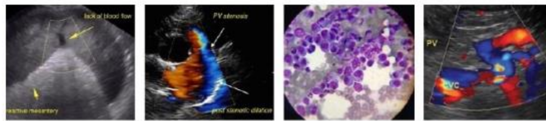




**PATIENT**

Ferrah Sheeler

**SPECIES**

Feline

**BREED**

Bengal

**SEX**

Intact Female

**AGE**

2 Years

**WEIGHT**

4.2 kg

**INTERPRETED BY**

Beth Johnson, DVM DACVIM

**IMAGING PERFORMED BY**

Kelly Reschny

**HOSPITAL NAME**

Hamilton Region VEC

**REFERRING VET**

Dr. Vercaigne

**INVOICE**

21082

**DATE**

2/13/23

## PRESENTING CLINICAL SIGNS

History: mild dehydration - serosanguinous vaginal discharge - mild abdominal distension, discomfort. Colon firm, mild to moderately full. Uterus palpates mild to moderately prominent. - 2 week Hx moderate frank hemorrhagic vaginal discharge. - 2+ days Hx lethargy, hyporexia

Abnormal PE/Chem/CBC/UA Results: Single lateral abdominal radiograph: - moderate stool within colon - mild to moderate gas filled SI loops with moderate soft tissue opacity within or summating with uterus potentially - area of bladder and uterus appear WNL - stomach moderately full soft tissue opacity similar to ingesta (hyporexia)

## 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 (3.61 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 (3.97 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 (0.27 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.25 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

### *Spleen*

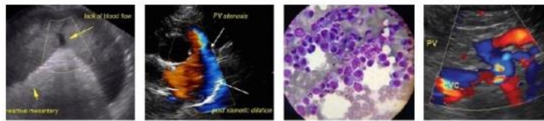
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

### *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*





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The visible stomach wall is normal in thickness and layering. The stomach is mildly distended and contains an echogenic interface with distal progressively shadowing material consistent with hairball density (or similar fluid absorbing material) noted.

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.

The visible colon is normal in wall thickness and layering. The colon is mildly subjectively overdistended with subjectively very firm stool.

### *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.

### *Other*

Both ovaries and the uterus are visualized without obvious notable pathology.

## ULTRASONOGRAPHIC FINDINGS

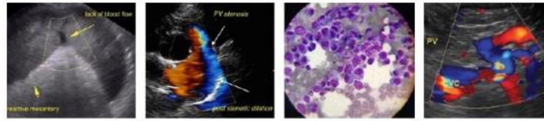
- Gastric Hairball – similar density soft foreign material cannot be ruled out. Given the suspicion of a postprandial abdomen, normal ingesta/gas as well, cannot be ruled out and this finding should be interpreted in combination with supportive clinical signs, as well as visual progression vs resolution of the gastric contents.
- Subjectively mild colonic distention, as well as firm stool.
- There is not an ultrasonographic explanation for this patients reported chronic hemorrhagic vaginal discharge.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a general metabolic health screen is recommended, including a CBC/chemistry panel, electrolytes, urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

If there is any history of clinical constipation in this patient, management could be considered in the form of rehydration +/- enema, stool softeners, etc., with monitoring of the lethargy and decreased appetite, etc., for improvement, however, this is likely not related to the chronic hemorrhagic vaginal discharge, and given that history, uterine pathology is suspected despite the lack of an obvious visible cause. One differential being an open pyometra, given the discharge, but the nondistended state of the uterus. Therefore, additional recommendations include an ovariohysterectomy if owner approved.

If ovariohysterectomy is declined, vaginal cytology is recommended, as well as potentially further investigation for possible infectious disease, and/or medical management of an open pyometra with





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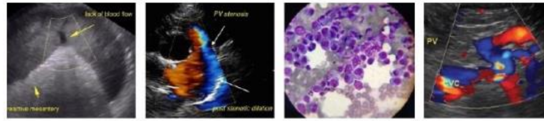
monitoring for progression vs improvement.





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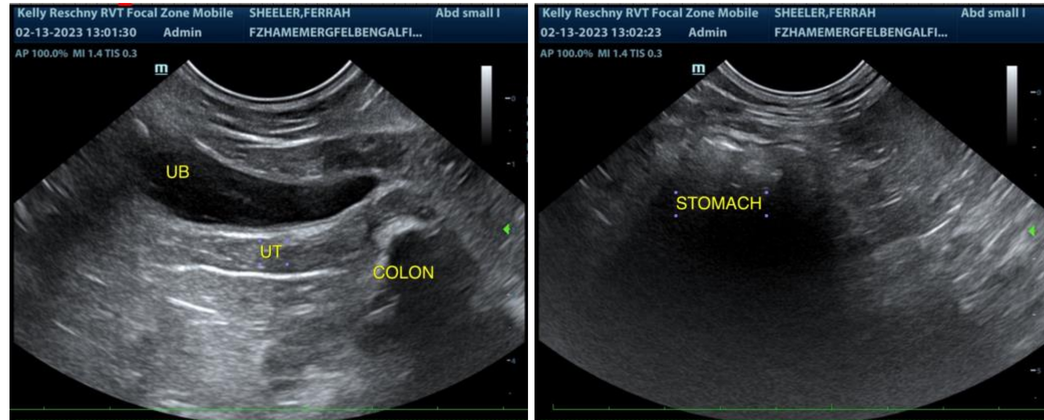


**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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