



**PATIENT PRESENTING CLINICAL SIGNS**

Wylie Adams blocked-FLUTD, soft tissue opacity at the bladder trigone on rads meds: cartrophen, metacam.

**SPECIES ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Feline Urinary System**

The urinary bladder is moderately distended with anechoic urine. The Bladder wall is diffusely thickened and slightly irregular, measuring 0.38 cm in thickness. There is a small amount of mineralized shadowing debris consistent with sandy debris in the dependent portion of the urinary bladder. Thickening is diffuse and extends to the level of the proximal urethra. There is a questionable opacity within the distal urethra, consistent with a possible urinary catheter(?). No discrete masses are observed. The trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

**BREED**

DSH

**SEX**

Neutered Male

The left kidney has a normal shape and size (5.02 cm) with two non-obstructive nephroliths and pyelectasia at 0.57 cm. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

**AGE**

10 Years

The right kidney has a normal shape and size (5.11 cm) with non-obstructive nephroliths. Overall echogenicity is slightly hyperechoic with poor 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, infarcts or hydroureter. Renal vasculature is normal.

**WEIGHT**

5.1 kg

**Adrenal Glands**

The left adrenal gland is normal in size measuring 0.31 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.

**INTERPRETED BY**

Kathleen Sennello DVM,  
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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.

**IMAGING PERFORMED BY**

Kelly Reschny

**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.

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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.

**REFERRING VET**

Dr. Morris

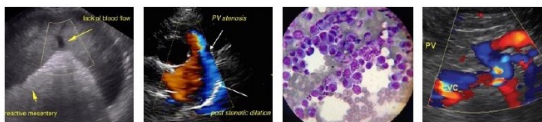
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The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

**DATE**

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**PATIENT**

**Gastrointestinal**

Wylie Adams

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.

**SPECIES**

Feline

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.

**BREED**

DSH

**SEX**

Neutered Male

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**

**AGE**

10 Years

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**

**WEIGHT**

5.1 kg

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 generally of normal echogenicity, but there is some increase in echogenicity around the urinary bladder neck, and a scant wisp of edematous tissue/fluid.

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**ULTRASONOGRAPHIC FINDINGS**

- Diffusely thickened urinary bladder wall with a small amount of sandy debris – Findings are most consistent with cystitis (bacterial or sterile). Underlying neoplasia cannot be 100% excluded, but seems unlikely.
- Decreased corticomedullary distinction in both kidneys with non-obstructive nephroliths and pyelectasia in the left kidney – Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. Pyelectasia of the left kidney could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.
- Area of inflamed/edematous mesentery near the cystourethral junction – The significance of this is unclear. It could be secondary to obstruction, associated inflammation, or trauma due to catheterization(?).

**IMAGING PERFORMED BY**

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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.

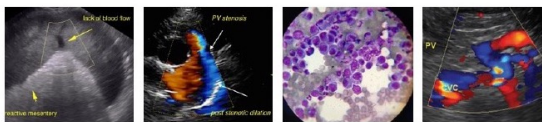
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- Urinalysis and culture are recommended.
- Due to the diffuse nature of the lesion, interstitial cystitis is suspected (if culture is negative).
- Treatment of FIC can be frustrating as it is a waxing and waning disease. Treatment strategies vary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



**PATIENT**

Wylie Adams

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.

**SPECIES**

Feline

- 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.

**BREED**

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- If symptoms are worsening re-evaluation with ultrasound should be considered.

**SEX**

Neutered Male

Additionally, there are chronic changes in the kidneys, and nephroliths. The left kidney should be monitored for progressive dilation, as it is possible that a stone could be causing a partial obstruction. Recommend blood pressure evaluation.

**AGE**

10 Years

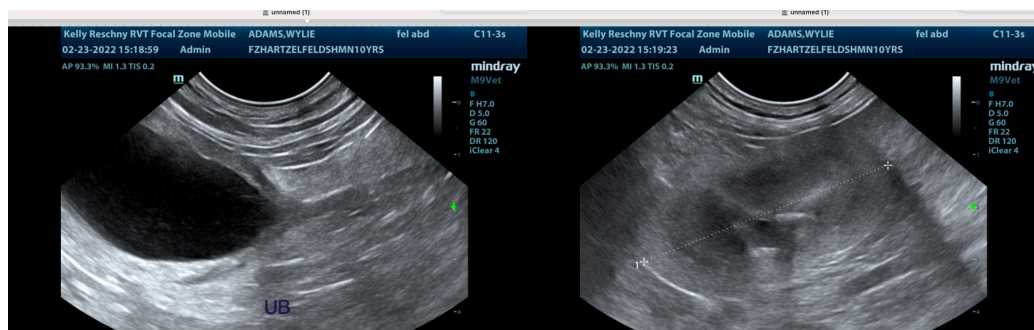
The significance of the inflammatory tissue around the urinary bladder is unknown. This could be associated with the recent episode of inflammation(?), recent catheterization(?), etc. You could consider instilling contrast material into the urinary bladder and looking for any evidence of a wall defect, etc. I suspect the area of inflammation is the abnormal lesion observed on radiographs.

**WEIGHT**

5.1 kg

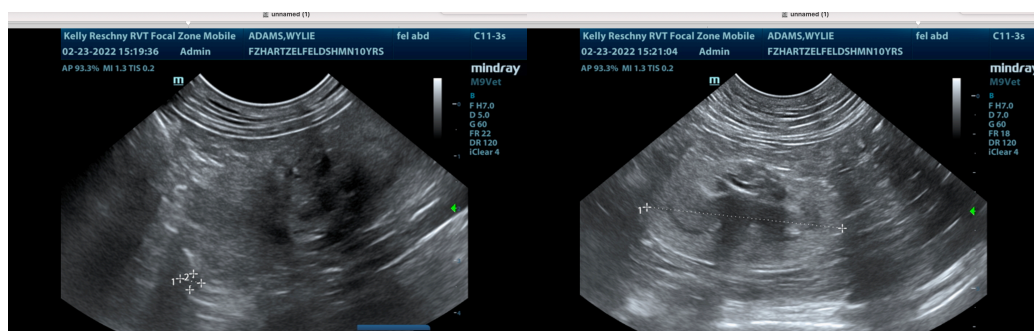
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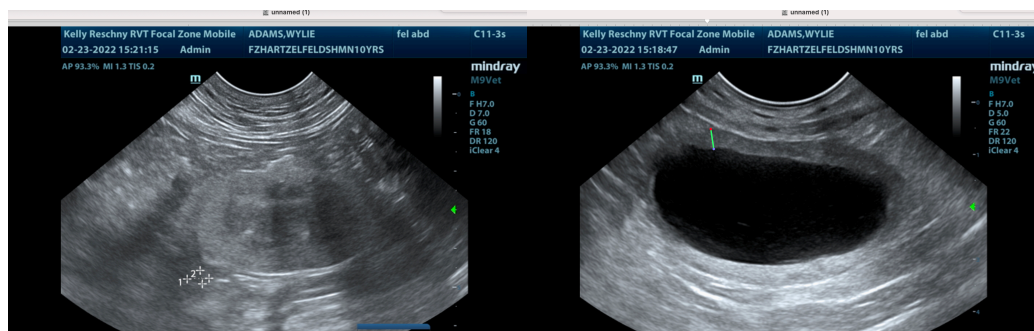


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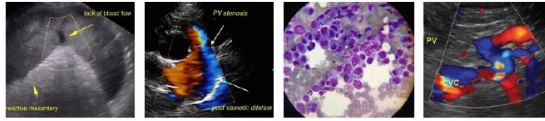


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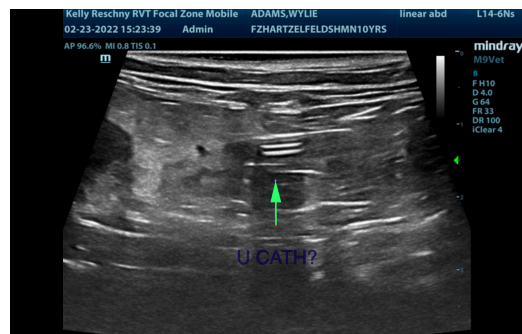
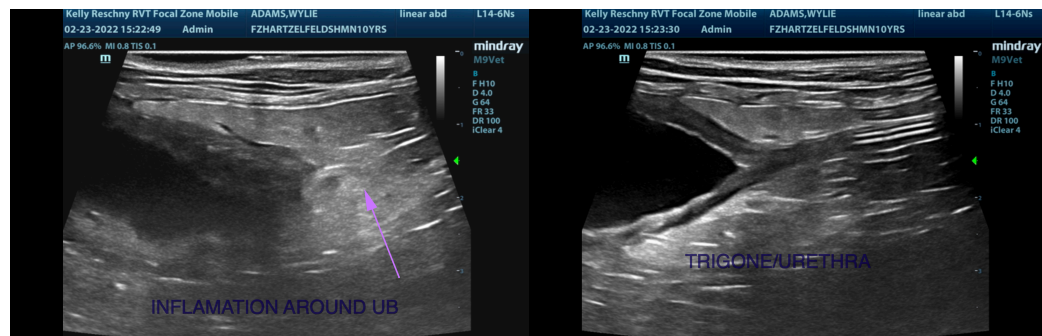
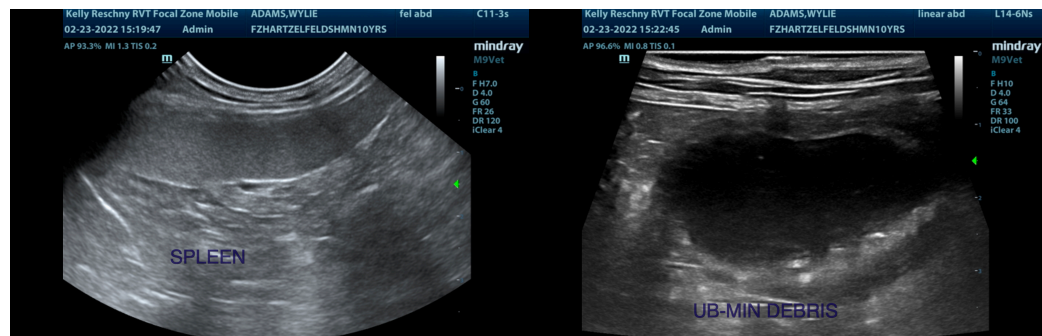
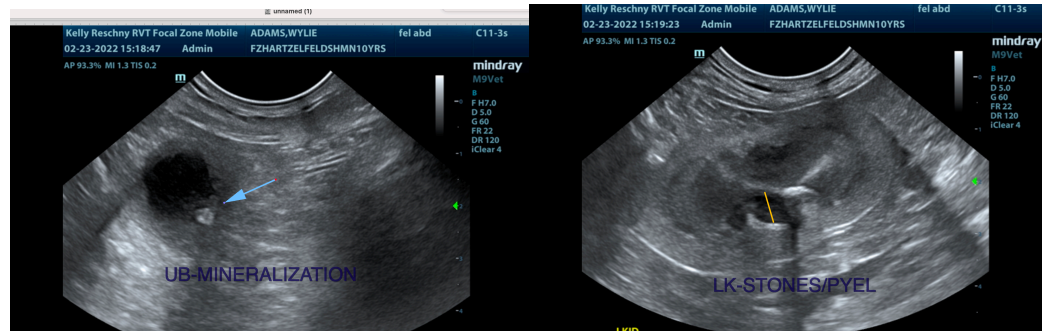
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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