



**PATIENT**

Potatoe Haake

**SPECIES**

Feline

**BREED**

Ragamuffin

**SEX**

MN

**AGE**

2 years

**WEIGHT**

14.82 lbs.

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Jenna Walsh, CVT

**HOSPITAL NAME**

West Eugene AH

**REFERRING VET**

Dr. Sundholm

**INVOICE**

16103

**DATE**

6/15/22

**PRESENTING CLINICAL SIGNS**

Potato has a history of hematuria starting in March 2022. FIC was diagnosed based on lack of evidence of uroliths on radiographs or UTI with a urinalysis. This is currently his third bout of hematuria and painful urination. The owner said that he is not an anxious cat at home. Potato has also been gradually losing weight (1 lbs since March) despite a normal appetite Current Medications Started Gabapentin, alprazolam, buprenorphine and prazosin on 6/14/22 Radiographic Findings From Willamette Vet: right lateral radiograph = aggregate of mineral opacity debris in urinary bladder but no discrete stone Primary Question/Differential to Be Answered in This Exam r/o causes of intermittent FLUTD signs, despite management for suspected FIC

Abnormal PE/Chem/CBC/UA Results: Most recent urinalysis was done April 2022: SG: > 1.050 pH:6.5 Nitrite:(+/-) neg Protein:+++300 Glucose:neg Ascorbic Acid: 10 Ketones: Neg Urobilinogen: Norm Bilirubin: Neg Blood:+++ 250 Leukocytes:+++500 Microscopy: RBCs TNTC, WBCs 1+. No crystals or bacteria noted

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder presented uniformly thickened urinary bladder wall isoechoic to the adjacent normal urinary bladder wall. The luminal margin of the thickened urinary bladder wall was mildly asymmetrical in contour. No overt evidence of masses noted. The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal tone. Anechoic urine was present in the lumen. Several luminal calculi were present in the mid to cranial primary dependent lumen. An example of calculus measured 0.67 cm in diameter. Concurrent areas of suspected adhered to possibly embedded mineral were noted along the ventral apical urinary bladder luminal surface. The ureteral papillae were normal. The ureters were not visible which is normal. The ventral apical urinary bladder wall measured 0.37 cm.

The area of the aortic trifurcation was free of pathology.

Normal size and 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 with no evidence of pelvic dilation. The left kidney measured 4.6 cm in length. The right kidney measured 4.6 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 0.41 cm.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.31 cm.

**Spleen**



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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.

**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. 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 stomach was moderately distended with nonshadowing ingesta/chyme. The visualized gastric walls were sonographically normal. The ventral gastric body wall measured 0.22 cm.

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. The duodenum wall measured 0.23 cm. The jejunum wall measured 0.23 cm. The ileocolic wall measured 0.34 cm.

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 were evident.

**Free Abdomen**

No omental masses, lymphadenopathy or peritoneal free fluid was present.

**ULTRASONOGRAPHIC FINDINGS**

- Cystitis pattern with concurrent luminal calculi and suspect focal areas of adhered to potentially embedded luminal surface mineral
- Sonographically normal bilateral kidneys
- Overtly normal gastrointestinal tract with moderate gastric ingesta/chyme

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Urine culture and sensitivity on sterile urine sample is suggested, if not recently done. However, given the lack of previous infection, sterile or interstitial cystitis may be present. It is suspected that the cystic calculi and mineral may be causing persistent irritation to the urinary bladder wall. Cystotomy with urinary bladder flush, as well as biopsies of the urinary bladder wall for histopathology, as well as tissue



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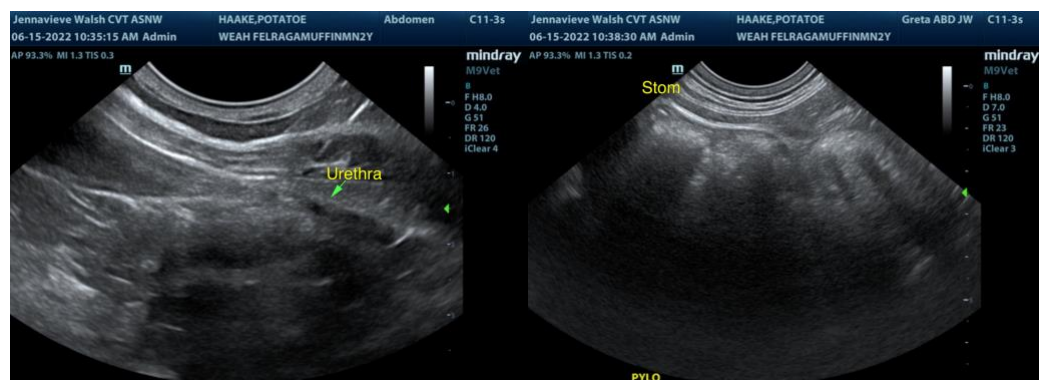
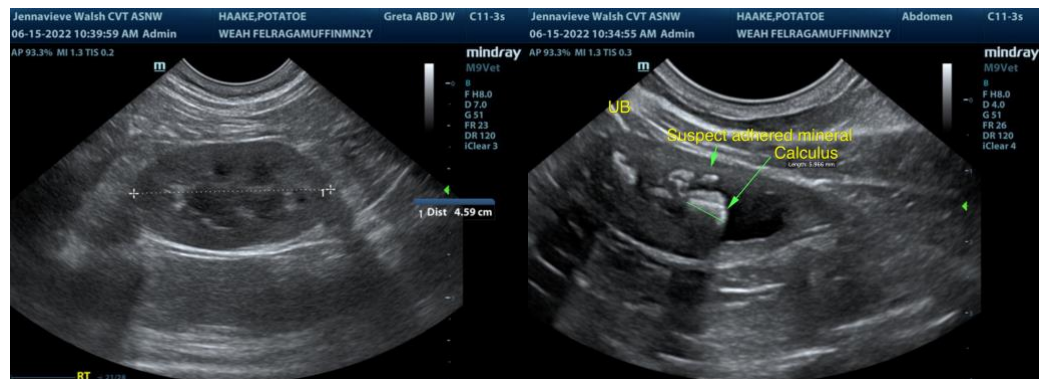
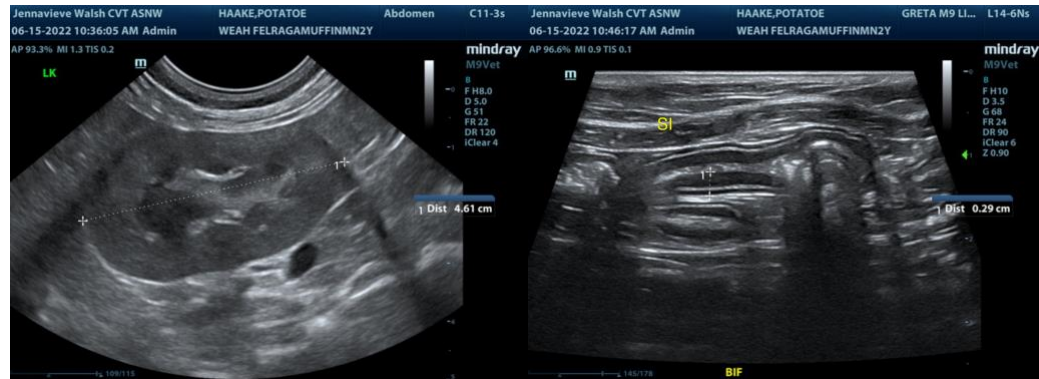
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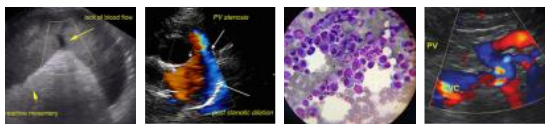
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culture and sensitivity, may be considered. Alternatively dietary therapy with continued therapy for idiopathic/interstitial cystitis with assessment of the clinical response would be reasonable.

Sonographic assessment or monitoring of the urinary bladder, pending response to therapy, or if persistent/progressive abnormal urinary signs, for evidence of progressive inflammatory mural changes, suggested.





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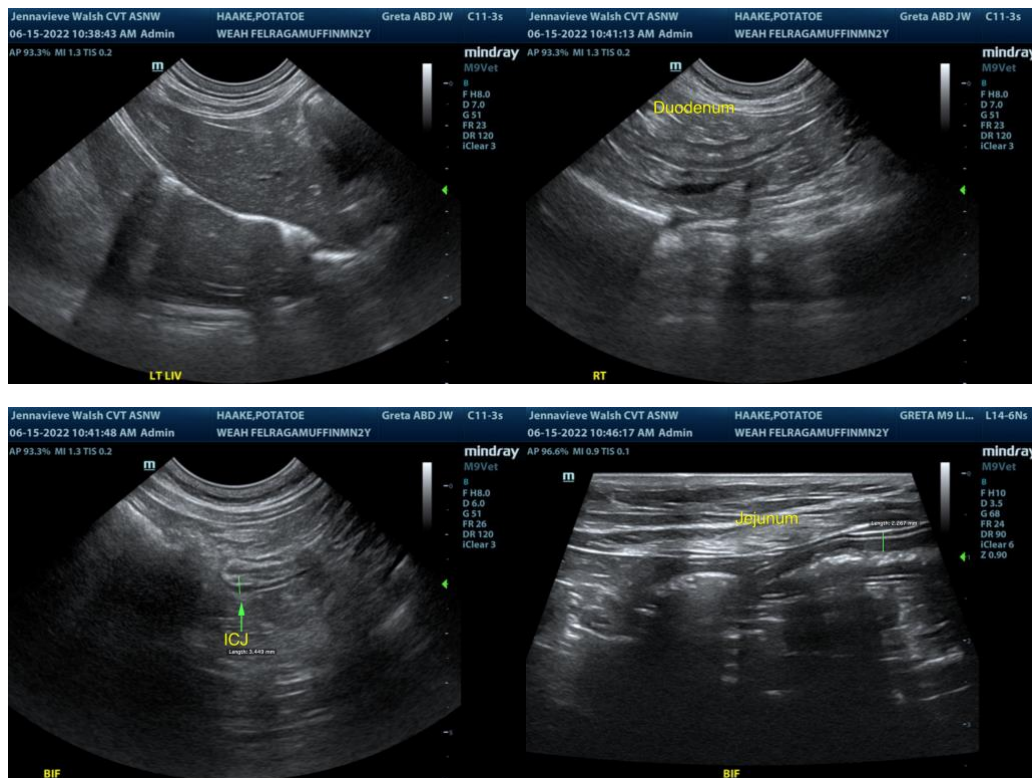
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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 info@SonoPath.com