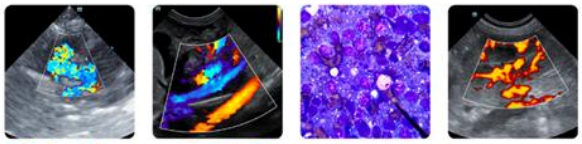


PATIENT

Alvin Roller

SPECIES

Feline

BREED

DMH

SEX

MN

AGE

9yr

WEIGHT

5.6kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Jessie Evoniuk

HOSPITAL NAME

State Avenue Vet Clinic

REFERRING VET

Dr. Jessie Evoniuk

INVOICE
24391

DATE
04/06/2026

PRESENTING CLINICAL SIGNS

Presented Thursday with cystitis and started medical management. Recheck Saturday with obstruction. Able to retropulse grit into bladder and placed Slippery Sam. Medical management, IV fluids/ urine outs monitored. Sunday AM removed U-cath and by afternoon re-obstructed. Replaced Ucath. Passing large amount of mucous

Abnormal PE/Chem/CBC/UA Results: Unkept appearance, QAR. No azotemia initially but now persistent. Thursday urine no bacteria, WBC 14/HPF, >50 HPF, Urine SpG 1.042, pH 6, urine protein 500. struvite <1/HPF, unclassified <1; Epi >10; BUN 32, Creat 2, Glc 208, K 3.4, T4 1.7, SDMA 11 4/4- BUN 102, Creat 6.8, Glc 170, K+ 4.5 4/5 BUN 52, Creat 3.4- removed U-cath that AM and continued fluids; by afternoon reobstructed (flushed bladder with saline, retropulse needed) 4/6- passing mucous. BUN 43, Glc 163,Creat 2.1, Alb 2.0, K 3.6, TP 5.3; urine WBC adn RBC >50. Suspected cocci and rod bacteria, epith 1-2, no struvite, pH 7, urine prot 30, SpG 1.018, pH 7 Started IV antibiotics, flushed bladder with saline.

LIMITED ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder initially mildly distended in size with suspect micturition or non-obvious catheterization during the ultrasound. Generalized mild thickened urinary bladder wall with maintained symmetrical luminal surface contour and homogenous mural echogenicity. Distended urinary bladder wall measured 0.35 cm wall width. Moderate non-dependent particulate urine sediment with concurrent moderate dependent lumen hyperechoic to shadowing sand / mineral present. No evidence of pathology at the level of the trigone or cystourethral junction. The proximal urethra was normal in structure with mild decreased tone to depth of 1 cm. Mild pericystic hyperechoic omentum consistent with mild pericystic inflammation was present.

Both kidneys were mildly enlarged in size exhibiting intact corticomedullary architecture and adequate corticomedullary border demarcation. Normal medullary volume. Bilateral mild pyelectasia. No evidence of left/ right retroperitoneal inflammation or effusion. No evidence of left/right hydroureter. The left kidney measured 5.0 cm in length. The right kidney measured 5.0 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary

- Diffuse mild cystitis pattern with mild pericystic inflammation
- Moderate particulate urine sediment and non-dependent lumen hyperechoic sand /mineral
- Bilateral mild renomegaly exhibiting intact architecture and mild pyelectasia

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of renal neoplastic criteria or left / right ureteral obstruction. The mild renomegaly may suggest emerging to mild nephritis given concurrent azotemia yet without definitive evidence of pyelonephritis criteria or evidence of left /right retroperitoneal inflammation. The pyelectasia noted in both kidneys may also be attributable to IV fluid therapy.

PATIENT

Alvin Roller

SPECIES

Feline

BREED

DMH

SEX

MN

AGE

9yr

WEIGHT

5.6kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Jessie Evoniuk

HOSPITAL NAME

State Avenue Vet Clinic

REFERRING VET

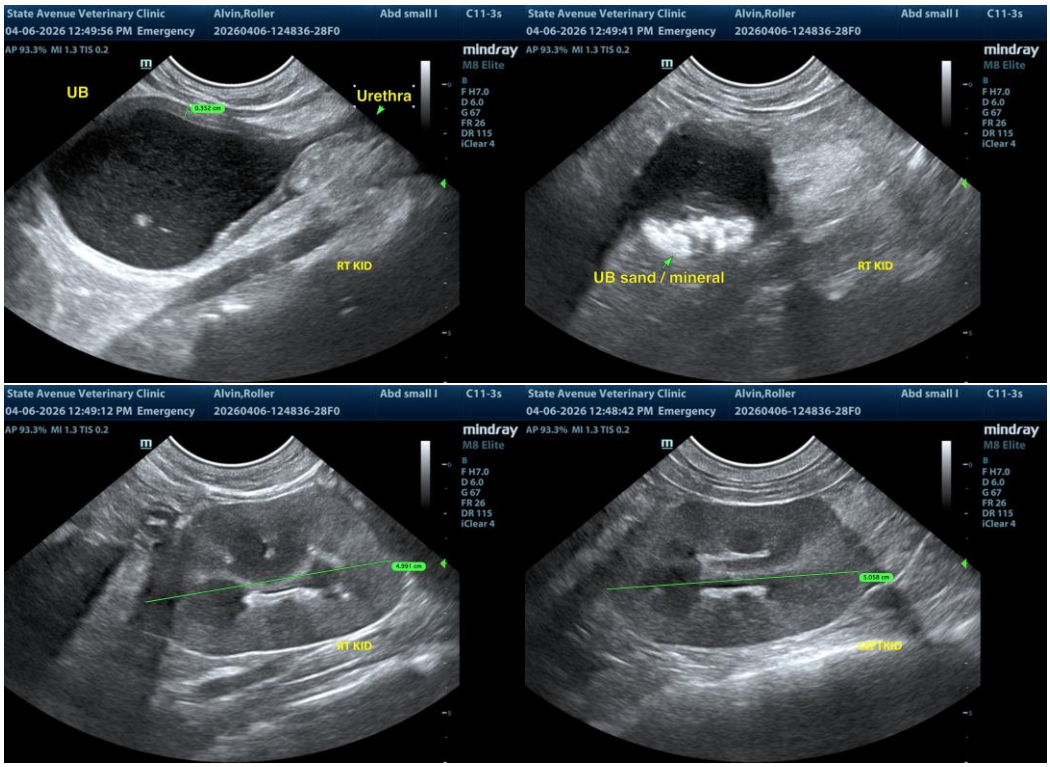
Dr. Jessie Evoniuk

INVOICE
24391

DATE
04/06/2026

Urine C/S on sterile urine sample if not done suggested despite current antibiotic therapy. Continued renal and urinary support with monitoring of renal parameters for further assessment and prognosis is recommended.

Recheck sonogram is indicated if progressive azotemia. If renal parameters are stabilized, cystotomy with urinary bladder flush and mineral/ sand analysis +/- urinary bladder wall biopsy for tissue C/S may be indicated.



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