteric lymph node visualized at 0.30 cm. The omentum is of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Diffusely thickened and mineralized urinary bladder wall with sandy debris and possible small stones – Correlate these findings with abdominal radiographs to better determine if any larger stones are visualized.
- Prominent, hypoechoic pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The urinary bladder is diffusely thickened and irregular with shadowing mineralizations, which I suspect represent sandy debris and tissue mineralizations. Larger stones are possible, so correlate with abdominal radiographs to see if there is anything worth surgically evaluating. I suspect this is a case of severe sterile cystitis.

- Urinalysis and culture are recommended.
- Due to the diffuse nature of the lesion, interstitial cystitis is suspected (if culture is negative)
- Treatment of FIC can be frustrating as it is a waxing and waning disease. Treatment strategies vary and there is no “one fits all” approach. There is currently no cure for FIC. Goals of therapy include reduction of severity and duration of clinical signs during an acute episode; increasing the interval between episodes; and decreasing severity of signs in cats with persistent FIC. Approximately 85% of cats will experience clinical improvement with or without therapy.
- Numerous therapies can be considered including: diet, multimodal environmental modification, analgesics, anti-inflammatories, anti-anxiety medications etc..
- Close observation is warranted as some cats do experience life-threatening urinary obstruction.
- If symptoms are worsening re-evaluation with ultrasound should be considered.



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This can be a challenging and frustrating problem in some cats, and there has been a lack of response as of yet to your therapies. If symptoms are worsening, you could consider surgical biopsies to culture bladder wall and perform histopathology to ensure you have the correct diagnosis. Frequent reassessment of the bladder wall helps to better determine the efficacy of therapies.

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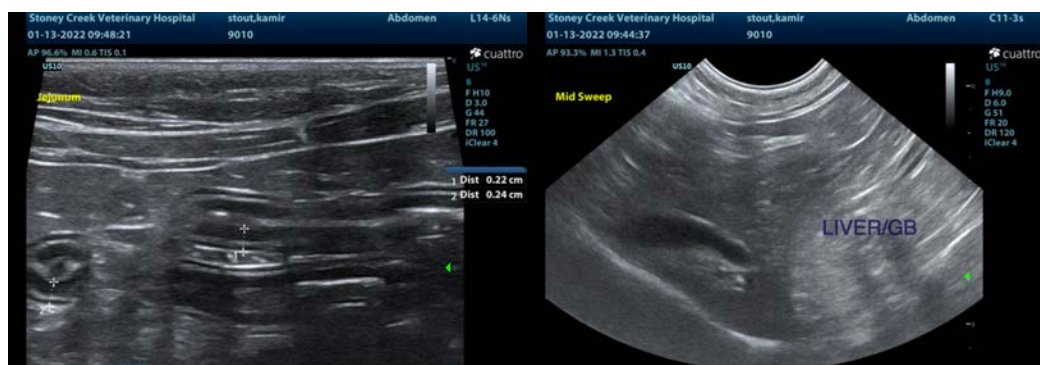
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)
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