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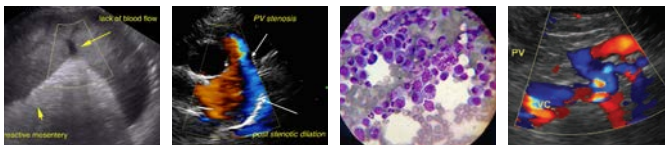
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com™
1-800-838-4268 info@sonopath.com

PATIENT

Maisy Margolis

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

9

WEIGHT

12.19

INTERPRETED BY

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

IMAGING PERFORMED BY

Elaina Petrone

HOSPITAL NAME

Long Branch AH

REFERRING VET

Dr. Elizabeth Griffin

INVOICE

43112

DATE

6/13/23

PRESENTING CLINICAL SIGNS

April 2023 - presented for hematuria, stranguria, and inappropriate urination. Responded to abx and NSAIDs. Presented end of May for similar issue. Urine MIC - enterococcus, starting Clavamox.

Abnormal PE/Chem/CBC/UA Results: UA/Urine MIC attached

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mild primarily suspended echogenic debris and some dependent shadowing/sandy 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, sandy debris or small calculi. Correlate findings with abdominal radiographs, urinalysis and culture.

The left kidney has a normal shape and size (3.7 cm). Overall echogenicity is slightly hyperechoic with mildly reduced 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 (4.11 cm). Overall echogenicity is slightly hyperechoic with mildly reduced 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 region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

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.

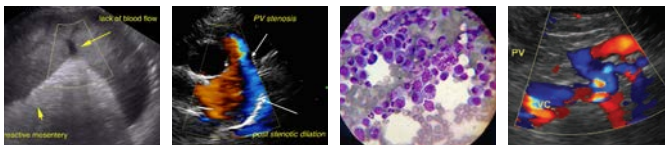
Spleen

The spleen is borderline large in size (1.1 cm) with a scalloped edge. Echotexture is homogenous. The blood flow through the hilus and splenic parenchyma appears normal. There are occasional small hyperechoic foci visualized in the parenchyma, examples of which measure at 0.20 cm and 0.25 cm.

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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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 0.20 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.

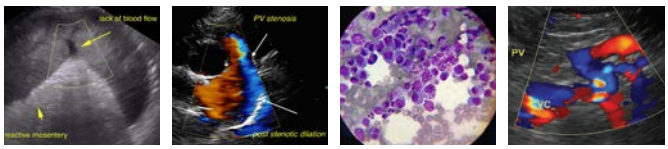
ULTRASONOGRAPHIC FINDINGS

- Suspended and dependent shadowing debris visualized within the urinary bladder – Findings are most consistent with sandy debris/small stones.
- Mildly reduced corticomedullary distinction – The bilateral renal findings are consistent with age-related change.
- Subjectively mildly large, scalloped spleen with hyperechoic foci – This could be within normal limits for a larger cat. Differentials could include congestion, infiltrative disease, etc. The appearance of the hyperechoic nodules trends towards a benign process. Consider a fine needle aspirate if the cat is systemically not doing well.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a large amount of suspended echogenic debris present, and a small amount of shadowing dependent sandy debris visualized in the urinary bladder. This likely contributes to some of the pollakiuria and stranguria described. Correlate findings with a urinalysis to try and determine if crystals are present to help identify the nature of the debris. No focal mass lesions are observed to explain the recurrent urinary tract infections. Consider treatment of the urinary tract infection and reevaluation to determine if the debris is persistent. If it is persistent, you could consider catheterization to try and flush out the urinary bladder and obtain samples. This is unlikely to be obstructive in a female.

Enterococcus bacteria is typically associated with chronic systemic antibiotic use. If this is not the case in this individual, recommend a culture and a cystocentesis sample to confirm, and recommend starting probiotic therapy (always space probiotics from antibiotics by at least two hours), and consider any other predisposing factors that could be contributing to urinary tract infections (renal disease, diabetes, spinal disease, etc.). Enterococcus infections are often very difficult to treat. If the patient is not



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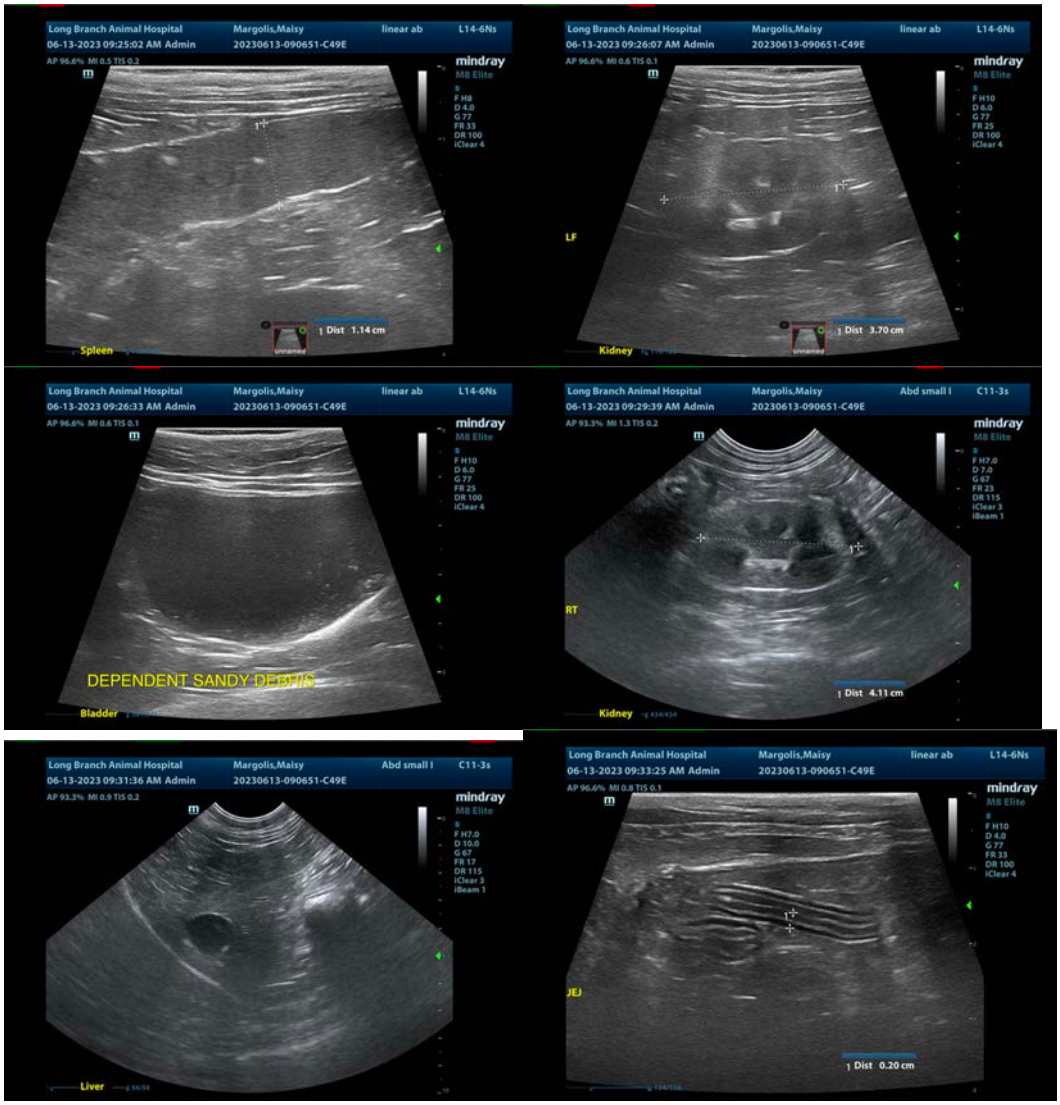
exhibiting clinical signs in the future, but an enterococcus infection is identified, consider close monitoring in hopes that the infection transfers over to a less resistant bacteria.



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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