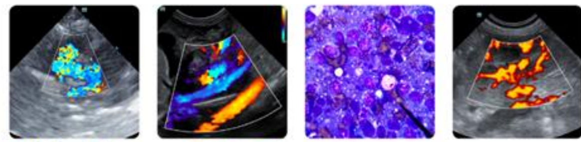

PATIENT
Ebby Reber

SPECIES
Feline

BREED
DSH

SEX
MN

AGE
5yr

WEIGHT
4.8kg

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

IMAGING PERFORMED BY
Renee Trionfetti, VMD

HOSPITAL NAME
Blue Pearl Wyomissing,

REFERRING VET
Blue Pearl Wyomissing,

INVOICE
24262

DATE
03/23/2026

PRESENTING CLINICAL SIGNS

- AUS to further evaluate a space occupying bladder lesion, hematuria, anemia (PCV 16%), persistent azotemia despite IVF. Currently hospitalized in the ER. Sick 1st time UO. Estimated ~5 YO MC DSH (outdoor cat). Currently ~48 hrs into hospitalization. Improved but persistent azotemia. Severe anemia. Concern for mass in bladder vs. large blood clot vs. other.
- Hosp mgmt: IV Fluids, Buprenorphine, Unasyn, Gabapentin tiny-tabs 50mg CP
- Abnormal PE/Chem/CBC/UA Results: 3/21/25 EPOC: Bicarb 13.7, iCal 0.65, BUN >120, Creat >15, Glu 99, K 8.6, Na 134, Lac 1.51 Chem: Cr 16.2, BUN >140, Glu 94, Phos >15, tbili 2.6 CBC: HCT 40.8, WBC 28.84k, Neuts 27.5k, Mono 0.83k, PLT 394k PCV/TS hosp trends: 44/8.2, 38/7, 29/7, 19/6.2, 16/6.8 FelV/FIV: neg radiographs: no stones noted AFAST: concern for large blood clot vs mass considered less likely causing firmness of bladder. can see ucath flushing in so do not suspect obstructed ucath at this time 3/23/25 PCV/TP @ 8 am = 16/6.8 EPOC = pH 7.350, cr2.16 (H), BG 129, BUN 61 (H), Na 164 (H), Cl 131 (H), iCa 1 (L)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was distended in size. A non-homogenous potentially focally cystic to cavitated lesion occupying the majority of the urinary bladder lumen was present. The lesion measured ~ 5.4 x 2.5 cm. Initial empty urinary bladder lumen. A catheter was present in the urethra and urinary bladder neck with infusion of saline. Mild to moderate dependent lumen to adhered mineral was present. Color Doppler assessment of the lesion did not overtly confirm intralesional blood flow with peripheral splash visualized. Subjective discernible ventral to apical urinary bladder wall adjacent to the lesion with urinary bladder wall width measuring 0.26 cm.

Mildly enlarged size and normal margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex. Minor left kidney pyelectasia. The left kidney measured 4.8 cm in length. The right kidney measured 5.1 cm in length.

No evidence of medial iliac or sublumbar lymphadenopathy or masses.

Adrenal Glands

The bilateral adrenal glands were overtly normal in size, position and shape. The left adrenal gland measured 0.35 cm width The right adrenal gland measured 0.35 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 thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted. The spleen measured 0.61 cm in width at the level of the mid spleen.

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Liver/Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. Normal vascular volume. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and mild non-organized 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 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 mechanical/metabolic ileus, obstruction or foreign material.

Normal visible colon wall layers were present with apparent 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

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

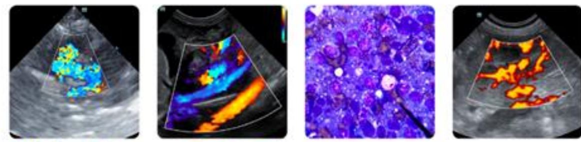
Primary

- Urinary bladder lesion occupying majority of the bladder lumen
- Mild dependent lumen to adhered urine sediment
- Normal visible proximal urethra structure /tone with urinary catheter
- Sonographically normal mildly enlarged kidneys with minor left kidney pyelectasia- no overt left or right hydroureter

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Considerations for the urinary bladder lesion may include significant inflammation, granuloma, expansive blood clot, hematoma, granuloma, neoplastic mass, FIP or other. Given the young age of the patient, lack of lesion blood flow on Doppler and subjective discernible adjacent urinary bladder wall, non-neoplastic lesion may be favored although transitional cell carcinoma, lymphoma or other neoplastic etiologies in conjunction with FIP is possible. Correlation with cytospin cytology of free catch urine sample to assess for atypical or neoplastic transitional cells in conjunction with urine C/S, leptospirosis titer/ PCR, CBC pathology review, clotting profile and recheck retroviral status are all warranted.

The kidneys are most consistent with acute nephropathy which may include infection or renal toxic insult. Continued renal and urinary support recommended with clinical and as needed sonographic



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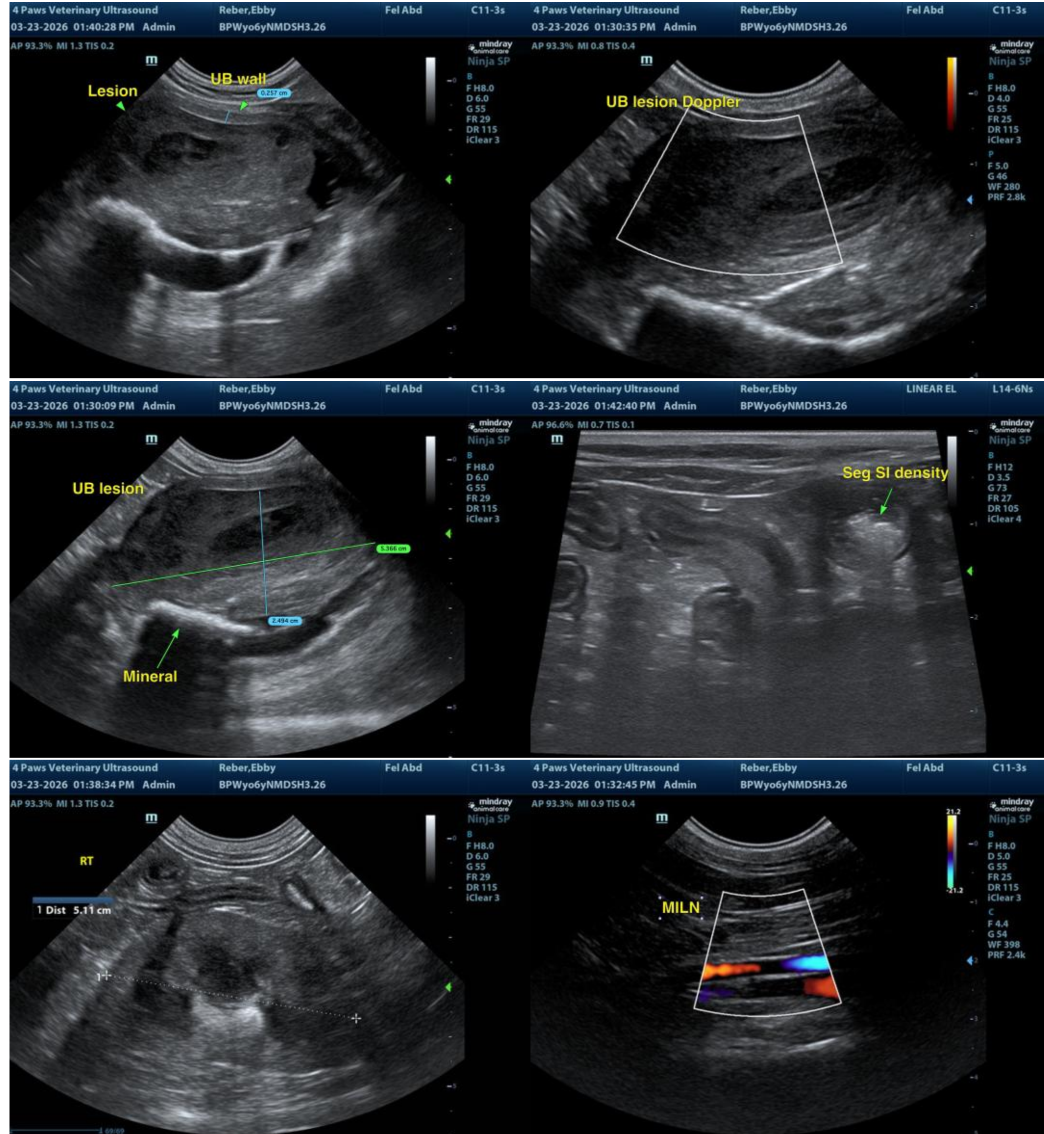
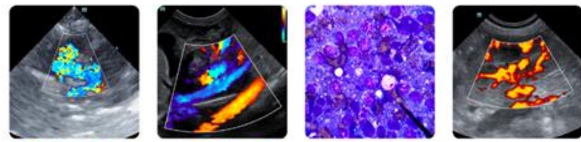
monitoring.





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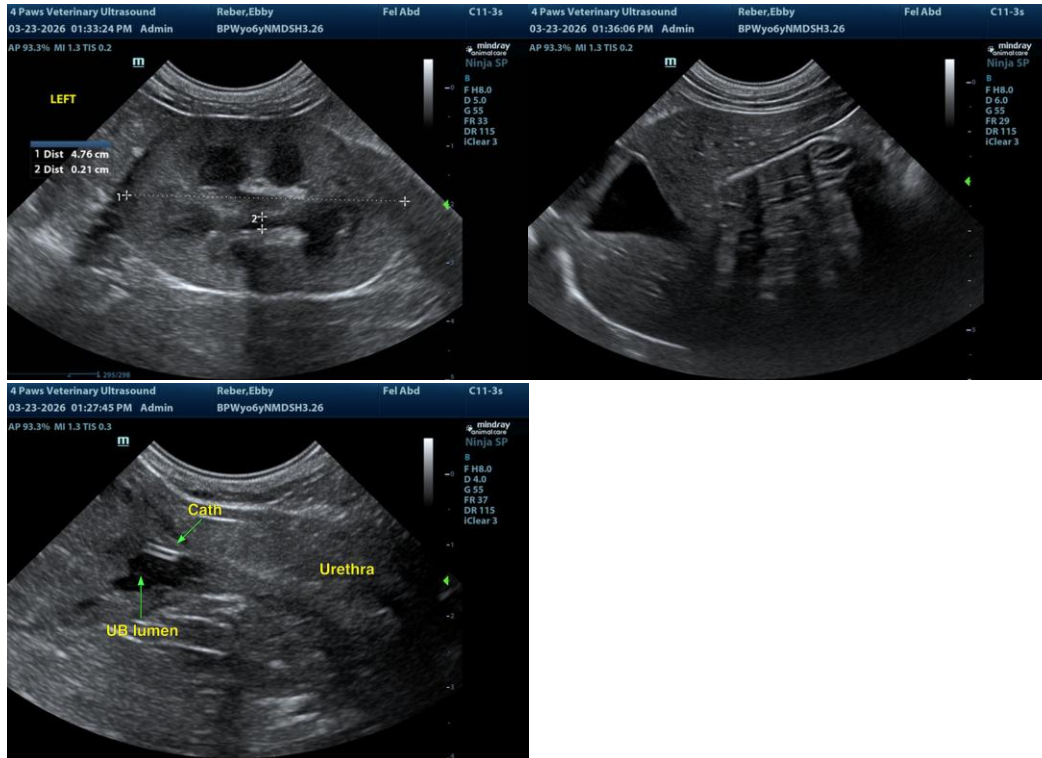

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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