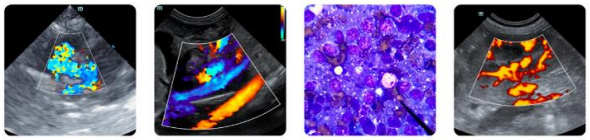


PATIENT

M Baur

SPECIES

Feline

BREED

DSH

SEX

SF

AGE

13 years, 9 months, 3 weeks old

WEIGHT

4.37 kg

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Dr. Jill Rankin

HOSPITAL NAME

Bridgeland Vet Clinic

REFERRING VET

Dr. Rachel

INVOICE

10650

DATE

2/24/26

PRESENTING CLINICAL SIGNS

History:

- This patient is a cat with a history of managed asthma, progressing chronic kidney disease (CKD), and a recently suspected bladder mass noted during an evaluation for weight loss.
- The asthma was diagnosed via x-rays, which confirmed inflammatory airway disease after the cat was observed to have labored breathing. The owner noted this breathing pattern was chronic. Initial treatment involved a short course of steroids, followed by daily fluticasone and a salbutamol rescue inhaler. For the first one to two months of treatment, both inhalers were used daily. The patient's condition has since improved, and she no longer requires salbutamol. Currently, she exhibits increased respiratory effort only when stressed and breathes normally at home. Chest x-rays taken at the time of diagnosis revealed a normal heart.
- The patient has a history of weight loss, which prompted blood work. While hyperthyroidism was ruled out due to normal thyroid levels, the results indicated a progression of her chronic kidney disease from Stage 1 to a stable Stage 2. During a scan, a possible mass was visualized in the bladder, though the owner reports no urinary signs at home

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

A sessile-based ventral mass extending mildly into the urinary bladder lumen was present with asymmetrical contour and nonhomogeneous parenchyma with hyperechoic parenchyma foci, consistent with focal mineralization. Blood flow was confirmed within the mass, measuring ~1.6 cm in diameter. The urethra exhibited normal structure and tone to a depth of 3.0 cm. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal.

No evidence of pathology in the area of the aortic trifurcation.

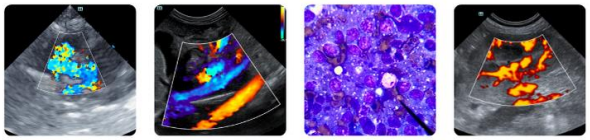
Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild to moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Bilateral mild pyelectasia was present. The left kidney measured 3.4 cm in length. The right kidney measured 3.0 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.37 cm width. No overt pathology was noted in the area of the right adrenal gland.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.



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Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. Normal hepatic vascular volume was present. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size containing primarily anechoic content with mild, nonorganized gallbladder debris. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild, primarily nonshadowing ingesta. Within the ingesta, a nonobstructive, mildly progressively shadowing density potentially suggestive of a small hairball was present, measuring 1.1 cm in diameter.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction, or foreign material. Segmental intestinal gas was noted without obstructive pattern to the level of the colon.

Normal visible colon wall layers were present with formed feces in lumen.

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

There was no significant omental lymphadenopathy. No evidence of peritoneal effusion was noted. Mineralized to mild nonhomogeneous nodule was noted in the mid-left abdomen in the area of the left adrenal gland, consistent with probable Bates body, measuring 0.6 cm diameter.

ULTRASONOGRAPHIC FINDINGS

- Urinary bladder mass – consistent with neoplastic criteria, i.e., transitional cell carcinoma
- Chronic renal changes exhibiting pyelectasia
- Mild nonshadowing gastric ingesta with possible small nonobstructive hairball-type density
- Mild gallbladder debris
- Probable small Bates body – benign

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Cytospin cytology of free catch urine sample to assess for atypical or neoplastic transitional cells is recommended. No overt regional lymphatic metastasis was noted. Potentially, the mass may be amenable to surgical resection, given the ventral wall location.

The pyelectasia in both kidneys may be owing to chronic renal changes, potential pelvic scarring possibly owing to previous calculi passage, IV fluid therapy (if applicable). Urine C/S and protein: creatinine ratio on a sterile urine sample is recommended. CKD therapy with monitoring of renal parameters is recommended.

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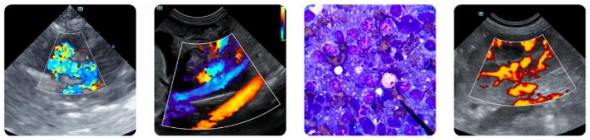

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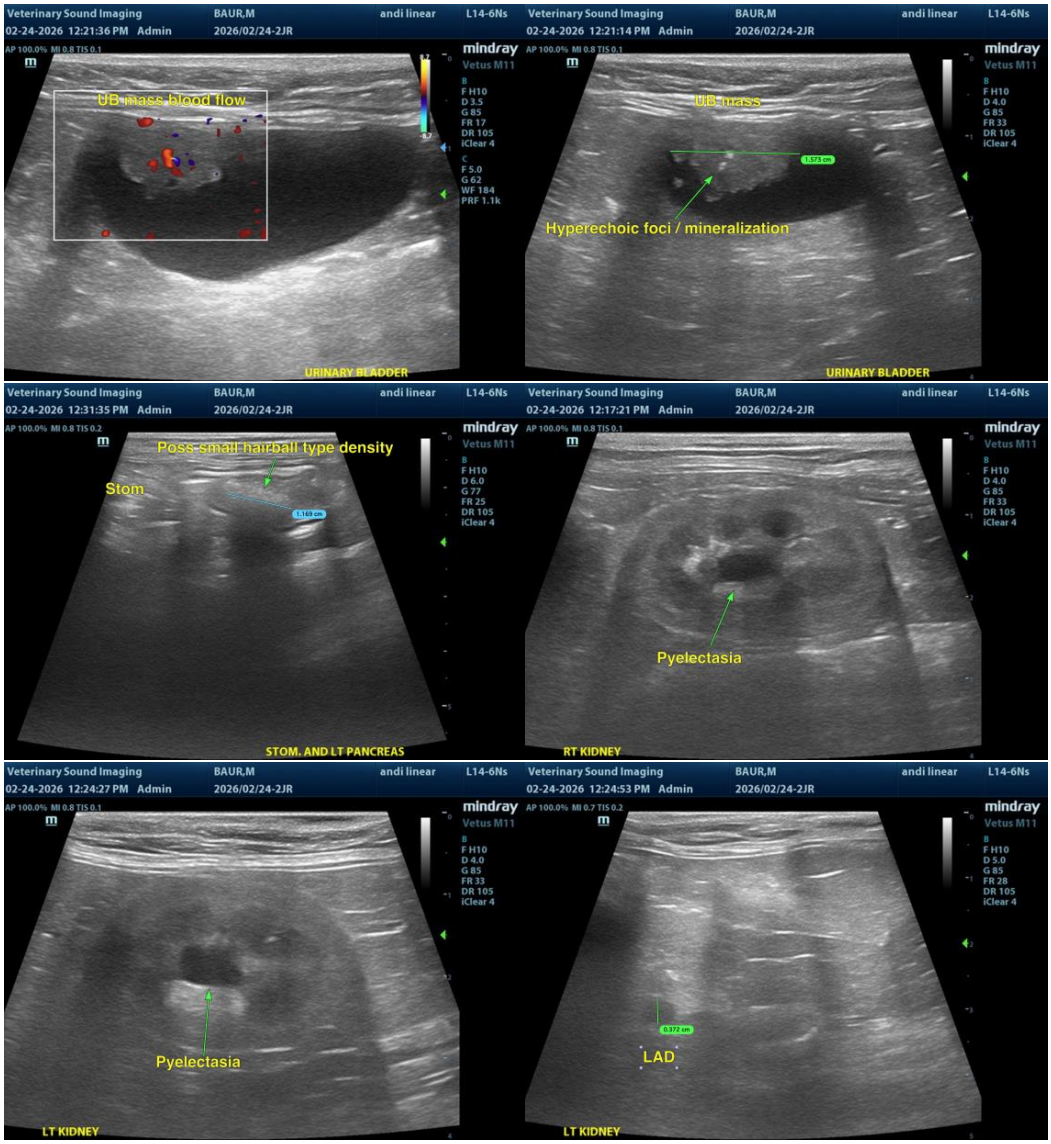

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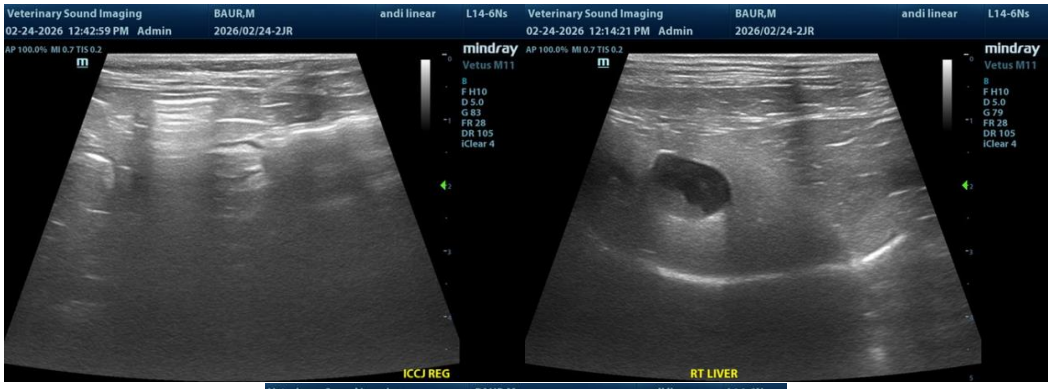

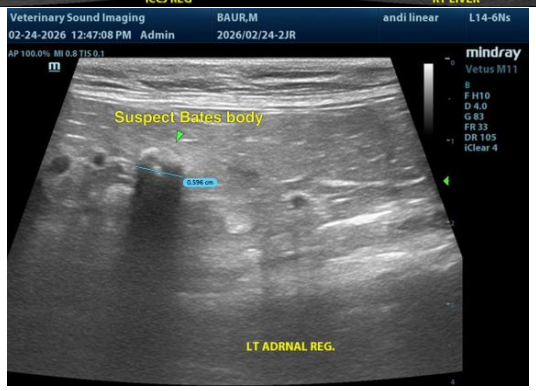

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
info@sonopath.com