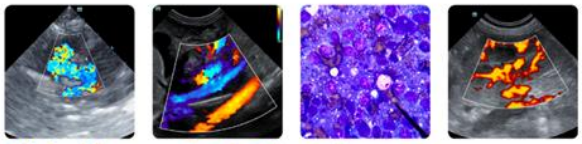



**PATIENT**
Ashe Jones

**SPECIES**
Feline

**BREED**
DSH

**SEX**
FS

**AGE**
11yr

**WEIGHT**
9.46lb

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

**IMAGING PERFORMED BY**
Karla Schultz

**HOSPITAL NAME**
Northshore Veterinary Hospital

**REFERRING VET**
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**INVOICE**
24822

**DATE**
05/12/2026

## PRESENTING CLINICAL SIGNS

-P presented as referral for ultrasound, for recurrent bloody urine with stranguria that responds to antibiotics but returns within a few days of stopping antibiotics. P is currently on veraflox, acting normal at home with good energy, appetite, attitude and no known dysuria.
-Urinary history: abnormalities starting Mid-April 2026- yowling with urination, some straining, o noted bloody mucoid discharge. Two week-long courses of clavamox resolved abnormalities when on ABX but they returned within a few days of discontinuing. P placed on veraflox most recently and urine culture submitted (urine sample taken prior to starting), urine culture was negative for bacterial growth. P is currently on veraflox and is asymptomatic.
-P has HX of hyperthyroidism dx 05/2025, well controlled with oral methimazole.
-P has HX of increased ALT since 05/2025 labs, no work up has been pursued.
Abnormal PE/Chem/CBC/UA Results: -PE: moderate generalized muscle wasting. No murmur/arrhythmia, normal lung sounds, abdomen soft, comfortable. MM pink/moist. -In-house cytology of ~1mm pellet found at deep vulvar opening: many clusters of cocci and rods along with keratinized epithelial cellls -CBC from 3/2026 WNL (repeated today, pending) -chem 10 from 5/2/2026 inc ALT (726) and mild inc ALP (206) (submitted chem25 today, pending) *chem panels run 5/2025 and 3/2026 both had elevated ALT at 288* -urinalysis from 5/2/2026: USG 1.023, 3+ blood, >100 WBC/HPF, 1+ epis, no crystals -urine culture from 5/2/2026: neg for growth -T4 checked 3/27/2026: 2.2 (WNL)

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder was normal in size and tone. Focal, thickened mid-dorsal urinary bladder wall measuring 0.3 cm in width was present. The trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no evidence of urine/lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal.

Normal size and margination was 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 with no evidence of pelvic dilation. A subtle hyperechoic corticomedullary band, consistent with a medullary rim sign, was present. This is a nonspecific finding seen in both normal and abnormal kidneys. It may be associated with interstitial renal disease, hypercalcemia, tubular necrosis, lymphoma, and FIP. However, it is a nonspecific finding. Potential discrete cortical infarcts. The left kidney measured 3.5 cm in length. The right kidney measured 3.9 cm in length.

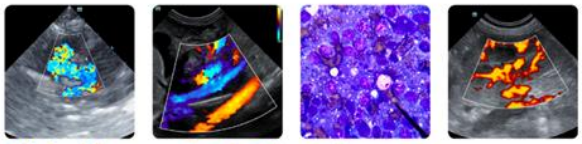
The area of the aortic trifurcation was free of pathology.

### *Adrenal Glands*

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.31 cm width. No obvious pathology in the area of the right adrenal gland, although not definitively visualized.

### *Spleen*

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Several mildly hyperechoic nodules were present throughout





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the cranial to caudal parenchyma. An example measured 0.55 cm in diameter. 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 or neoplastic changes were not noted. The echogenic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas.

### *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 primarily anechoic luminal content. 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. The small intestinal wall measured 0.23 cm in width.

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.

Transdiaphragmatic view of the caudal thorax revealed pleural effusion.

## ULTRASONOGRAPHIC FINDINGS

### Primary

- Focal minor thickened dorsal urinary bladder wall, otherwise, sonographically normal urinary bladder and visible proximal urethra- suspect small dorsal polyp or focal cystitis, possible early emerging tumor thought less likely yet not excluded
- Bilateral chronic renal changes exhibiting mild nonspecific discrete medullary rim and possible indistinct cortical infarcts
- Sonographic normal liver / gallbladder
- Structurally normal gastrointestinal tract
- Transdiaphragmatic pleural effusion

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If negative urine culture, focal to mild idiopathic cystitis is favored, although sonographic monitoring of the focal thickened dorsal urinary bladder wall for evidence of progression is indicated. Correlation of

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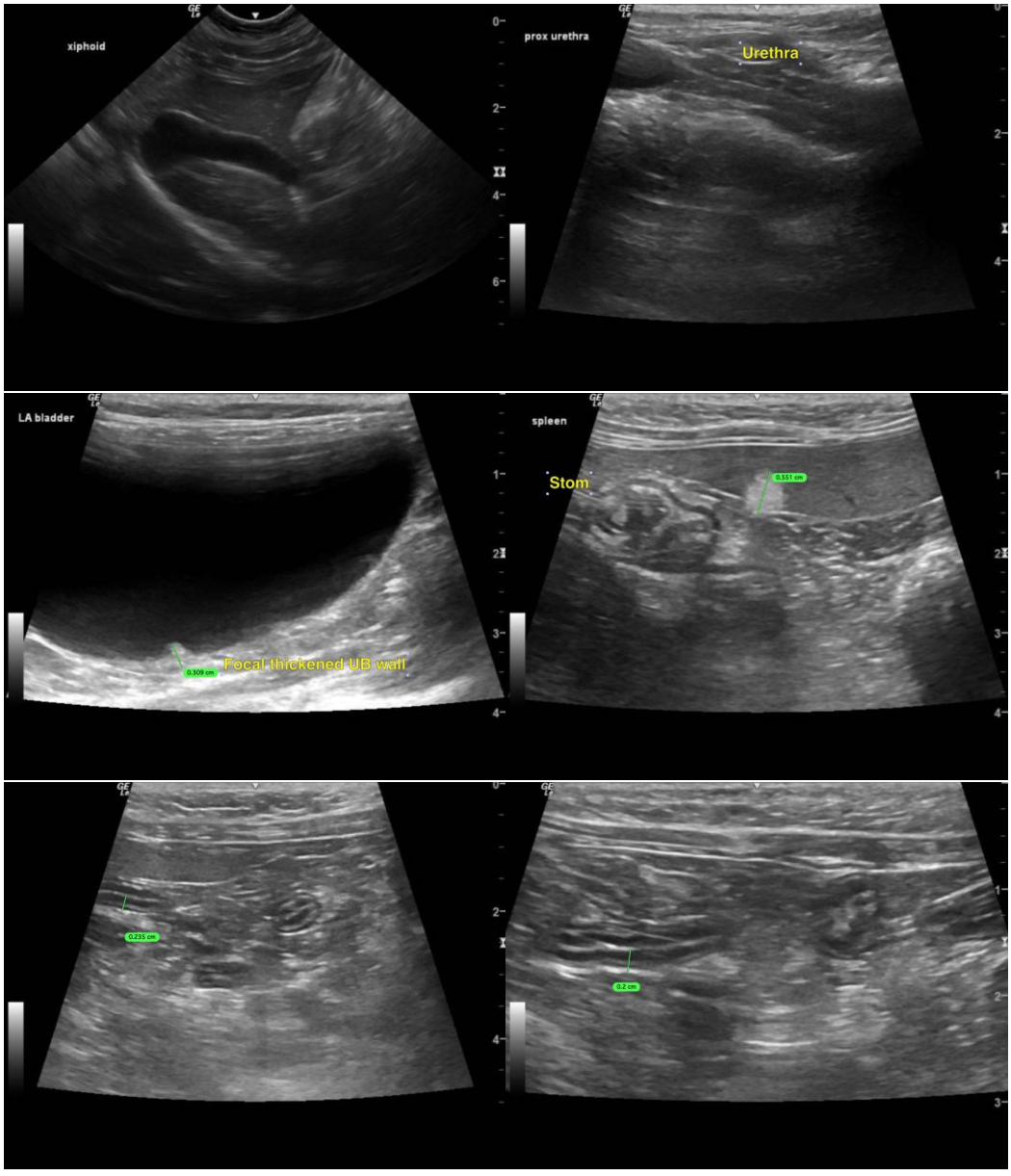
the previous hepatopathy yet current sonographically unremarkable liver with pending lab work for evidence of persistent hepatopathy. If present, benign criteria is favored, although nonspecific.

FNA cytology of the liver assuming normal clotting status and using 25ga needle may be considered. A GI panel to include PLI/TLI/cobalamin and folate and pleural effusion analysis recommended to assess for occult disease as a potential contributing factor to reported generalized muscle wasting.



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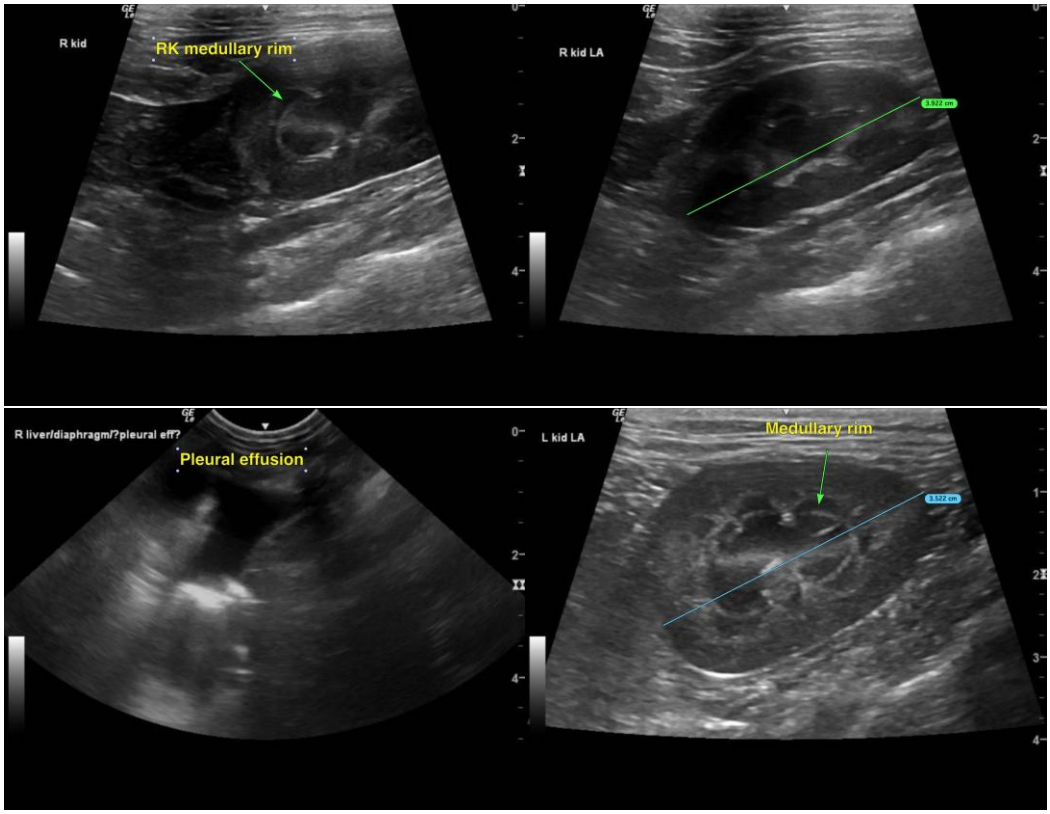


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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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