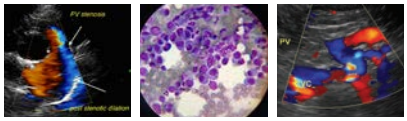
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE

1/31/23

PATIENT

General Bennett

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

6/1/13

WEIGHT

13 Pounds

INTERPRETED BY

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

HOSPITAL NAME

Cat Sense Feline Hospital

REFERRING VET

Dr. Sinclair

INVOICE

44627

PRESENTING CLINICAL SIGNS

Presented for straining to urinate, hematuria. X-ray shows possible crystalline material in the bladder even though none seen on the urinalysis. Would like to verify if there are crystals/small stones in the bladder to assess risk for urinary blockage.

Current Medications: Gabapentin 50mg bid, Prazosin 0.5mg bid, Buprenex 0.04mg bid
Lab Results: U/A has TNTC rbcs
Radiographs: See attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended with mildly echogenic urine occasional suspended debris. The Bladder wall appears very mildly thickened in the dependent portion of the urinary bladder with very mild mucosal irregularity, measuring at 0.43 cm. This mild thickening extends into the trigone region, where there is some mild surrounding inflammation. No mass lesions are observed. The area of the trigone, ureteral papillae, and proximal urethra appear free of any calculi or significant mass lesions. There is a small amount of suspended echogenic debris present and possibly a very small amount of dependent sandy debris.

The left kidney has a normal shape and size (4.38 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal 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 (4.3 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal 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 0.45 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 0.30 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 (0.67 cm), 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 mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

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. The duodenum measured as normal (between 0.13-0.38cm in wall thickness) and the jejunum measured as normal (between 0.15-0.36cm.) 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.

Pancreas

The pancreas is normal and isoechoic to surrounding 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, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Questionable mild dependent bladder wall thickening with a small amount of echogenic debris – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus. The bladder mucosal changes could be consistent with cystitis or artifactual due to lack of adequate luminal distension. Bladder neoplasia cannot be ruled out but is considered unlikely in this patient.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is very mild/subjective dependent bladder wall thickening. This could be exacerbated by the non-distended urinary bladder. Additionally, there is some very mild echogenic debris present. No focal lesions are observed.

- Urinalysis and culture are recommended.
- Due to the relatively diffuse nature of the lesion, interstitial cystitis is suspected (if culture is negative)

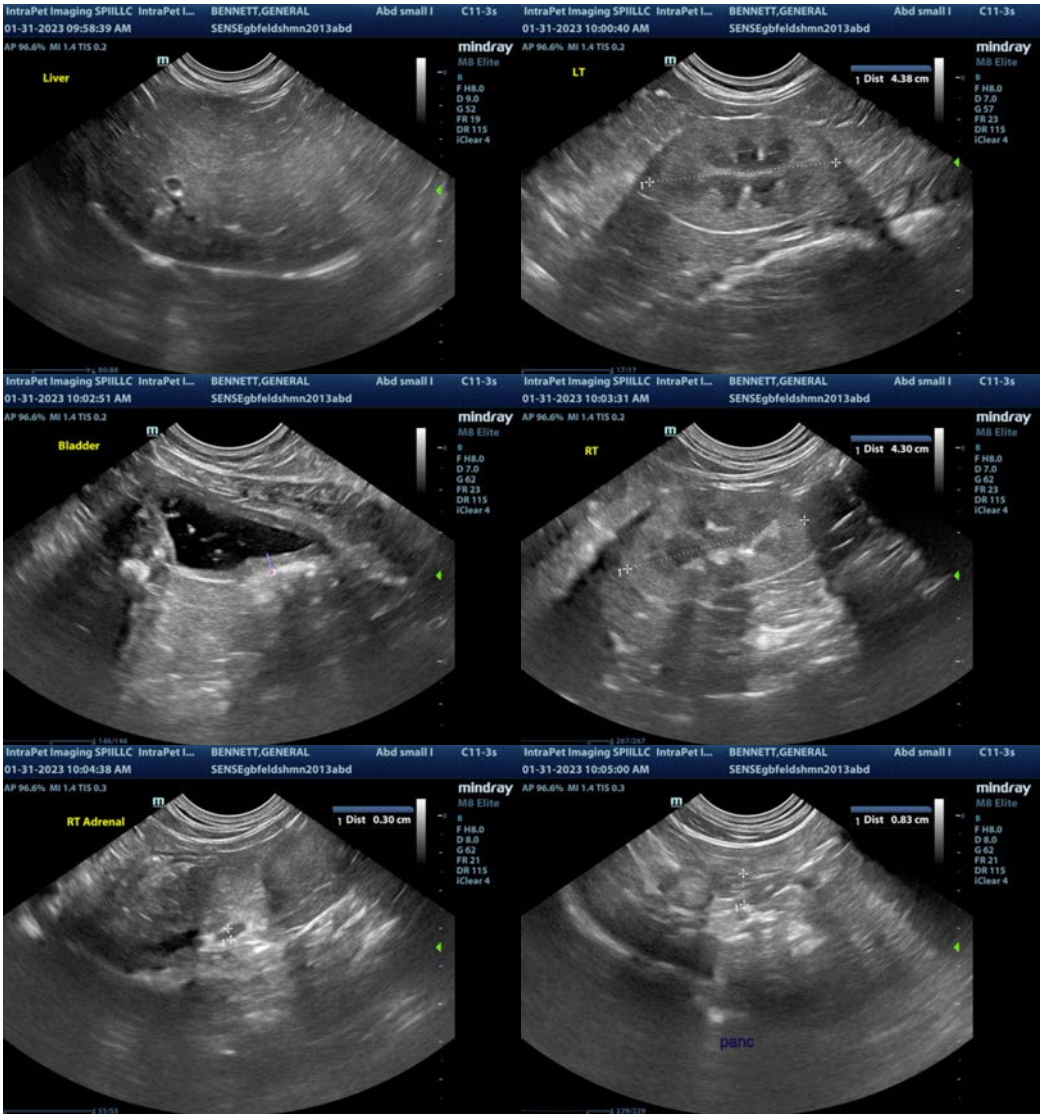
If attempts to culture the urine are negative when the patient is off antibiotics consistently, then sterile cystitis could be present.

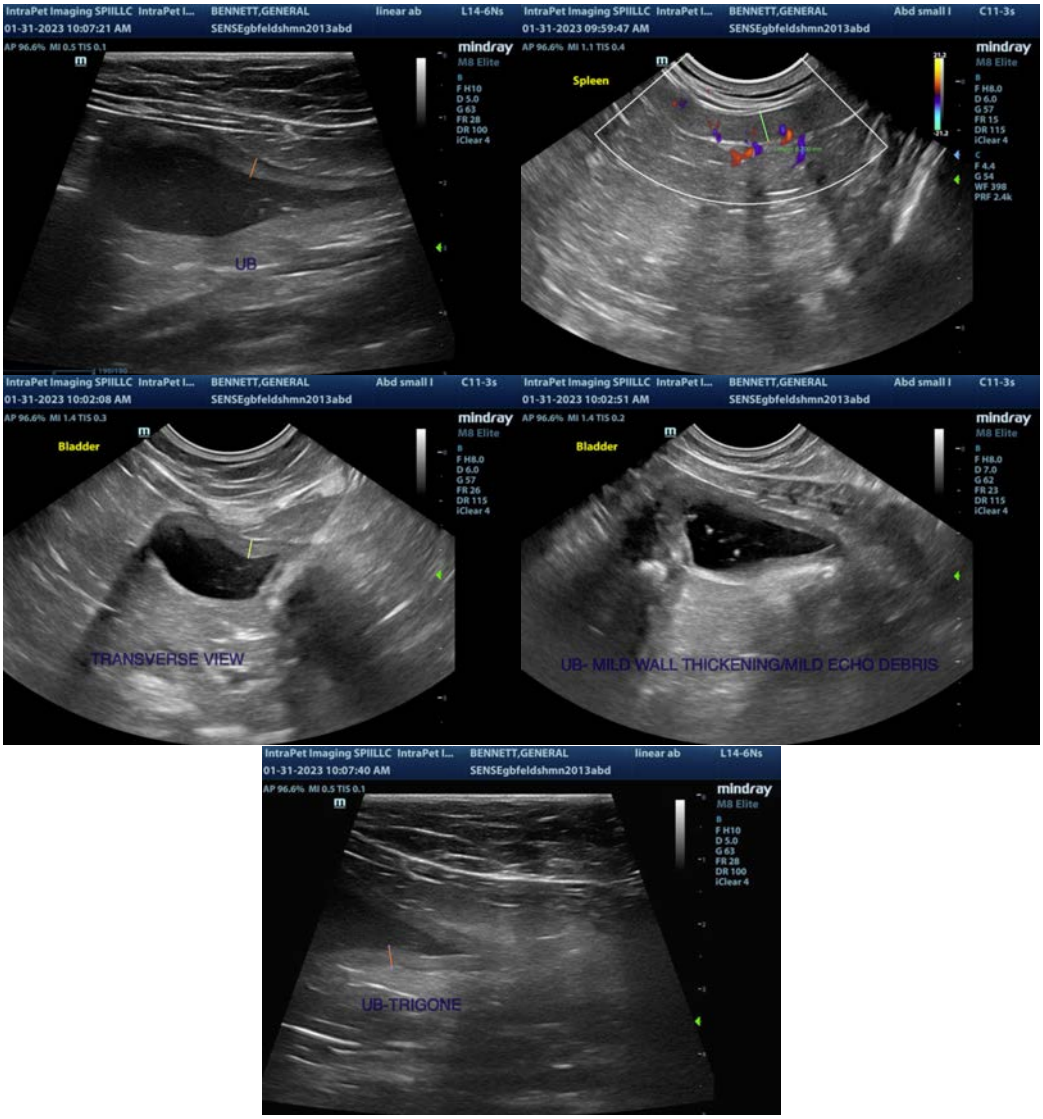
- Treatment of FIC can be frustrating as it is a waxing and waning disease. Treatment strategies vary and there is no “one fits all” approach. There is currently no cure for FIC. Goals of therapy include reduction of severity and duration of clinical signs during an acute episode; increasing the interval 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.





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.

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