

PATIENT PRESENTING CLINICAL SIGNS

Green Desrochers

SPECIES

Feline

BREED

Maine Coon X

SEX

Neutered Male

AGE

14 Years

WEIGHT

4.44 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Beattie PH Burlington

REFERRING VET

Dr. Murota

INVOICE

21234

DATE

2/28/23

History: Feb-17th-2023 after 2 weeks of antibiotics pet is not improving. loss of appetited now and increased uncontrolled runny stool. receiving medications - pred, metronidazole, clavaseptin, gabapentin, Pale pink, slightly uncomfortable on abdominal palpation , Feb-19th-2023 Recheck QAR, mm slightly pale pink, crt <2s Slightly prolonged skin tent ~5 % dehydrated Weight maintained since last visit - but 1.5kg drop since Nov Comfortable upon abdominal palpation, but very fluidly loops of SI palpable. Tiny bladder HR 188 , RR 24 T37.5, BCS 4/9 Current Medications On metro, prednisolone, clavaseptin and mirtazipine. Gets B12 q1mo, Cerenia 0.43ml SC Mirtazapine 1/4 tablet PO EOD nth, Abnormal PE/Chem/CBC/UA Results: L Urea (BUN) 3.5mmol/L 5.7 - 13.2 mmol/L H Calcium c 3.1 mmol/L 2.2 - 2.7 mmol/L L Globulin 29 g/L 30 - 59 g/L Albumin: Globulin 1.3 g/L Ratio 0.5 - 1.2 g/L H Spec fPL d 7.9 0.0 - 3.5 ug/L Urinalysis results Color Dark Yellow Clarity Cloudy Specific Gravity 1.048 pH 5.5 Urine Protein 2+ (1 g/L) Glucose 2+ Ketones Negative Blood / HemoglobinTrace-Lysed Bilirubin 1+ Urobilinogen Normal White Blood Cells 2-5 /HPF Red Blood Cells 0-2 /HPF Radiographic Findings Lots of gas within colon. No obvious masses or obstruction seen. Bladder appears normal.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended (empty). Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. If there are urinary signs and/or concern for urinary bladder pathology, reassessment after complete filling is recommended.

Left kidney is normal in size (3.99 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 in size (3.82 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 (0.4 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.29 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.



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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.

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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 empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness and layering. Contents are consistent with soft stool.

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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.

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Free Abdomen

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

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ULTRASONOGRAPHIC FINDINGS

- Gastric Hairball – similar density soft foreign material cannot be ruled out. Normal ingesta/gas cannot be ruled out, but the shadowing is concerning.
- Soft stool in the colon, consistent with this patients reported diarrhea.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

IMAGING

PERFORMED BY

Kelly Reschny

It is unclear in this patients history what the clinical signs were that resulted in the patient being put on antibiotics, and the decreased appetite and diarrhea are reported to have begun after antibiotic therapy, and therefore may be secondary to the antibiotics. Having said that, underlying chronic infiltrative bowel disease cannot be ruled out, especially if my interpretation of the history is inaccurate. In that case, 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.

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A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease.

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Additionally, given this patients reported hypercalcemia, further evaluation is recommended with a malignancy panel to include PTH, PTHrP and ionized calcium.

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In the meantime, in addition to discontinuing antibiotics, if possible, supportive/symptomatic therapy is recommended with a probiotic, such as Visbiome or Provable, empirical deworming with a 5-day course of Panacur, and potentially if tolerated, once appetite improves, transition in diet, potentially to a hydrolyzed protein diet or a bland easy to digest diet or other, based on trial and error response, if this patients gastrointestinal signs are chronic vs acute after beginning antibiotics.

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Regarding the suspicious appearance of the gastric wall, recommendations are partially dependent on



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patients clinical history and could include a conservative approach, characterized by fasting for 12-24 hours and recheck imaging of the stomach to help further evaluate normal gas, ingesta, etc., vs foreign material. Additional imaging, such as a Barium swallow, or even an upper GI gastroscopy/endoscopy, which if chosen, should be used to obtain biopsies of the stomach and small bowel at the same time.

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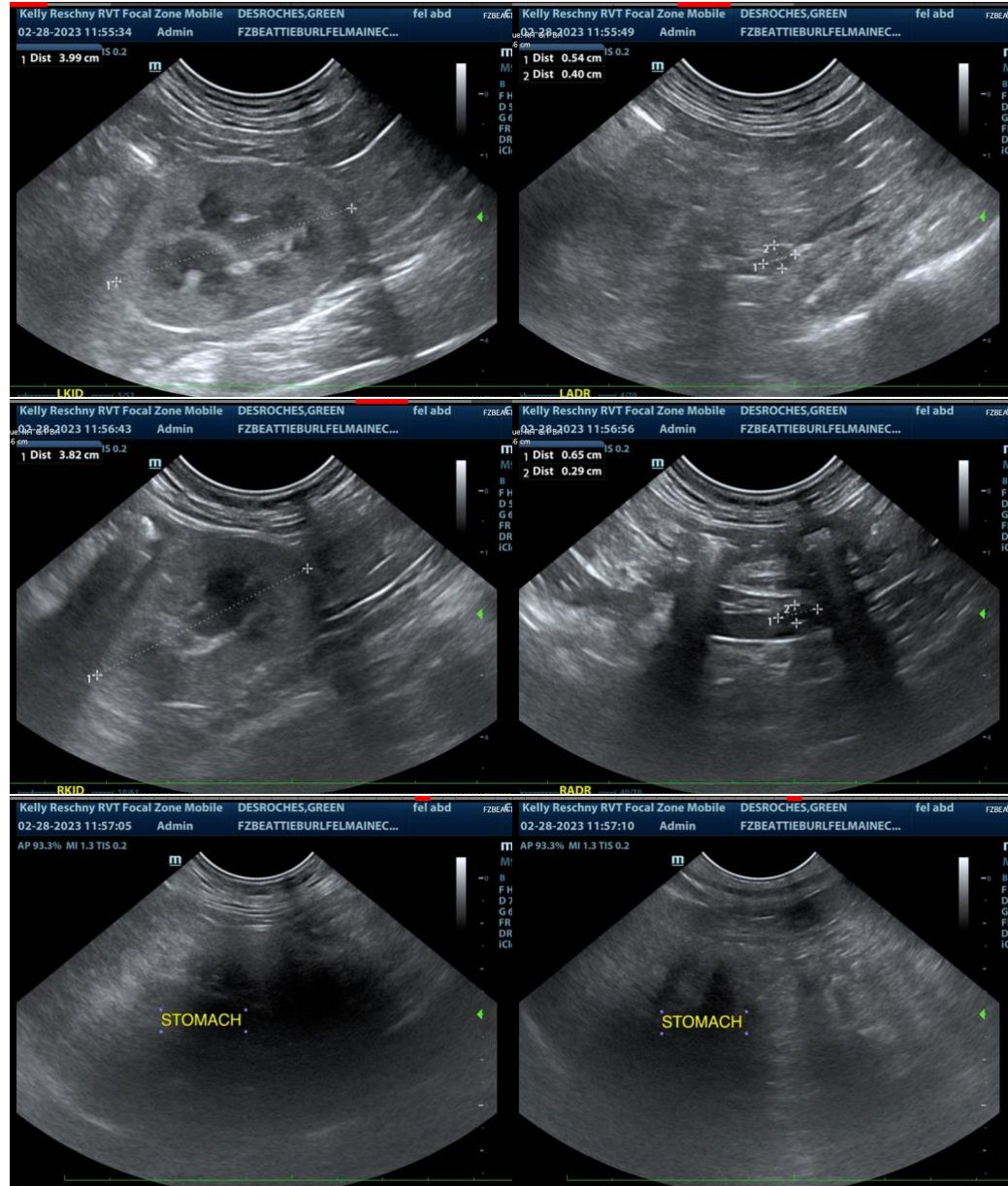
Dr. Murota

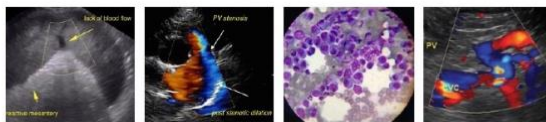
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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