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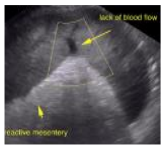
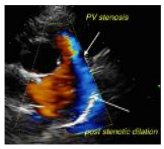
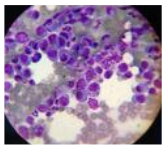
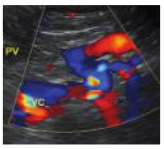





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Solveig Mathison

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

1.5 Years

WEIGHT

3 kg

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Patti Mayfield, DVM

HOSPITAL NAME

Bend Animal ESC

REFERRING VET

Patti Mayfield, DVM

INVOICE

13818

DATE

10/17/21

PRESENTING CLINICAL SIGNS

History: Patient went missing for 5 days. Upon her return, she was eating/drinking normally x 2 days. For last 5 days, patient has been increasingly lethargic and anorexic. No VD in history. 5 days ago, patient was evaluated at primary care DVM. Blood work was reportedly unremarkable. Patient received SQ fluids and Cerenia. 2 days ago, patient was not improved and was re-evaluated at primary care DVM. Radiographs performed were unremarkable. Additional SQ fluids and Cerenia administered. Patient presented to ER last night due to no improvement and persistent lethargy with one episode of acute bilious vomiting. Patient has been receiving IVF, methadone, cerenia

Abnormal PE/Chem/CBC/UA Results: Physical exam: ~9% dehydrated. Abdominal pain with possible mass effect. Weight loss. Blood work: CBC: Hemoconcentration w/ left shift, thrombocytopenia likely due to slow draw through butterfly catheter HCT: 60% PLTS: 50,000/uL CHEM: Mildly elevated GGT, 7 U/L (0-4) BG: 181 mg/dL (stress) ABDO rads: Diffuse gas distention throughout GIT, however no obvious FB/obstructive pattern

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A mild to moderate amount of aggregated echogenic suspended debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2.0 cm, are normal.

The left kidney is normal size (3.78 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (3.88 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.22 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

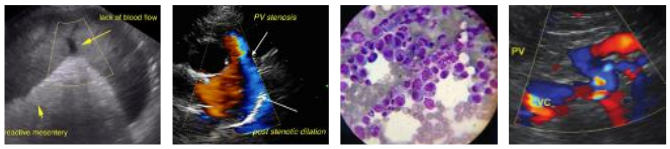
The right adrenal gland is normal size (0.21 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.91 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or



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regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed.

The gall bladder lumen is moderately distended. Bilobed conformation is suspected. The wall is normal in thickness. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly gas distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The proximal duodenal lumen is not dilated. The remaining small intestinal segments are mostly mildly to moderately fluid distended and hypomotile. The small intestinal wall is normal in thickness with a normal layering pattern. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. The colonic lumen is fluid distended. There is no obvious evidence of obstruction/foreign body.

Pancreas

The pancreas is diffusely prominent in size with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated. There is no evidence of peripancreatic effusion.

Free Abdomen

The peritoneal cavity is normal.There is no evidence of inflammation or effusion. Several prominent lymph nodes are observed in the mid to caudal abdomen, the largest measuring 1.17 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bowel pattern- The bowel pattern is most consistent with diffuse enteritis. A partial small intestinal obstruction cannot be completely excluded but no obvious foreign body is seen.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.

Secondary Finding

- The mild urinary debris is likely a benign, incidental finding.
- Suspected bilobed gallbladder-incidental

*An obvious cause for the patients' clinical signs is not identified. Given the patients' history, infectious/parasitic disease (i.e., Salmonella) and dietary indiscretion are considerations. If the patient has a chronic history of GI signs, other differentials (i.e., inflammatory bowel disease, food allergies, chronic pancreatitis, metabolic issue) should also be considered.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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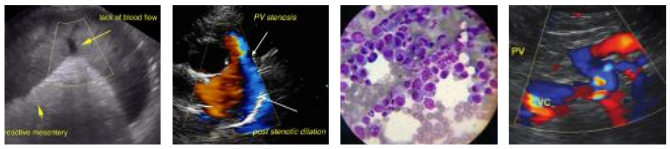

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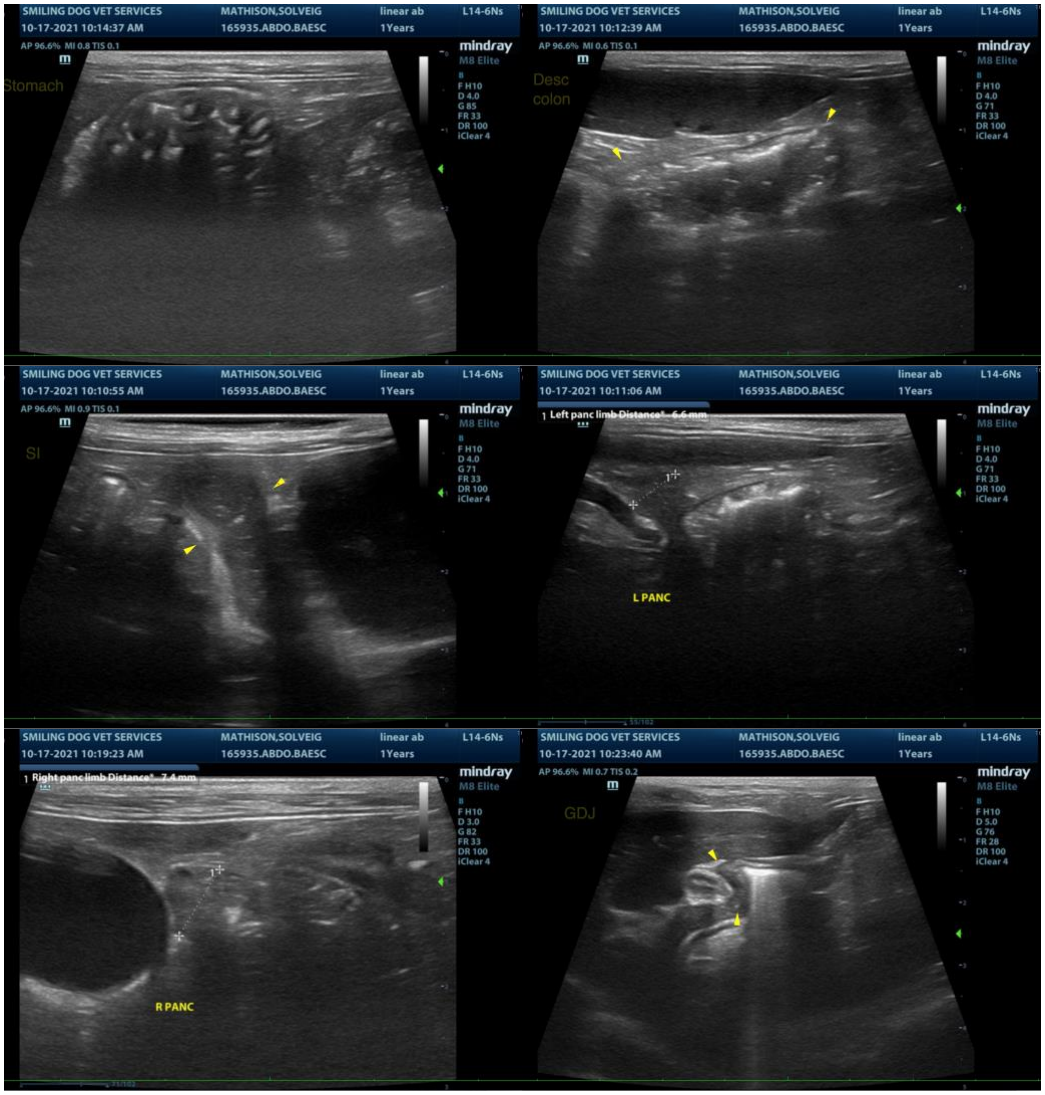
- Supportive care for acute gastroenteritis/pancreatitis is recommended.
- Consider a fecal evaluation for ova and giardia as well as a fecal PCR fast panel to further assess for infectious diseases.
- If clinical signs do not improve with supportive care, repeat abdominal ultrasound +/- more advanced GI work up (i.e., malabsorption panel +/- gastrointestinal biopsies) may be warranted.
- Given the patients' history of being missing for 5 days, 3 view thoracic radiographs are also recommended to assess for occult disease in the chest.



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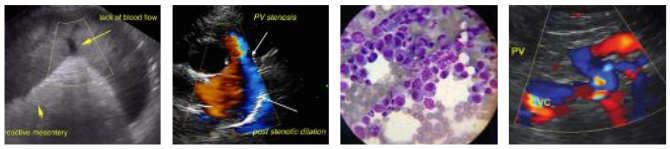

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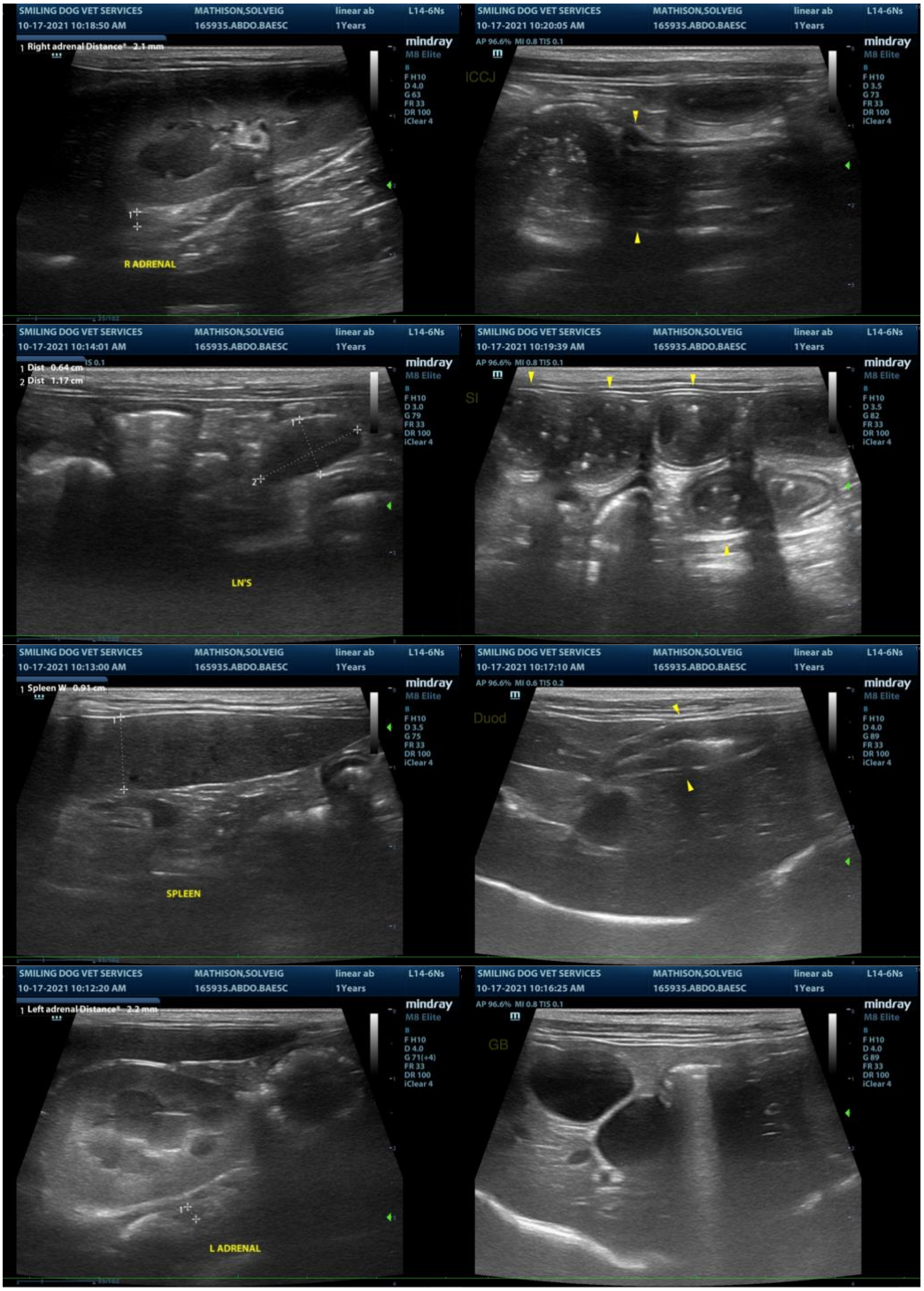

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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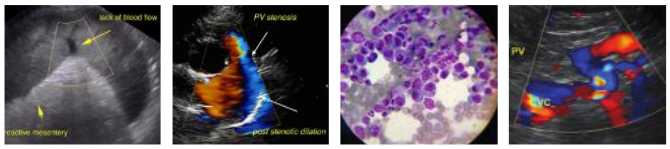

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