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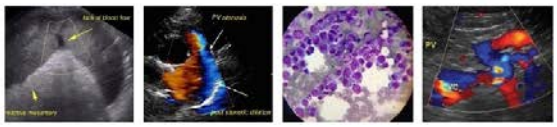

THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Royce Stan

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

15 Years

WEIGHT

7.18 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Buck Animal Hospital

REFERRING VET

Dr. Gilmer

INVOICE

44685

DATE

2/2/23

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: 1/30/23 presented for leaking bloody urine, not eating as well, low energy, UTI diagnosed 2/1/23 Lethargic, going in litter box but no urine, dripping urine, partial blockage (will urinate when bladder expressed, but not on own). X-rays done, possible lesion at neck of bladder 2/2/23 urinated a few drips, small stream can be expressed Current Medications Prazosin 1mg @10:30am (Feb 2), Slow-release Buprenorphine Feb 1 @7:50pm, Dexamethasone 5mg IM (0.3 ml) Feb 1, Insulin 1 IU q12hr

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is severely distended with mildly echogenic urine. The Bladder wall appears focally thickened at the level of the cystourethral junction with a mass effect measuring approximately 2.07 cm x 4.72 cm. This lesion falls at the cystourethral junction and appears to either obstruct or invade into the proximal urethra. The remaining urinary bladder wall appears normal with no evidence of additional mass lesions. No calculi are observed.

The left kidney has a normal shape and size (4.24 cm) with mild hydronephrosis with renal pelvis measuring 0.83 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.92 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 0.52 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 region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

Spleen

The spleen is subjectively normal in size, 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.

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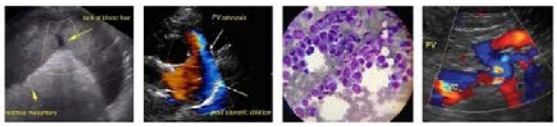

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Gastrointestinal

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. Jejunum wall measures 0.30 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 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

- Large obstructed urinary bladder with a mass effect at the cystourethral junction – The thickened mass effect is most concerning for a neoplastic lesion. There is possible invasion into the proximal urethra, but this is not definitive. Transitional cell carcinoma would be the primary differential, but other possibilities exist.
- Mild hydronephrosis of the left kidney – This is likely due to ureteral obstruction at the level of the urinary bladder by the mass effect.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a thickened irregular mass effect at the level of the cystourethral junction that appears to be causing the obstruction noted. The most likely differential is a transitional cell carcinoma, although other differentials exist. Options for obtaining a more definitive diagnosis would include cytology on a catheterized urine sample if it is highly cellular, a traumatic catheterization, or surgical biopsies. You could consider a transabdominal fine needle aspirate, but there is significant risk of tracking neoplasia across the body wall.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.

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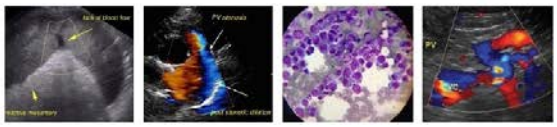

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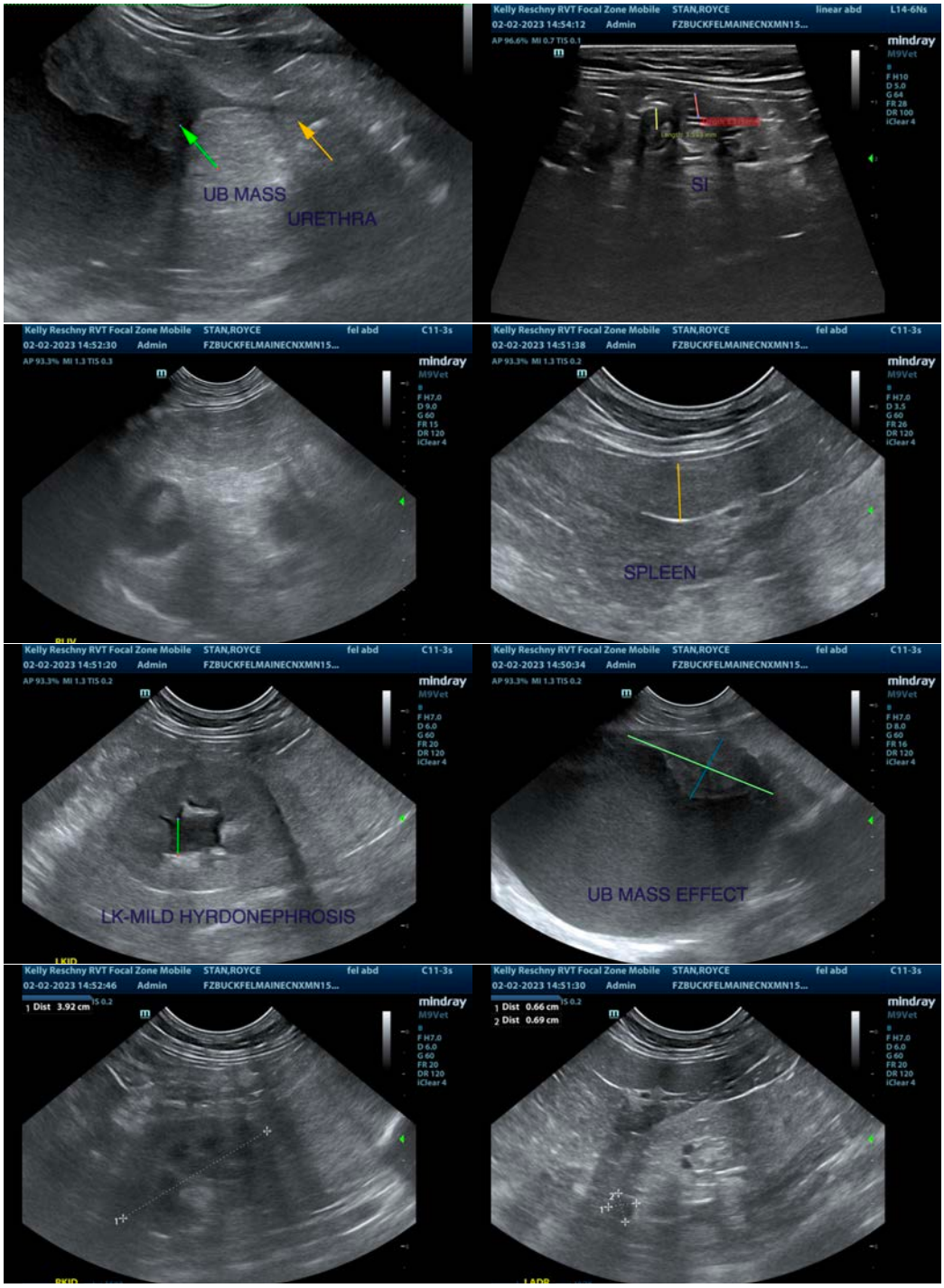

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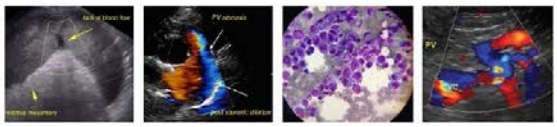

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

kathleen.sennello@sonopath.com