

**PATIENT**

Percy Taylor

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

7 Years

WEIGHT

9.8 Pounds

INTERPRETED BYBeth Johnson, DVM
DACVIM**IMAGING PERFORMED BY**

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VETFamily Pet Practice -
Dr. Craig**INVOICE**

44551

DATE

1/26/23

PRESENTING CLINICAL SIGNS

Current Medications: Meds/Supps: Fluticasone (Inhaler) 44mg/puff 1 puff given yesterday AM and revolution monthly. Patient History: Here for vomiting after o gave inhaler tx. Yesterday AM o gave the inhaler and 30 min later p vomited 4 times then again 1 hour later. P then did not eat at all the rest of the day. P was lethargic and did not get up to use the litter box at all. P not drinking water. P was crying in pain yesterday. P urinated in litter box in room today.

Abnormal PE/Chem/CBC/UA Results: 1. QAR 3. epiphoria OU 6/7. Normal heart sounds, clear lungs. No sneezing/coughing noted at home. Hx of asthma 9/10. Vocalizing on palpation over bladder- Bladder large, semi-firm. Small amount of stool palpable in colon. No known fb/toxin ingestion Vomiting occurred 30 min after nebulized treatment. unknown water intake per O **gave P litterbox with sand while in exam room- urinated in box, no straining per O. Large amount of CBC Mild neutrophilia Chem- Mild elevations in amylase/lipase, rule-out early pancreatitis, stress hyperglycemia UA- Hematuria, few struvites noted, pH 8, proteinuria, occ rod (possible contamination from box/voided sample) Tx: Cefovecin 0.44ml SQ Maropitant 0.44ml SQ Dasuquin recommended off label for cystitis Discussed possible stress induced pancreatitis/cystitis. dark urine produced

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are normal in size with increased cortical echogenicity. Normal smooth peripheral margination and shape are maintained. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed. Infiltrative disease (infectious, neoplastic, etc.) or nephritis cannot be ruled out but is considered less likely. The right kidney measures 4.19 cm. The left kidney measures 4.1 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.32 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.35 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

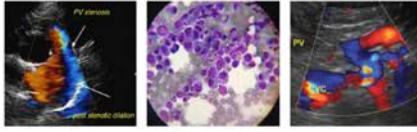
The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. The cystic and common bile duct are mildly distended, measuring up to 0.52 cm with some echogenic debris/sludge noted within the lumen at the level of the duodenal papilla.

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Gastrointestinal

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

BREED

DSH

The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

SEX

Neutered Male

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

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Pancreas

The observed pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Pancreatic duct dilation is noted. There is a 0.50 cm in diameter cyst on the left limb of the pancreas. Enhanced hyperechoic ill-defined surrounding fat and a scant amount of anechoic free fluid is noted around the pancreas.

WEIGHT

9.8 Pounds

Free Abdomen

There is no evidence of free peritoneal effusion noted in these images.

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There is no apparent lymphadenopathy noted in these images.

PRIMARY FINDINGS

- Moderate to severe acute pancreatitis and possibly cholangitis or "Triaditis"

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SECONDARY FINDINGS

- Moderate to large amount of urinary bladder debris

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A quantitative PLI is recommended if not recently evaluated.

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Dr. Craig

Medical management of pancreatitis with anti-emetics, gastroprotectants, appetite stimulants or nutritional support (including a feeding tube) as needed, pain management, broad spectrum antibiotics, and fluid therapy is recommended. Monitoring of the pancreas with power doppler is recommended to identify possible necrosis as well as other potential sequelae such as abscesses, etc.

Given the reported urinary signs and urinalysis results, a sterile obtained urine sample for urinalysis, and if indicated based on urinalysis results, a urine culture, are also recommended.

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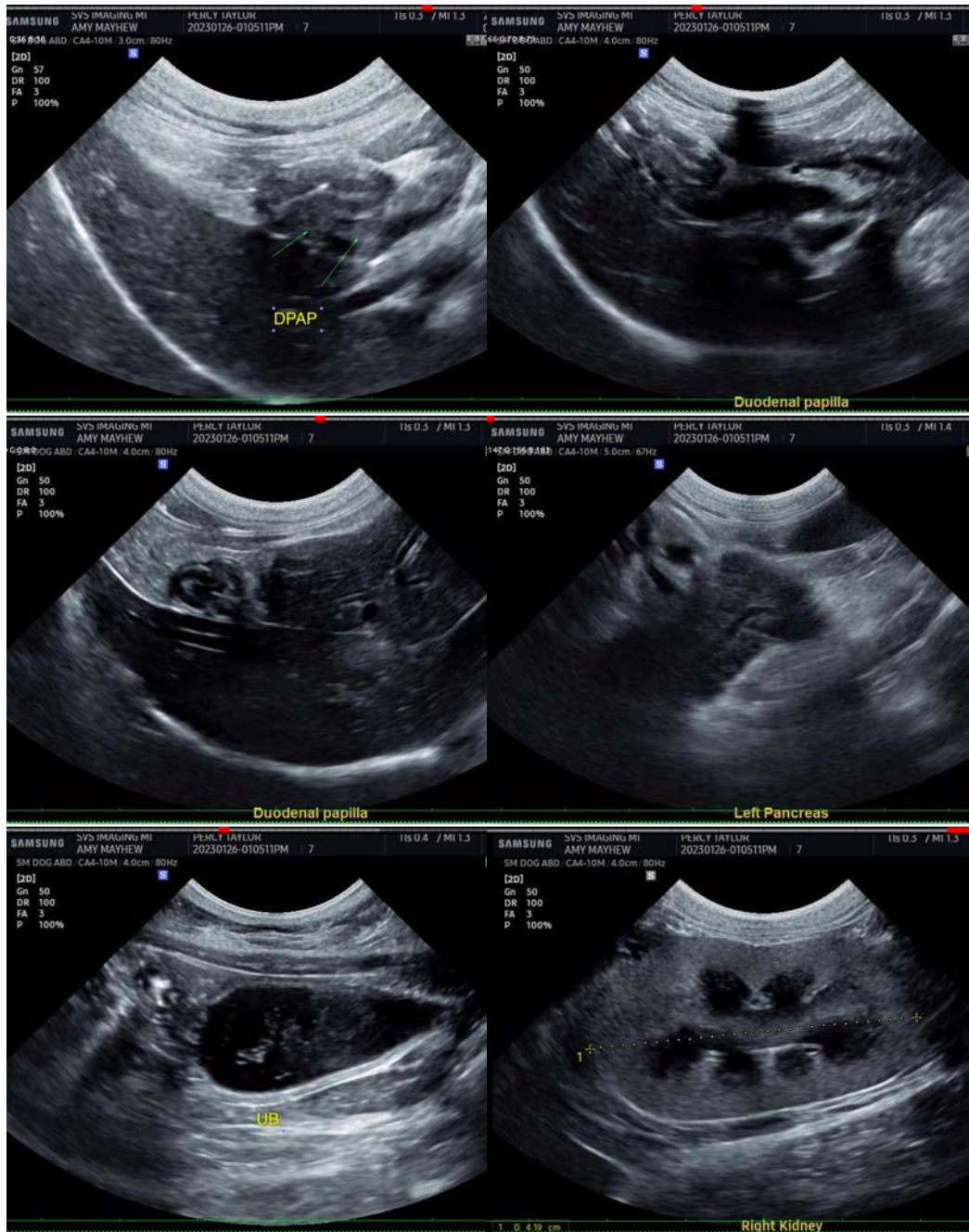
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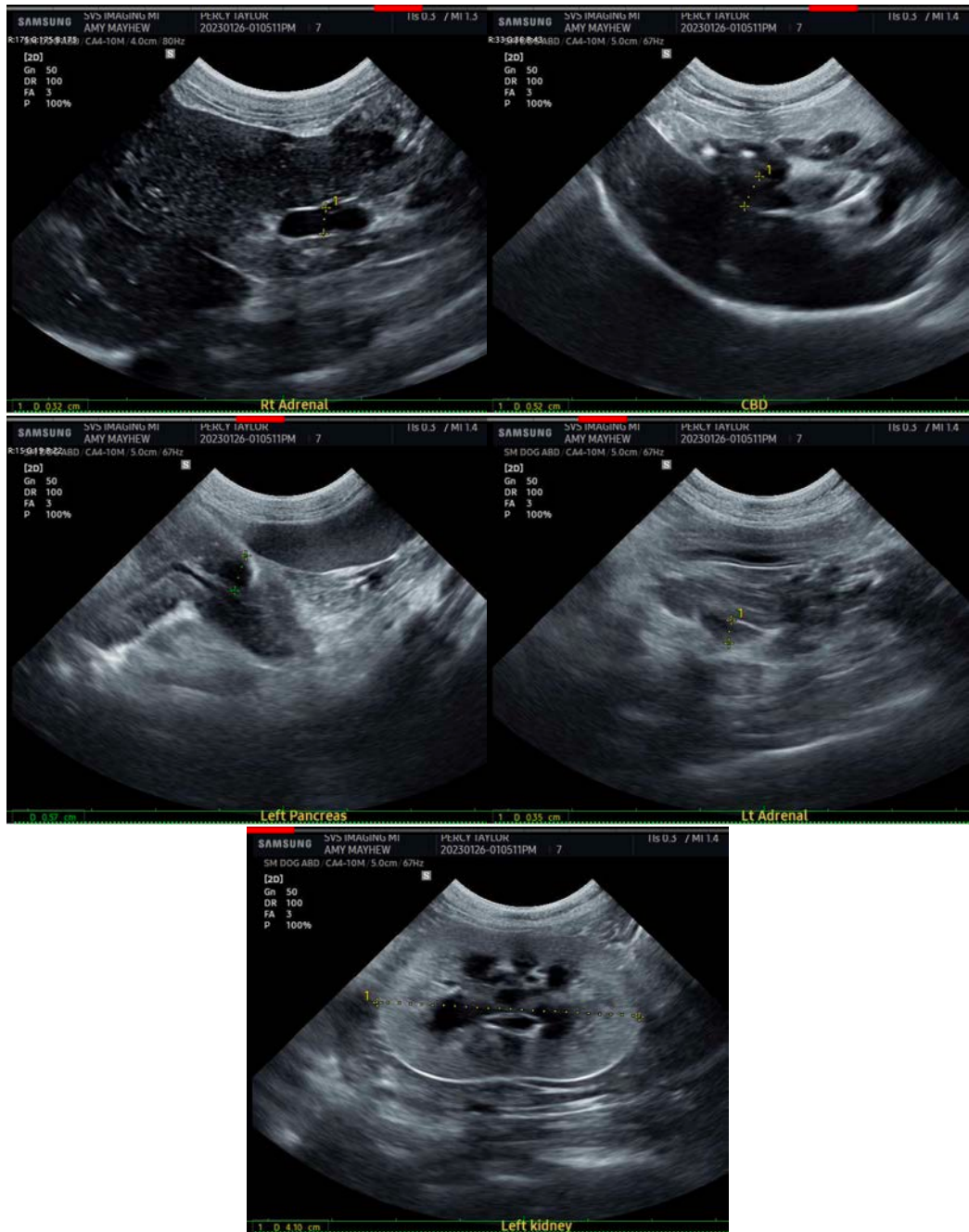
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
Beth.Johnson@sonopath.com