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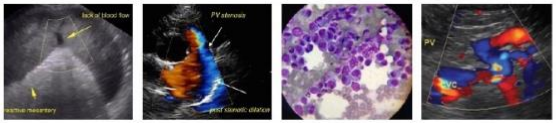


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

P-Body Henry

SPECIES

Feline

BREED

Manx-X

SEX

Neutered Male

AGE

10 Years

WEIGHT

3.2 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Hamilton Regional EC

REFERRING VET

Dr. Bourque

INVOICE

20874

DATE

1/31/23

PRESENTING CLINICAL SIGNS

History: Presented to emergency clinic re: decreased appetite, lethargy and projectile vomiting 1.5 days. Previously tentatively diagnosed with IBD by family DVM and has been on prednisolone for ~ 1 yr as sole therapy (There was no abdominal ultrasound/no biopsies were taken, also no diet changes) Patient still has soft stool and now has diarrhea and is now losing weight again (stools were never normal, even when started on prednisolone) Dehydrated 10-12% (skin tent persists, CRT slow, eyes sunken in orbits, dry mucous membranes) General: dull, ambulatory but ataxic and has had episodes of twitches (? partial seizures?) Eyes: normal, no discharge, anterior chamber/lens/iris appears normal. PLRs normal. Ears & Nose & oral exam: normal Cardiovascular: normal initally but now bradycardic - no murmur Respiratory: normal now but did have open mouth breathing which resolved with rest/oxygen support in kennel - since oxygen been DC has been fine - no nasal discharge, normal lung sounds Abdominal palpation/Gastrointestinal: increased borborygmus, thickened intestines Musculoskeletal: moderate muscle wasting Nervous System: no obvious deficits, ambulatory but is a bit ataxic, no head tilt. No obvious CN deficits. Lymph nodes: normal Skin: normal Urogenital: normal (initially no urine in bladder on presentation but is producing urine) Rectal: normal external Rule outs: sepsis, SIRS, AKI, ARF, AKI on CKD, neoplasia, FeLV/FIV/FIP or combo of any of these. Has been on Methadone, Maropitant, Pantoprazole, Cefazolin, IVF and Prednisolone over the last year. Ate a very small amount of canned a/d this morning by 6 am.

Abnormal PE/Chem/CBC/UA Results: Creatinine above readable range, working on dilution value. BUN 42.9(5.7-12.9) Phos above analyzer range - greater than 5.2 SDMA elevated 22 Hyponatremia 133, hypochloridemia 95, hyperkalemia 7.4, Tprotein 89(57-89) Albumin 44(23-39) Urine Sp gravity - 1.025 pH 5 protein 30g/dL and casts present.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal is size (4.31 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

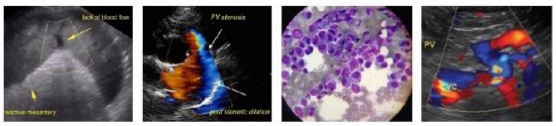
Right kidney is normal is size (4.34 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

Left adrenal gland is normal in size (0.36 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.44 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen



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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

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.

Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal, but it is markedly overdistended with echogenic appearing fluid and chyme. There is no evidence of foreign material present but gastric outflow obstruction cannot be ruled out.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty, except for just medial to the spleen, there is a mildly fluid distended loop of bowel that contains a small echogenic curvilinear foci with acoustic shadowing that likely represents normal ingesta/gas, but given the marked fluid dilation, a subtle foreign body cannot be definitively ruled out.

The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

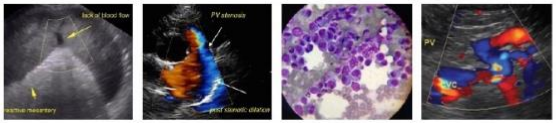
ULTRASONOGRAPHIC FINDINGS

- Marked gastric dilation, which most likely indicates gastric stasis/ileus secondary to this patients reported underlying infiltrative bowel disease. There is no evidence of infiltrative bowel disease in these images at this time, however, changes could be masked by the Prednisone being administered. Having said that, gastric outflow obstruction/foreign body cannot be definitively ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

When patient is more stable, down the road, additional diagnostics, given the chronic diarrhea, despite medical management for presumed inflammatory bowel disease, will be recommended, including a fecal exam, as well as a fecal enteropathogen PCR panel to Texas A&M GI Laboratory, for further evaluation of possible infectious disease.



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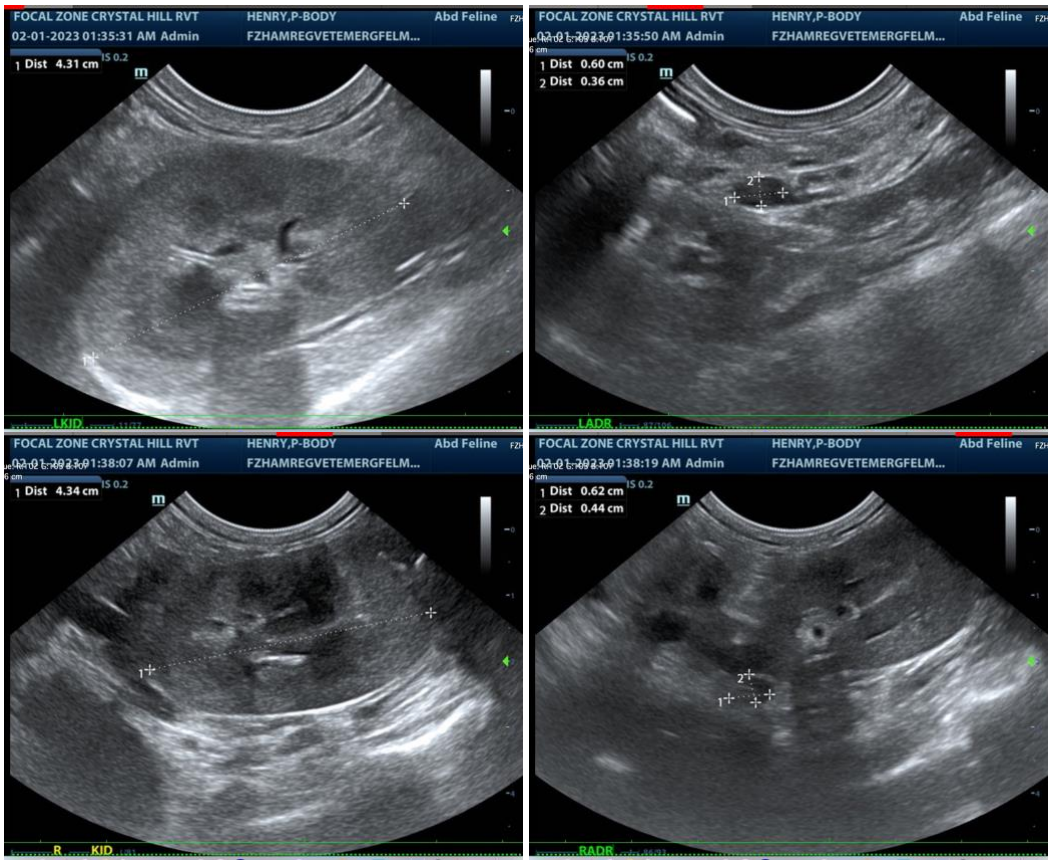
Additional therapeutic recommendations may include empirical deworming with a 5-day course of Panacur, a probiotic, such as Visbiome or Proviable, cobalamin supplementation, etc. However, at this time, given the reported severe dehydration and probable acute on chronic kidney insult, supportive/symptomatic aggressive medical management, including aggressive rehydration/diuresis (as much as can be tolerated), antiemetics, gastroprotectants, pain management (if indicated), etc., is recommended.

Placement of a nasogastric tube may also be beneficial for both gastric suctioning to offer patient relief and improved imaging interpretation, as well as for nutritional supplementation once food is restarted.

For now, another 12-24 hours of fasting is recommended while administering supportive care, so that if clinical signs persist and/or gastric distention persists, recheck imaging can be pursued to help further differentiate gastric stasis, secondary to underlying metabolic disease vs obstruction.

Additionally, if not recently evaluated, a urine culture could be considered and while pending results, empirical antibiotics could be added to the therapeutic recommendations stated above.



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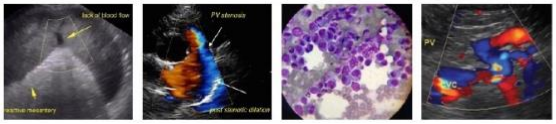

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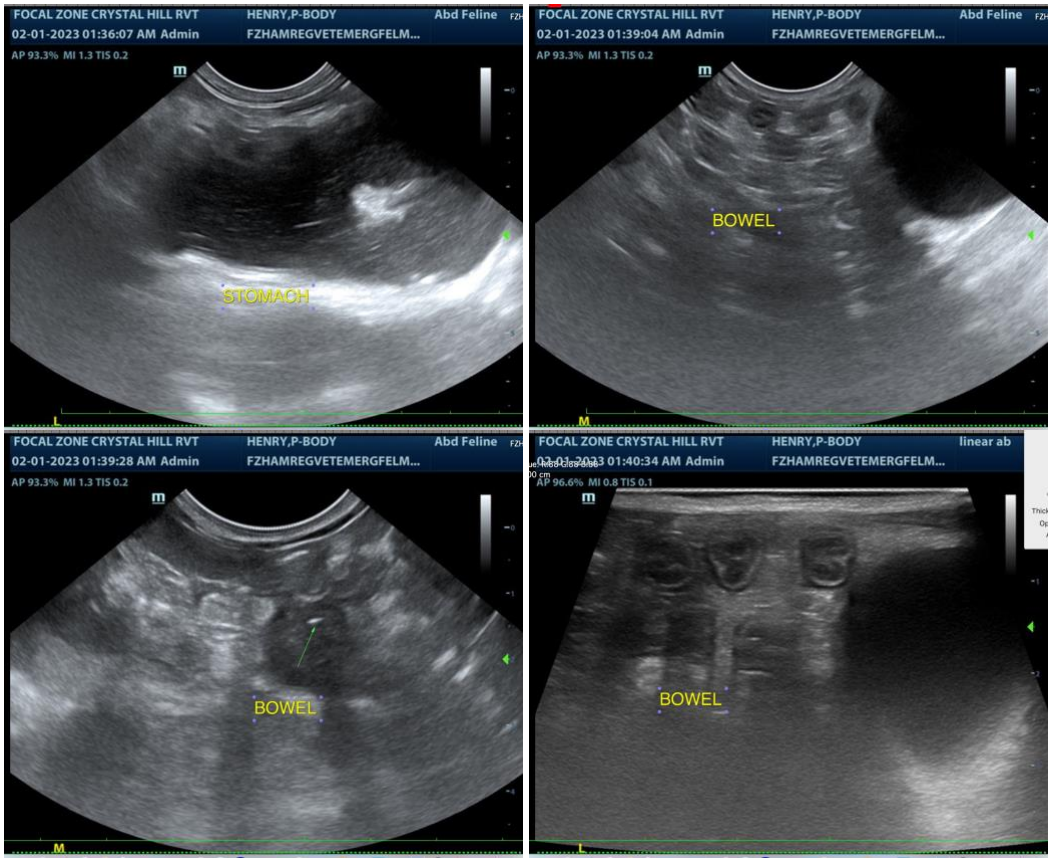

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM DACVIM

Beth.Johnson@SonoPath.com