PATIENT
Callie Bain

SPECIES
Feline

BREED
British Longhair

SEX
Spayed Female

AGE
3 Years

WEIGHT
7 lbs

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

IMAGING PERFORMED BY
Loetitia Saint-Jacques, LVT

HOSPITAL NAME
VCA Feline Animal Hospital

REFERRING VET
Dr. Smith

INVOICE
72136

DATE
11/26/25

PRESENTING CLINICAL SIGNS

Sedated for exam-History - Presenting concerns: Chronic history of inappropriate urination. Large home with 8 litter boxes (3 other cats). O notes pt will urinate on almost anything and it is becoming unsanitary. O also seems to do nothing but eat and cannot gain weight. O notes pt will eat other cats food. Has been seen at previous vet and was noted as otherwise healthy per O. Previous CBC/Chem unremarkable, T4 grey-zone (r/o normal variation, enteropathy, less likely hyperthyroidism), UA shows concentrated urine (USG 1.058) with Struvite (4-10/hpf) and amorphous phosphate (2-3/hpf) formation (r/o artifact vs. struvite urolithiasis). Has never tried medications. Recently moved from Elk Grove, CA and also wanting to establish. C/S/V/D? none Diet: FF, Friskies wet Supplements: none Medications: none indoor only Parasite prevention: none ***Struvite crystal in urine, Large, rounded cardiac silhouette on radiographs, Inability to gain weight, Inappropriate urination

Abnormal PE/Chem/CBC/UA Results: RAD report attached 11/24/2025: BUN 37 Neu 2112/uL (WBC wnl). USG 1.032 pH 8.0 Trace proteinuria

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mild primarily suspended echogenic debris present. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (3.36 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 (3.34 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 0.30 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 0.29 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 (1.05 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.

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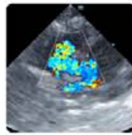
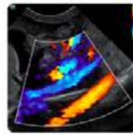
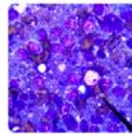
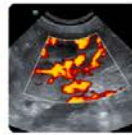

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Liver

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 gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and likely incidental at this time. The common bile duct is mildly dilated and tortuous, measuring 0.20 cm. At the level of the duodenal papilla it is normal at 0.12 cm.

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 measures 0.27 cm. Jejunum wall measures 0.19 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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 visible/mildly mottled in the left limb. 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 no evidence of a significant lymphadenopathy. A prominent mesenteric lymph node is visualized measuring 0.34 cm. A lymph node near the ileocecal junction measures 0.31 cm.

ULTRASONOGRAPHIC FINDINGS

- Mild pancreatic remodeling.
- Mildly dilated/tortuous bile duct – This is likely insignificant at this time. Recommend continued monitoring.
- Mild reactive lymphadenopathy.
- Mild echogenic debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.

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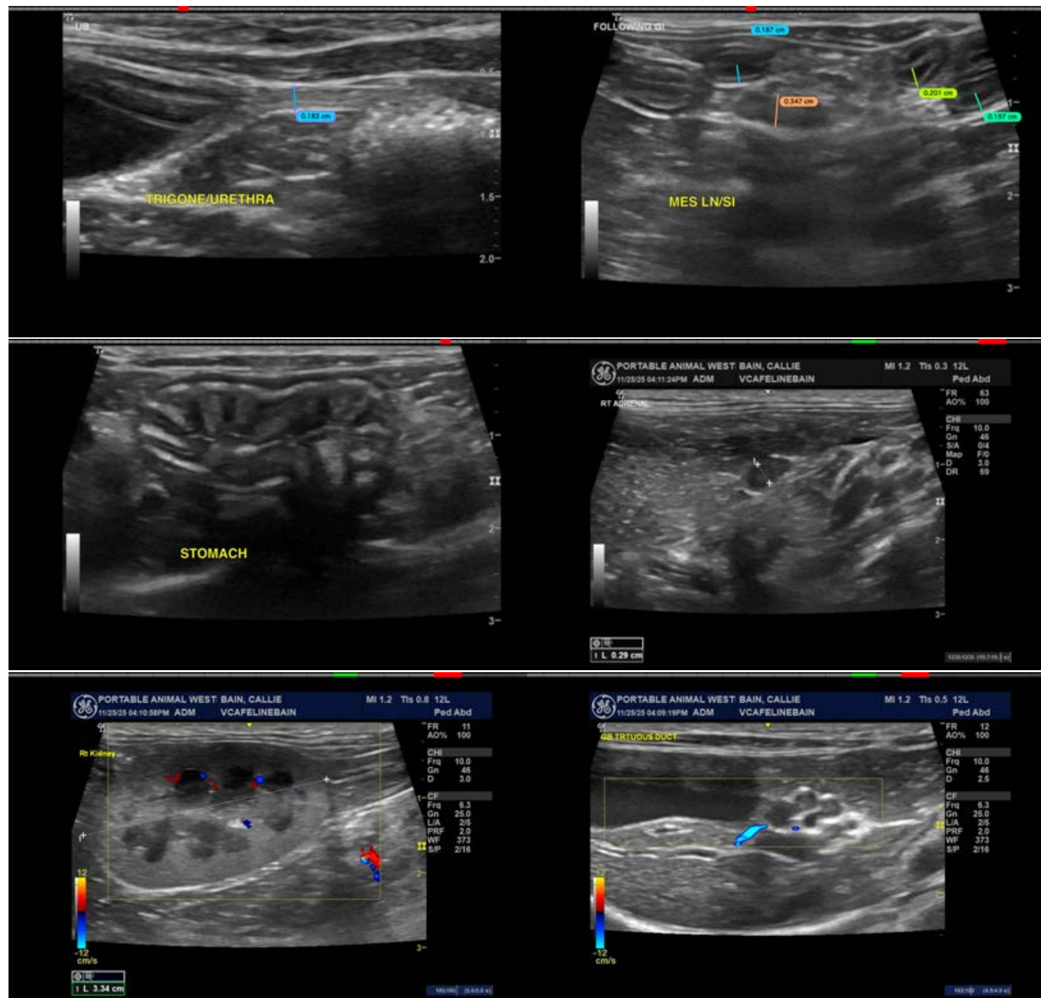
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the urinary tract to explain the inappropriate urination reported. This does not rule out the possibility of mild cystitis, a more distal urethral lesion, etc. In the absence of inflammation on urinalysis, behavioral modification would be my primary concern.

No evidence of an enteropathy is present. This does not rule out the possibility but makes it somewhat less likely. You could consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate to look for evidence of underlying gastrointestinal disease, which may indicate a need for further investigation.



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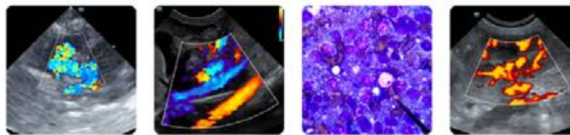

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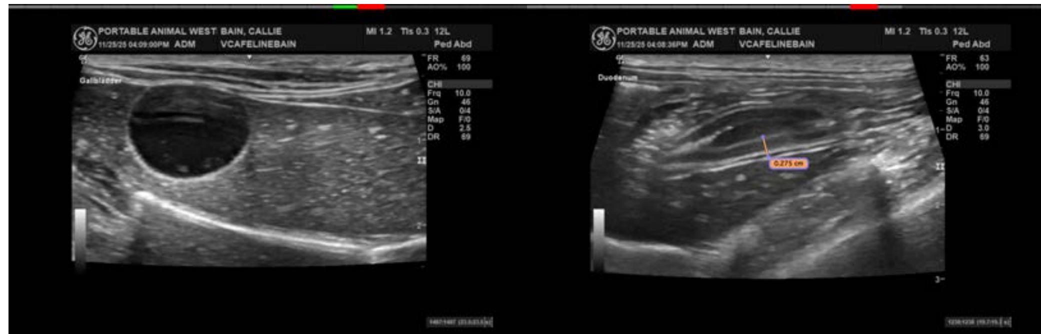

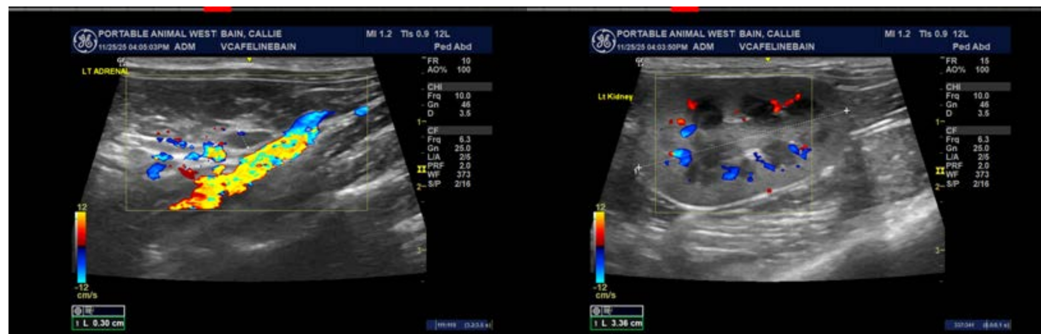

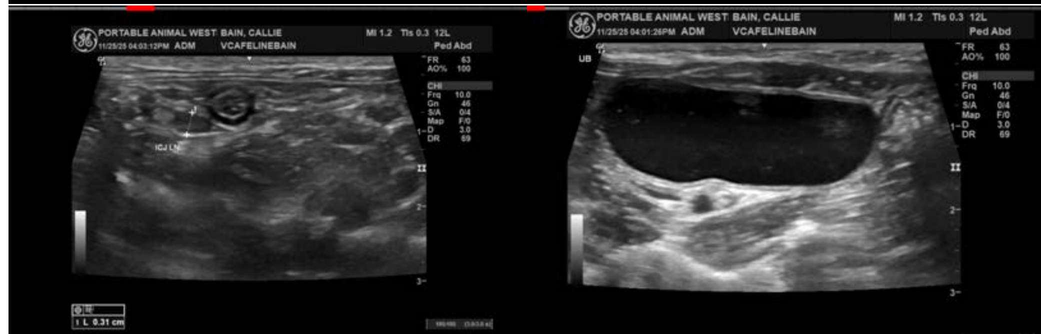

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

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