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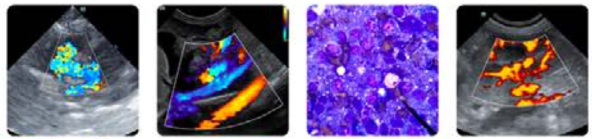


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT

Peanut Frances Simon

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed Female

AGE

16 Years 6 Months

WEIGHT

5.98 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Melinda Persson

HOSPITAL NAME

At Home Veterinary

REFERRING VET

Dr. Melinda Persson

INVOICE

72490

DATE

12/10/25

PRESENTING CLINICAL SIGNS

*Acute onset pollakiuria and dribbling *Bladder palpated firm and thickened *Unable to collect urine sample to evaluate urine *Historical liver cysts identified in February 2024 on ultrasound *Suspect benign splenic nodules identified in February 2024 on ultrasound *Late stage 2 renal disease

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall is severely thickened and diffusely scalloped, measuring at 0.69 cm in the ventral wall. No focal areas of normal bladder wall are visualized. The region of the urethra is not clearly visualized.

The left kidney has a normal shape and size (3.42 cm). Overall echogenicity is slightly hyperechoic with poor 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 (3.68 cm) with mild pyelectasia at 0.22 cm. Overall echogenicity is slightly hyperechoic with poor 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 0.32 cm at the cranial pole and 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.

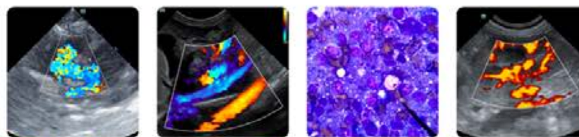
The right adrenal gland is normal in size measuring 0.35 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (0.65 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There are numerous poorly defined hyperechoic nodules throughout the parenchyma, most consistent with benign myelolipomas.

Liver

The liver is large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There are numerous cystic lesions visualized throughout the liver. There are some irregular cystic lesions towards the caudal aspect of the liver measuring 3.16 cm and 3.81 cm. On the right side more cranially there is a complex cystic lesion measuring 2.71 cm x 2.21 cm.



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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 cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains mild to moderate fluid. 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 uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. Bowel loops follow a typical curvilinear path with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.37 cm. Jejunum wall measures 0.25 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. 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/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

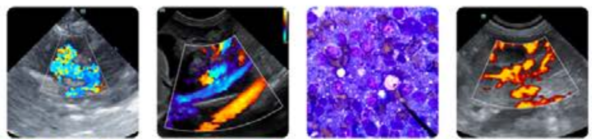
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

PRIMARY FINDINGS

- Diffusely thickened bladder wall – Findings are most consistent with cystitis (sterile versus bacterial). A neoplastic process cannot be ruled out.
- Age related changes visualized associated with both kidneys.
- Mildly heterogeneous liver with too numerous to count irregular, cystic parenchymal lesions – Findings are most consistent with cystadenomas or cystadenocarcinomas.
- Diffusely prominent muscularis layer in some sections of small bowel with segmental thickening – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.

SECONDARY FINDINGS

- Hyperechoic splenic lesions most consistent with benign myelolipomas – Recommend continued monitoring.
- Pancreatic changes most consistent with chronic pancreatic remodeling.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The wall thickening visualized is diffuse and most consistent with cystitis. No focal lesions were observed.

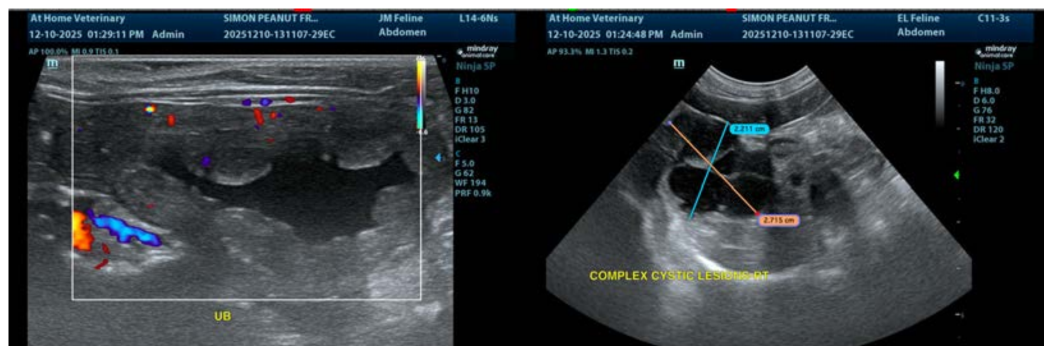
- Urinalysis and culture are recommended.
- Due to the diffuse nature of the lesion, interstitial cystitis is suspected (if culture is negative)
- Treatment of FIC can be frustrating as it is a waxing and waning disease. Treatment strategies vary and there is no "one fits all" approach. There is currently 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.

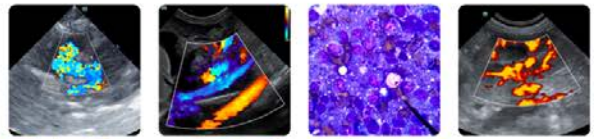
Although this is a diffuse lesion, an underlying neoplastic process cannot be ruled out. If there is no response to therapy, a biopsy of the bladder wall may be warranted.

Additionally consider reevaluation of the bladder when the patient is feeling better to reassess if the wall thickening resolves.

There are numerous variably sized irregular (sometimes complex) cystic lesions visualized in the liver. These have the appearance most consistent with cystadenomas or cystadenocarcinomas. Based on the relatively diffuse nature of these lesions, I suspect surgical resection would be unlikely. If there was a focal area that was thought to be causing discomfort, etc., a contrast CT scan could be considered to determine if surgical intervention is an option.

The small intestine appears mildly diffusely thickened with a prominent muscularis layer. The significance of this in the absence of underlying gastrointestinal symptoms is uncertain. If gastrointestinal symptoms develop, weight loss, etc., then further evaluation for an underlying enteropathy may be warranted.





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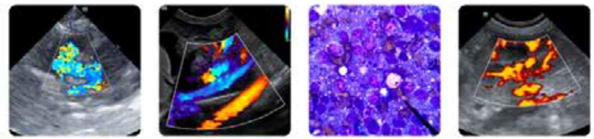

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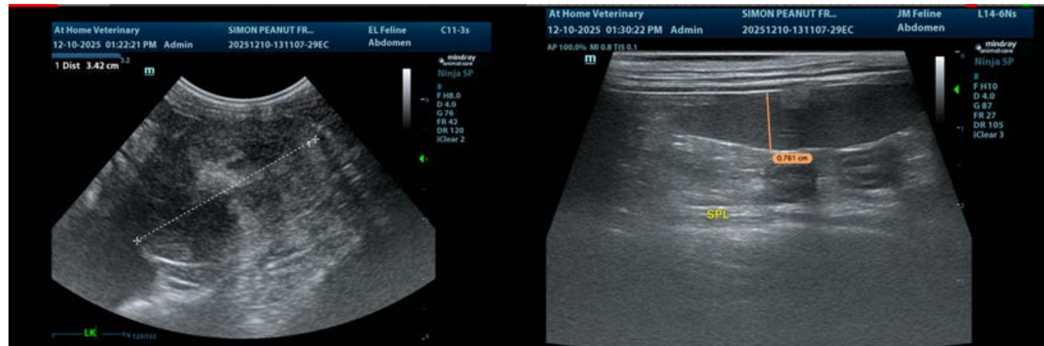

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com