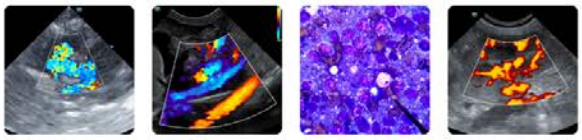


PATIENT

Sally Haigh

SPECIES

Feline

BREED

DLH

SEX

Spayed Female

AGE

19 Years

WEIGHT

7.3 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

SAGE Veterinary Clinic

REFERRING VET

Dr. St. Hill

INVOICE

75178

DATE

5/14/26

PRESENTING CLINICAL SIGNS

No sedation-Urinary issues, O states for the past 3 months P is having UTI. P was straining to urinate and had blood in her urine. O took P to Peak Pet. Urgent care on Tuesday last week. Vomited Saturday 3 times and then again sunday morning. Sally, a 19-year-old female cat, presented for evaluation of recurrent episodes of gross hematuria. The client reported that last Tuesday, Sally began leaving bloody urine throughout the house. This has occurred on 3 separate occasions over the last 2-3 months.

Historical Conditions: Sally has a history of similar urinary episodes and was evaluated in December and March. A urine culture performed in March showed no bacterial growth. Bloodwork results from Blue Pearl, dated March 17, 2026, were reviewed. The results indicate stable kidney function consistent with Stage 1 Chronic Kidney Disease.

Drinking/Urination: During episodes, the client observes Sally making frequent trips to the litter box. She then postures on the floor and leaves a pool of bloody urine when she moves. The client has noted a distinct pattern where the hematuria and urinary leakage resolve completely after Sally urinates at a veterinary facility, prior to the administration of any medication.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall appears mildly thickened with a smooth mucosal surface. There is more pronounced thickening in the ventral wall where it measures up to 0.37 cm. The region of the trigone, ureteral papillae, and proximal urethra appear free of any mass lesions or calculi.

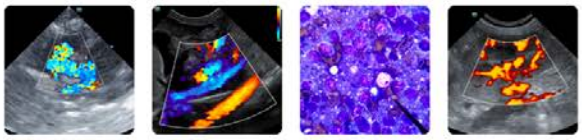
The left kidney has a normal shape and size (3.27 cm) with mild pyelectasia at 0.11 cm. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of nephroliths or infarcts. Visible/mildly dilated ureter noted at 0.19 cm. Renal vasculature is normal.

The right kidney has a normal shape and size with pyelectasia at 0.31 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 a nephrolith visualized measuring 0.56 cm x 0.23 cm with surrounding fluid (associated with the renal pelvis), and proximal ureteral dilation at 0.29 cm. There is a small shadowing ureterolith visualized in the proximal ureter measuring 0.33 cm. Distally at the level of the urinary bladder there is a smaller stone visualized measuring 0.27 cm (ureter measures 0.28 cm distally). There is no evidence of infarcts. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.33 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 XX 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.



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Spleen

The spleen is subjectively normal in size (0.77 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 but slightly irregular in shape. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. On the left side of the liver the liver lobe appears prominent and rounded in the dorsocaudal region. This could represent an isoechoic mass effect or an anatomic abnormality.

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 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 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 0.33 cm. Jejunum wall measures 0.26 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 left limb of the pancreas is prominent and hypoechoic as compared to the surrounding isoechoic 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. No significant lymphadenopathy. The omentum is generally normal in echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Decreased corticomedullary distinction in both kidneys with mild bilateral pyelectasia and ureteral dilation. There is a nephrolith visualized in the right kidney as well as two ureteroliths. Findings are consistent with intermittently obstructive nephrolithiasis and chronic renal disease.

- Pancreatic changes most consistent with chronic pancreatic remodeling.

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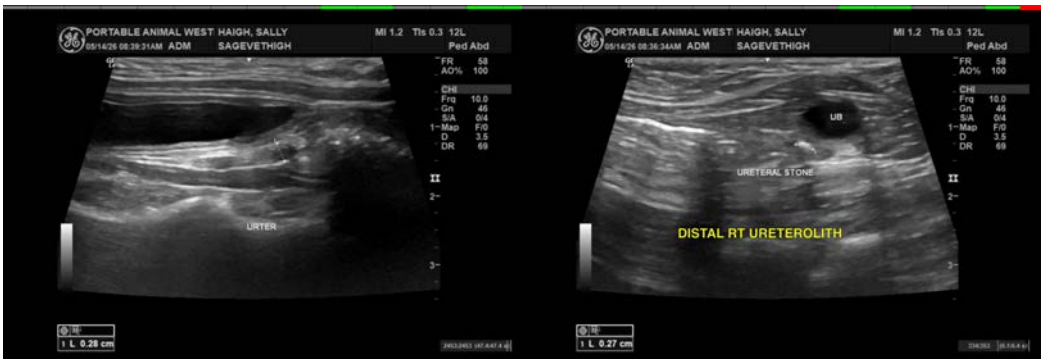
- Rounded left region of the liver – This could represent an anatomic abnormality or an isoechoic mass effect. Consider a fine needle aspirate.
- Diffusely thickened small intestine with a prominent muscularis layer – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.
- Mildly thickened bladder wall with ventral irregularity – Findings are suggestive of cystitis type changes. A neoplastic process is thought less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Both kidneys have mild dilation of the renal pelvis and ureters. There is a stone in the right kidney with two small ureteroliths. Based on this presentation and the history provided, the suspicion would be that this individual is intermittently passing stones into the urinary bladder and then passing stones through the urethra, causing a partial intermittent obstruction. Correlate findings with urinalysis and culture results. Consider modifying the diet to increase fluid intake and possible pain medications if discomfort arises with close monitoring for any evidence of a complete obstruction. Additional dietary management may be warranted if the stone type can be identified.

The left side of the liver appears irregular and rounded. The significance of this is uncertain. Consider continued monitoring +/- a fine needle aspirate of the left rounded lobe.

The small intestine appears diffusely thickened with a prominent muscularis layer. Correlate with clinical signs, as this could be consistent with inflammatory GI disease. You could consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate for further evaluation. Ultimately, empirical therapy could be considered if this is symptomatic, and/or biopsies of the GI tract to definitively diagnosis.



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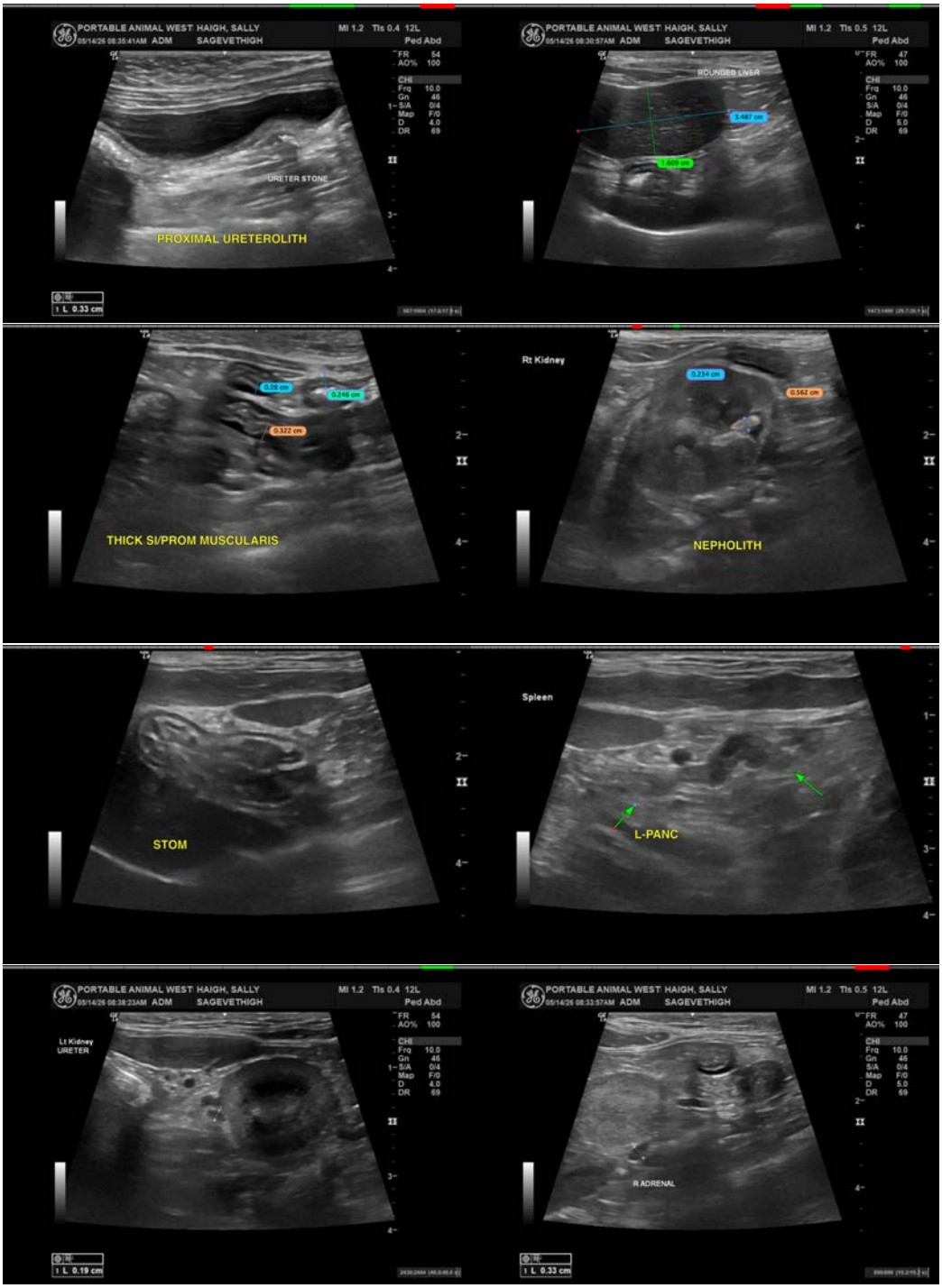

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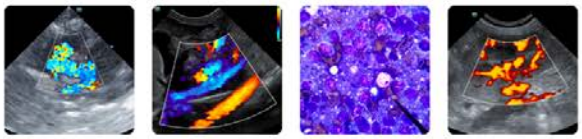

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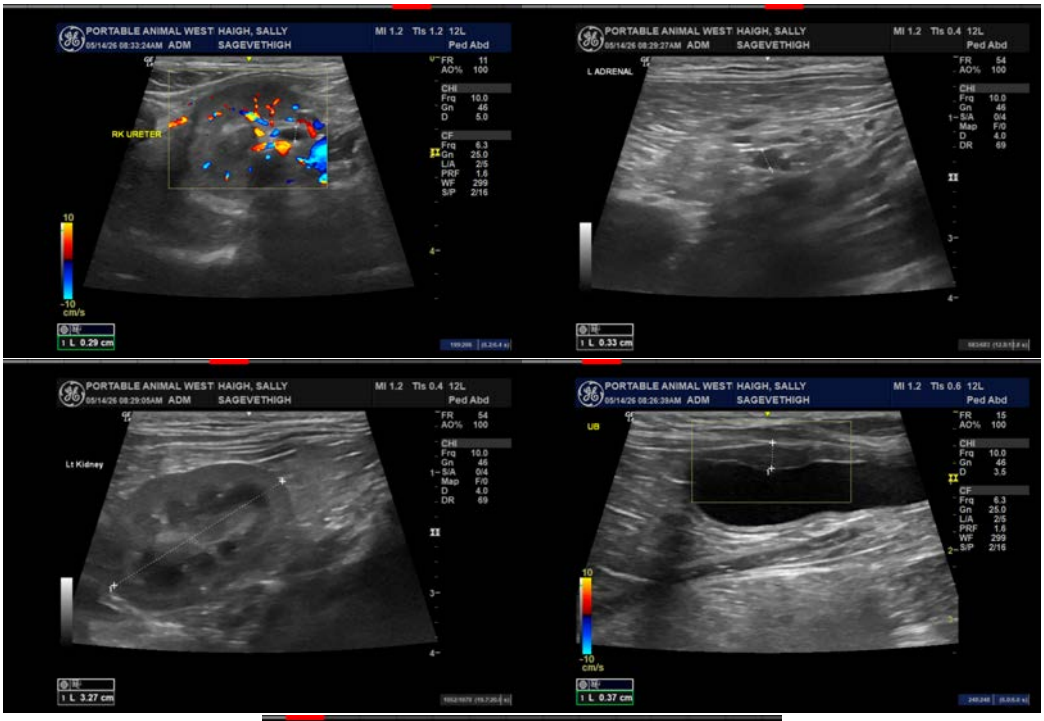

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com