

PATIENT

Wasabi Soule

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

09/01/09

WEIGHT

3.8 kg

INTERPRETED BY

R. McKenzie Daniel,
DVM, DABVP (Canine
/ Feline Practice)

**IMAGING
PERFORMED BY**

Loetitia Saint-Jacques,
LVT

HOSPITAL NAME

Incline Veterinary
Hospital

REFERRING VET

Dr. Kateryna Sovik
DVM

INVOICE

14375

DATE

03/16/26

PRESENTING CLINICAL SIGNS

- History of IBD, managed with a transdermal prednisolone pen for years.
- History of stress-related cystitis noted in previous records.
- Client's severe cough has been disrupting the patient's sleep at night for the past month
- Gross hematuria noted by client since Friday 03/06/2026, with large bloody spots in the litter box and on the client's comforter.
- Client reports the hematuria is less severe today than on Friday.
- Exhibiting signs of urinary discomfort: pollakiuria, stranguria, circling the litter box, and periuria.
- Lethargic since Friday 03/06/2026.
- Hiding in the guest room instead of her usual spot by the fireplace.
- Abdominal Ultrasound was recommended to evaluate bladder wall thickening and rule out neoplasia.
- Working diagnosis
- Hematuria, pollakiuria, periuria - r/o feline idiopathic cystitis, urinary tract infection, urolithiasis, kidney injury, urinary bladder/kidney neoplasia, other

Abnormal PE/Chem/CBC/UA Results: RETIC 2.8 3.0 - 50.0 K/ μ L LOW NEU 13.20 2.30 - 10.29 K/ μ L HIGH LYM 0.86 0.92 - 6.88 K/ μ L LOW MONO 0.97 0.05 - 0.67 K/ μ L HIGH MPV 9.7 11.4 - 21.6 fL LOW GLU 190 71 - 159 mg/dL HIGH BUN 47 16 - 36 mg/dL HIGH GGT 6 0 - 4 U/L HIGH K 3.0 3.5 - 5.8 mmol/L LOW MEDS_ prednisolone

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 1.0 cm exhibited normal thickness and tone. 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 inflammatory or neoplastic change were noted.

The area of the aortic trifurcation was free of pathology.

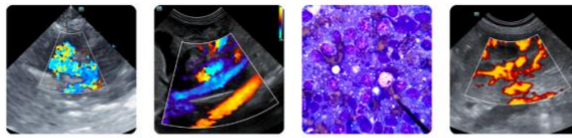
Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Areas of mild medullary dystrophic mineralization was present with mild right kidney pyelectasia. The left kidney measured 3.1 cm in length. The right kidney measured 3.1 cm in length.

Adrenal Glands

The adrenal glands were subnormal in size likely secondary to chronic Prednisone therapy. The right adrenal gland measured 0.29 cm width. The left adrenal gland measured 0.29 cm width.

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



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thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver & Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mild nonuniform and hypoechoic to the spleen with a mild coarse echotexture and subjective mild parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. A solitary discrete nonhomogenous noncapsule deforming nodule was present adjacent to the gallbladder measuring 0.61 cm in diameter.

The gallbladder was non distended in size with mild nonorganized biliary sludge. The proximal common bile duct was dilated and tortuous without overt post hepatic obstruction. Mild proximal common bile duct mucus/sediment was present.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

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.

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

Pancreas

The pancreas presented variably to moderately enlarged with capsule asymmetry and nonhomogenous hypoechoic to nodular parenchyma. Prominent pancreatic duct.

Free Abdomen

No obvious visualized significant or swollen mesenteric lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Variably enlarged nonhomogenous nodular pancreas.
- Subtle nonhomogenous splenic nodule.
- Mild gallbladder and proximal common bile duct debris with nonobstructive proximal common bile duct dilation.
- Sonographically unremarkable gastrointestinal tract.
- Chronic renal changes exhibiting medullary dystrophic mineral and mild right kidney pyelectasia.
- Sonographically normal urinary bladder and visible proximal urethra.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of current cystitis criteria or lower urinary tract neoplastic criteria. Monitoring of urinalysis +/- renal staging to include culture/sensitivity or UPC level if non-inflammatory proteinuria is recommended. Conservative supportive care for mild idiopathic cystitis if lower urinary tract signs would be reasonable. Chronic to chronic active pancreatitis with remodeling is suspected.



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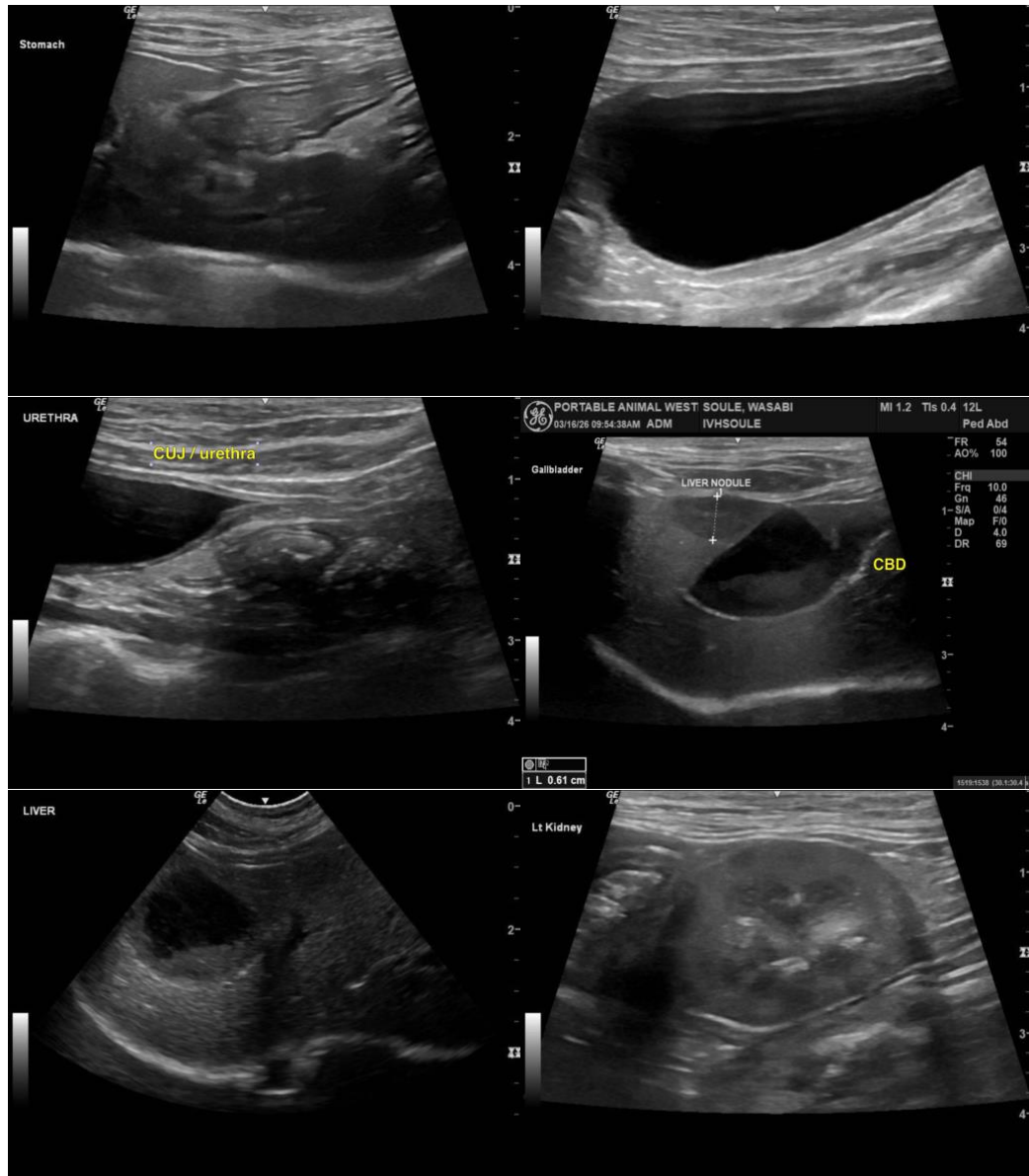
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The subtle liver nodule, likewise, suggests benign criteria, i.e. hyperplasia or small granuloma. Potential for pancreatic or emerging nodular hepatic neoplastic criteria is thought less likely yet not excluded. Chronic triad disease could be a consideration if previous or future hepatic enzyme elevations given short half-life of hepatic enzymes in cats.

Further assessment may include (assuming normal clotting status) screening pancreatic and hepatic +/- nodule FNA cytology. Screening GI panel to include PLI, TLI, cobalamin and folate may be considered.





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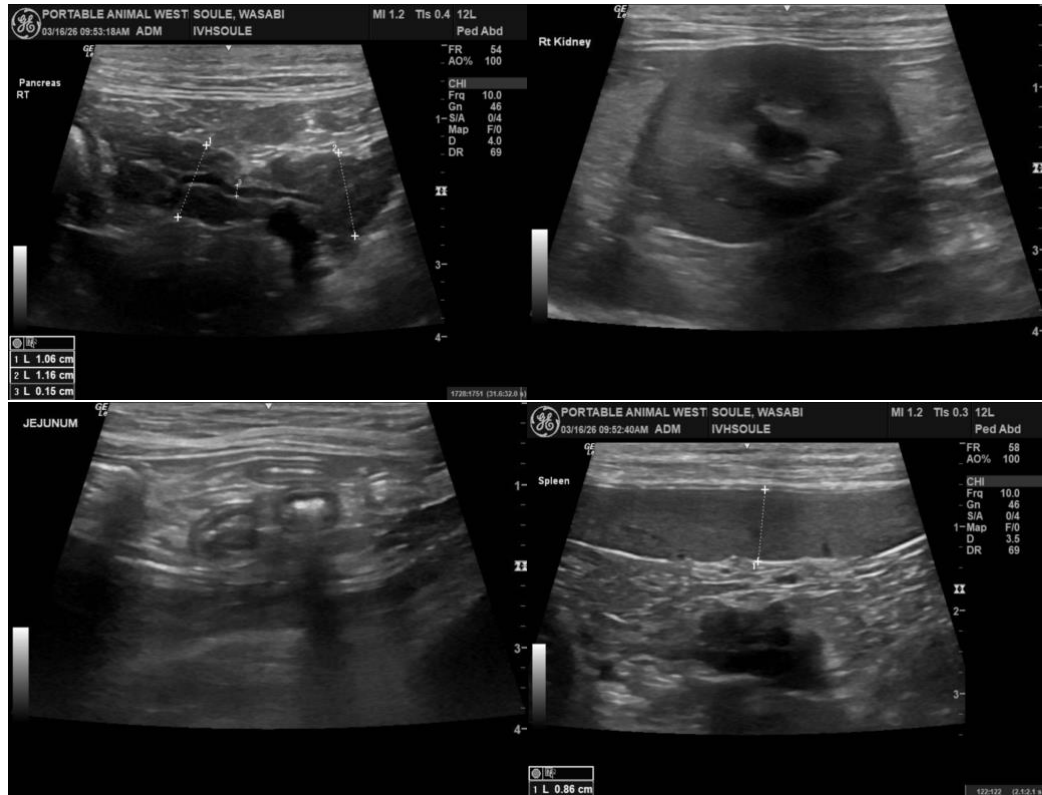
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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