Charleston Mobile Veterinary Services
IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND

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FOSTERING THE ART OF VETERINARY MEDICINE
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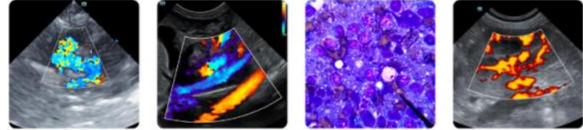

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT
Skye Mathewson

SPECIES
Feline

BREED
DSH

SEX
Female Spayed

AGE
1 year 7 mos

WEIGHT
3.76 kg

INTERPRETED BY
Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY
Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME
Blue pearl MtP ER

REFERRING VET
Dr Abby Seeley

INVOICE
22644

DATE
3-2-26

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Presents for second episode of anorexia/lethargy in the past 3 weeks, this one began ~48 hours before presentation.

Patient sedated with butorphanol and Alfaxalone for this study.

Attitude: BAR - moderately fractious, less is more, hates alcohol
Hydration: Dehydrated 5%
BCS: 5/9 MCS: 3/3
Pain: 0/4
MM: pink tacky
CRT: <2s

EENT: minimal dental calculus and gingivitis, no oral foreign objects or masses appreciated, no nasal, aural or ocular discharge, bilateral airflow through nares
PLNS: all peripheral LNs normal in size, soft, symmetric, and non-painful
CV: no obvious murmurs auscultated- additional sounds appreciated (auscultated S3/4 vs arrhythmia/irregular placement of sounds), regularly irregular rhythm, femoral pulses strong and synchronous
RESP: increased RR, bronchovesicular sounds increased but normal in all lung fields
ABD: soft, non-painful, no palpable organomegaly, fluid wave or masses
UG: bladder soft and moderate in size, normal external genitalia
M/S: normal ambulation, no evidence of lameness or muscle wasting
INTEG: full hair coat, no alopecia, scale, erythema, or evidence of ectoparasites
NEURO: normal mentation, normal CNs, no ataxia, normal CPs and withdrawals x 4, no spinal or cervical pain noted
RECTAL: DNP due to P size/temperament but normal external tone and anatomy no masses or draining tracts, normal brown stool on rectal thermometer; P passed very firm stool while waiting in triage cage

Abnormal lab-work values:
CBC: Retic Hgb 13.1 (L), Hct 32.6% (N), WBC 22.15 (H), Neu 17.28 (H) bands suspected, Mono 0.98 (H), Eos 0.1 (L), Plt 139 (L)
- 2/13: All values WNL
- Chem17: Glu 176 (H), BUN 14 (L)
- 2/13: All values WNL
- ProBNP: Abnormal

Radiographic Findings:
6 radiographs of the thorax and abdomen are reviewed.

The cardiac silhouette and pulmonary vasculature are within normal limits for size. No pulmonary parenchymal abnormalities are identified. The pleural space is within normal limits. The mediastinal structures are unremarkable.

The liver, spleen and kidneys are within normal limits. The urinary bladder is small. The stomach contains a small volume of gas. The small intestines contain gas and soft tissue opaque material and are considered normal for size. On the lateral projection there is impression of slight bunching of a segment of intestine within the caudal abdomen. This is less distinct on the VD projection. Feces are present within the colon. Adequate serosal margin detail is identified throughout the peritoneal cavity.
Assessment:
Unremarkable thorax.

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The slight bunching of the small intestine within the caudal abdomen on the lateral projection is a soft finding. Linear intestinal foreign material cannot be excluded although this cannot be confirmed on the current images. A repeat lateral projection utilizing a compression technique (wooden spoon or spatula compressing the caudal abdomen to separate small intestinal segments from one another) may be helpful to assess for repeatability of this finding. An abdominal ultrasound or contrast study could be considered.

Gastroenteritis, pancreatitis and infiltrative intestinal disease (IBD, etc.) as a cause for the patient's clinical signs cannot be excluded.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. A small amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (3.73 cm in length) with a normal shape, architecture and 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 in size (3.96 cm in length) with a normal shape, architecture and 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 (0.35 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.34 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is prominent-in-size (1.05 cm in width at the level of the hilus) with smooth peripheral contours. Using a high-frequency probe, the parenchyma appears subtly mottled. No focal lesions are observed. Splenic vasculature is normal.

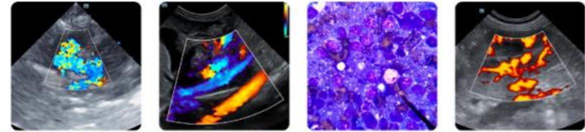
Liver

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 regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal. The duodenal papilla is normal-in-size (0.18 cm in width).

Gastrointestinal

The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.



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Pancreas

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Lymph Nodes

Two-to-three prominent mesenteric lymph nodes are visualized (one measuring 1.57 x 0.71 cm).

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

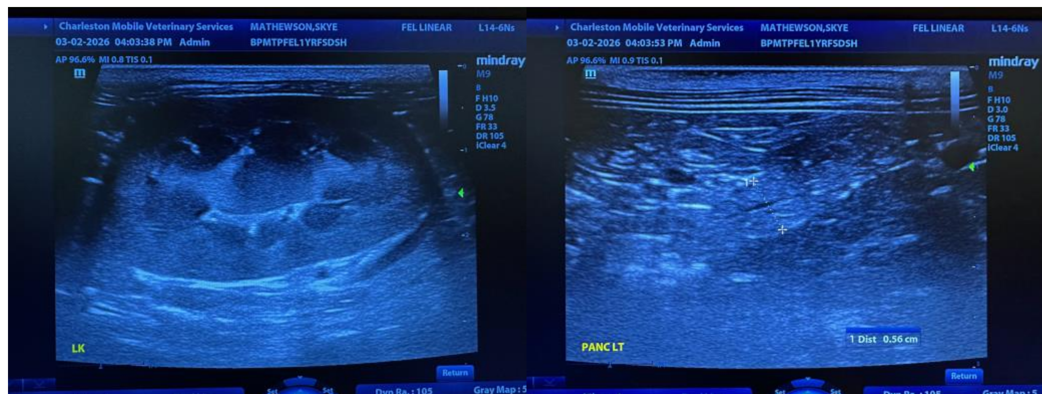
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

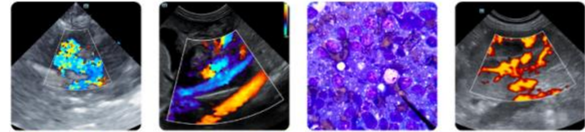
- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a lower possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia). The mild splenomegaly is likely secondary to sedation.

*An obvious cause for the patient's inappetence is not definitively identified in this study. Broad considerations include primary enteropathy (i.e., food allergy/intolerance, inflammatory bowel disease, infectious/parasitic disease), underlying metabolic issue, cardiovascular disease, orthopedic or neurologic disease, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Consider a fecal evaluation for ova and Giardia, as well as a GI panel including serum cobalamin and folate, TLI and PLI. Depending on these results as well as the echocardiogram, further work-up (i.e., GI biopsies) may be indicated.





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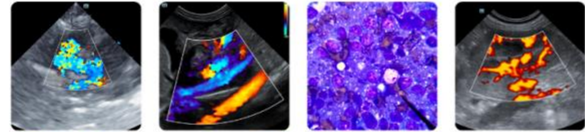

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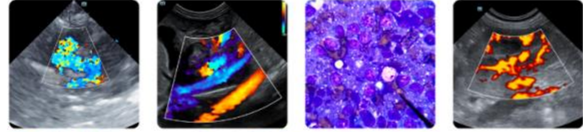

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com