



**PATIENT**

Christopher Pockers

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Spayed Female

**AGE**

12 years

**WEIGHT**

7.6 lbs

**INTERPRETED BY**

Andrea Nicastro, DVM,  
Diplomate ACVIM  
(Small Animal Internal  
Medicine)

**IMAGING PERFORMED BY**

Amy Mayhew LVT

**HOSPITAL NAME**

SVS Imaging Michigan

**REFERRING VET**

Family Pet Practice

**INVOICE**

11398

**DATE**

8.12.22

**PRESENTING CLINICAL SIGNS**

**History:** Large amount of tartar - worse upper right arcade, sensitivity noted on oral exam- discussed possible contributing factor to decreased appetite, may do better encouraging canned diets.

Gallop rhythm

Single coughing episode yesterday morning, not coughing throughout the day and not noticed this morning. Reviewed monitoring for progressive cough, may be indicator of metastatic disease, consider rechecking thoracic radiographs

Mastectomy (done 7/27/22) incision healing well, mild crusts on surface of skin, incision appears closed/healed. SQ sutures palpable. Large amount of firm stool in colon, medium sized soft bladder. O unsure when P last defecated, Has not seen P straining to urinate or defecate. Discussed abdominal radiographs/AUS- evaluate for constipation, gross metastatic disease, other inflammatory changes. May recommend enema if rads suggestive of constipation- sedation necessary for enema

Tech notes- AFH:

Patient was in for a Bup SR injection post-surgery on 7/30/22, helped a lot. Was lat in 8/9/22, doing well at this time, able to give more free range of house after healing process from surgery. Starting 2 days ago patient has had decreased appetite, decreased drinking, decrease in stool and urinations per owner. Patient hiding more now and acting lethargic at home. Per owner patient had a cough yesterday morning but hasn't had any since. No vomiting per owner. Per owner seems interested in food but not able to eat as much. No difficulty breathing per owner, no wheezing per owner.

Eosinophilia. The remainder of the bloodwork is unremarkable.

**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 scant amount of suspended, echogenic 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 1-2 cm, are normal.

The left kidney is normal size (3.44 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.

The right kidney is normal size (3.76 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

**Adrenal Glands**

The left adrenal gland is normal size (0.33 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

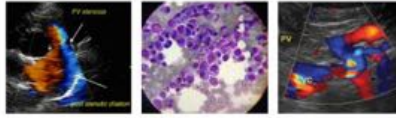
The right adrenal gland is normal size (0.28 cm width). Normal shape and glandular echogenicity. The phrenicoabdominal vein and surrounding vasculature are normal.

**Spleen**

The spleen is normal in size (0.66 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 regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence

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of congestion. No pathological hepatic lymphadenopathy observed. The portal vein to caudal vena cava ratio is approximately 1: 1.

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The gall bladder is moderately distended. The wall is normal in thickness. A bilobed conformation is suspected. A 0.49 cm cholelith as well as some gravity dependent mineralized sand is observed within the lumen. The cystic and common bile ducts are normal.

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**Gastrointestinal**

The gastric wall and pylorus are normal in thickness with a normal layering pattern. There is an abnormal gastric gas pattern obscuring the acoustic window of the gastric lumen. The small intestinal lumen is not dilated. The small intestinal wall is normal to borderline thickened (up to 0.26 cm) with a normal layering pattern and appropriate mural detail. There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

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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.

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**Free Abdomen**

There is questionable trace ascites. The abdominal lymph nodes are normal/not visible.

**ULTRASONOGRAPHIC FINDINGS****WEIGHT**

7.6 lbs

**Primary Findings**

- Bowel pattern consistent with inflammatory bowel disease with some potential for emerging lymphoma.
- Cholelith and mineralized gall bladder sand – incidental
- Abnormal gastric gas pattern, the significance of which is unclear.

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\*An obvious cause for the patient's clinical signs is not identified in this study. Considerations include underlying GI disease (inflammatory bowel disease flareup, dietary indiscretion, food allergy/intolerance), mild pancreatitis, underlying metabolic issue, other.

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**Secondary Findings**

- Questionable trace ascites

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS****REFERRING VET**

Family Pet Practice

- Regarding the unusual gastric gas pattern, a 12-hour fast followed by a recheck ultrasound is recommended to re-evaluate the region.
- Given the clinical history and sonographic bowel changes, consider a malabsorption panel, including serum cobalamin and folate, TLI and PLI.
- Given the eosinophilia, consider a search for GI and ectoparasites. An ACTH stimulation test can also be considered to assess for hypoadrenocorticism (although uncommon in cats).

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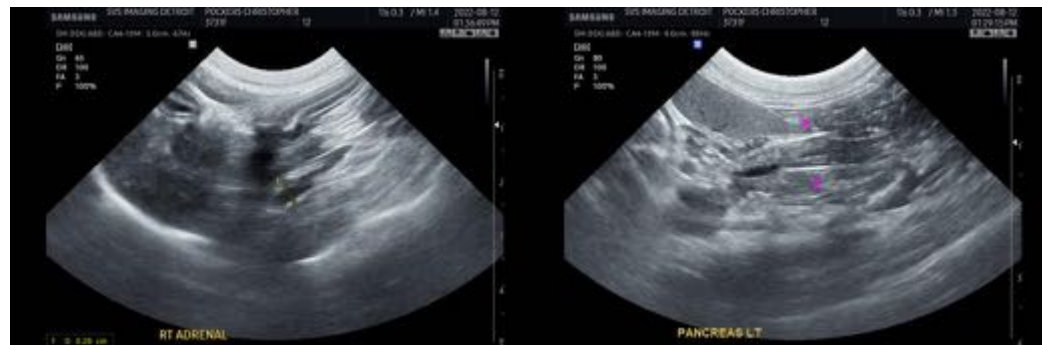
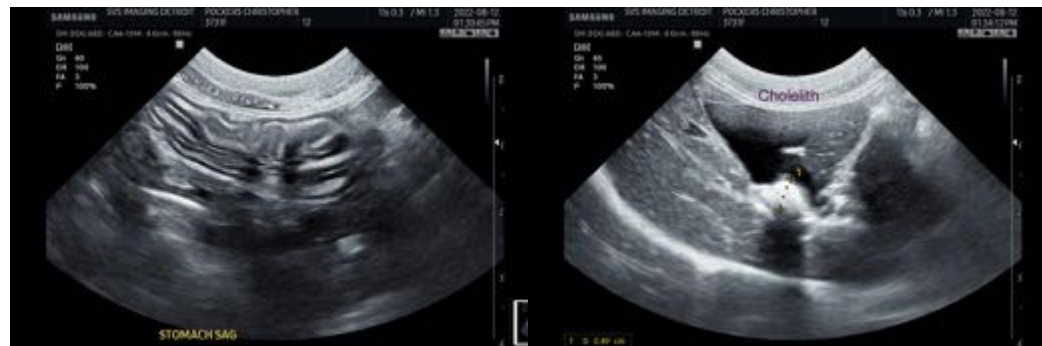
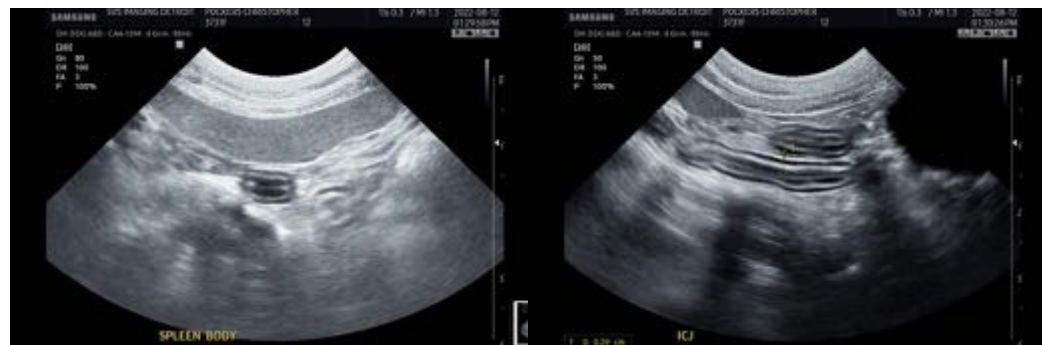
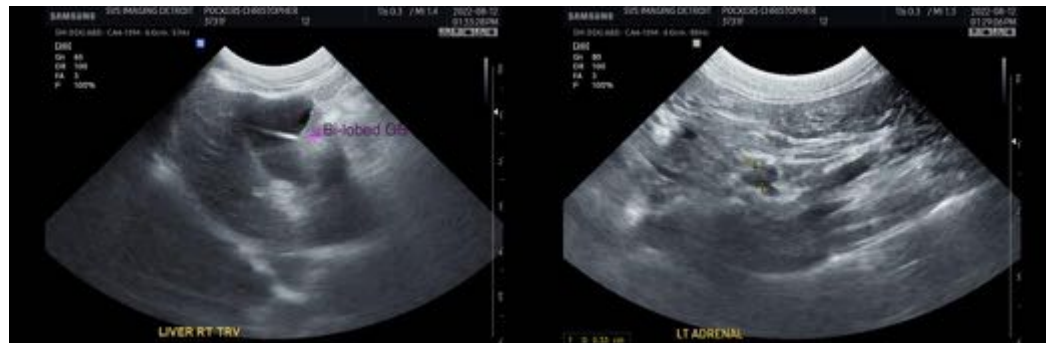
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)**  
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