

**PATIENT**

Zuko Wine-Bock

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

5 Years

**WEIGHT**

12 Pounds

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

Amy Mayhew, LVT

**HOSPITAL NAME**

SVS Imaging MI

**REFERRING VET**

Family Pet Practice

**INVOICE**

42231

**DATE**

10/21/22

**PRESENTING CLINICAL SIGNS**

Current Medications: Gabapentin 25mg 1 tab PO 98-12h Laxatone gel 1/2 teaspoon SID SQF administered 10/18/22 maropitant 10mg/ml 0.54mL SQ administered 10/18/22 Patient History: Presented 10/18/22 for not passing stool x 2 days. Vomited AM of 10/28, licking rear end excessively. Vomiting resolved following visit on 10/18, p acting normal but still has not passed a stool at home.

Abnormal PE/Chem/CBC/UA Results: Exam 10/18/22 1. BAR, stressed P 5. Mild to moderate generalized tartar, CRT <2 seconds, pink moist MM 6. Normal heart sounds 7. Tachypnea, panting started during rectal exam, lungs clear, not panting at home per O 9/10. Firm stool palpable within intestinal loop mid abdomen. Bladder small/soft. Some liquid fecal seepage around anus. Rectal exam (after radiographs obtained)- removed 2 firm fecoliths with excessive fur, p contracting abdomen to pass feces. O brought in small firm fecal pellets that P passed today. Per o Pate well this AM but vomited shortly after. Radiographs- gas with small amount of ingesta in stomach. large fecolith transverse to cranial descending colon- intermixed gas pockets, feces also noted near anus. Cannot rule-out colonic fb or gastric fb. CBC- mild leukopenia Chemistry- Phos 2.1, Glucose 151 (Stress), chol 244, AST 90- suspect secondary to straining, rule-out other trauma See attached labs.

**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 observed. A small 0.22 cm cystolith is noted. 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 left kidney measures 3.7 cm. The right kidney measured 3.82 cm.

**Adrenal Glands**

The right adrenal gland is normal in size (0.31 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.38 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. There is no evidence of cystic or common bile duct dilation.

***Gastrointestinal*****SPECIES**

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The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

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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 mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease.

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The visible colon is normal in wall thickness (< 0.2 cm) and layering. It is subjectively overdistended with normal appearing formed fecal contents.

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***Pancreas***

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

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***Free Abdomen***

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

There is no apparent lymphadenopathy noted in these images.

**INTERPRETED BY**Beth Johnson, DVM  
DACVIM**ULTRASONOGRAPHIC FINDINGS**

- Urinary bladder debris with a small cystoliths
- Full colon – consistent with the patient's reported history of constipation.
- Otherwise unremarkable/normal abdomen

**IMAGING PERFORMED BY**

Amy Mayhew, LVT

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Recommendations include managing this patient's constipation with adequate hydration, potentially in the form of subcutaneous fluid therapy at home. Stool softeners such as lactulose +/- enemas and potentially transition to a fiber response or colitis diet. If that doesn't alleviate the problem, an anesthetized de-obstipation may be necessary. After relief, stool softener may be able to be discontinued. However, if well tolerated, the diet could be continued long-term to minimize or prevent occurrences.

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SVS Mobile Imaging MI 734-637-7711  
svsimagingmi@gmail.com



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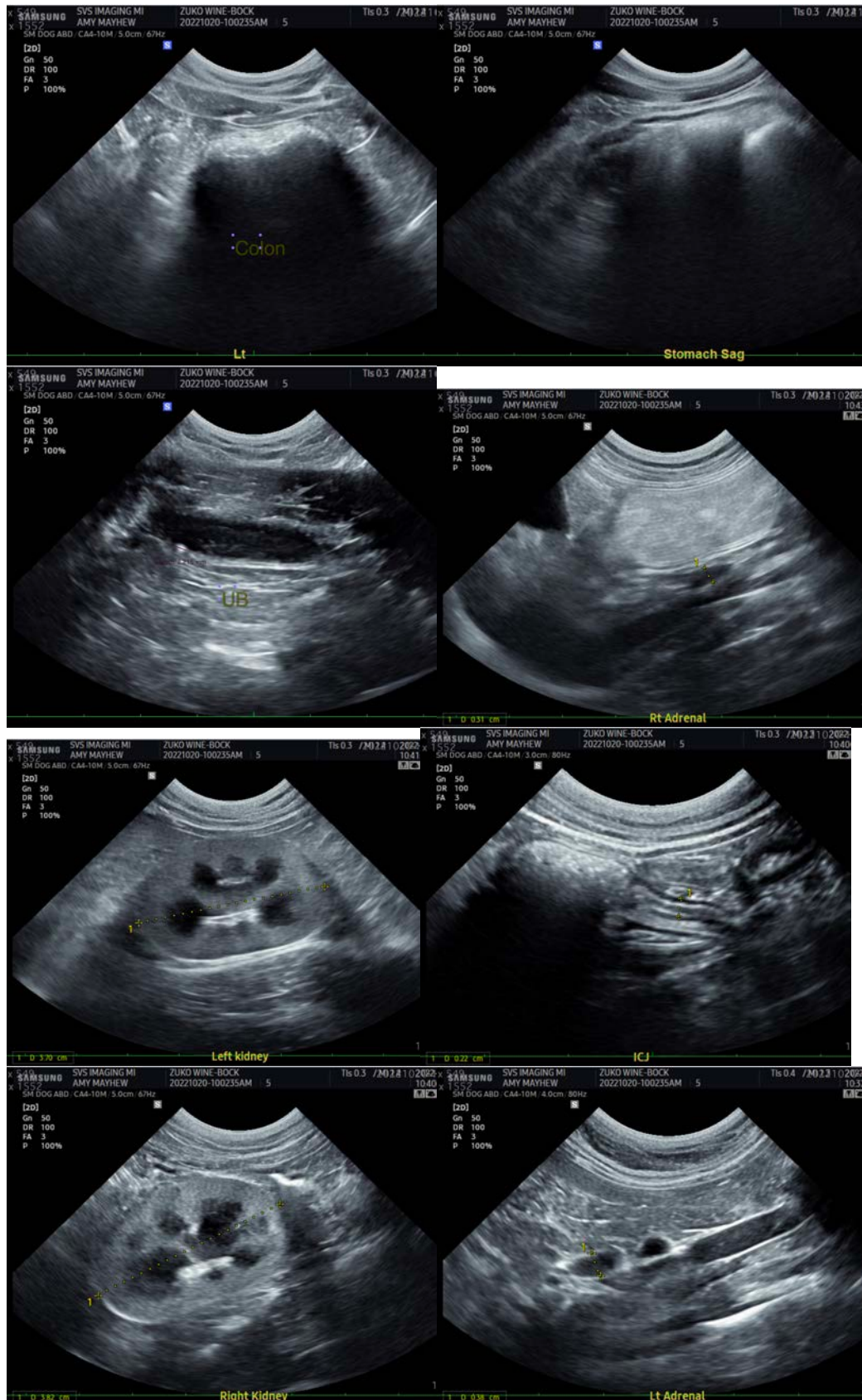
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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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Beth.Johnson@sonopath.com

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