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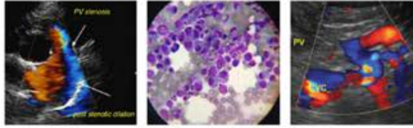
SVS Mobile Imaging MI 734-637-7711
svsimagingmi@gmail.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT
Charlie Crocker

SPECIES
Feline

BREED
DSH

SEX
Spayed Female

AGE
5.5 Years

WEIGHT
9.5 Pounds

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Amy Mayhew, LVT

HOSPITAL NAME
SVS Imaging MI

REFERRING VET
Family Pet Practice

INVOICE
39992

DATE
8/1/22

PRESENTING CLINICAL SIGNS

urgent exam no improvement since OVRS visit yesterday. It has been 14 hours since OVRS visit. O withheld food as rec, no further V. Offered H2O as directed - no interest. P goes outside generally from 4a to 10a (times change depending on who is home to let cat in and out) P came in on Sunday around 10a and vomited multiple times and seemed lethargic. O took to OVRS for treatment. No vomiting noted since then. P belly bloated today and seems uncomfortable. P does want to go outside-Os have not allowed. O noted poss BM with grass and thick.
Abnormal PE/Chem/CBC/UA Results: BAR 5. No visible oral fb or wounds 9/10. Medium sized bladder, fluid sounds on palpation over caudal abdomen SI. - Paste like stool noted at home. Sample not available for testing. No palpable masses/fb 13. 1lb weight loss since last visit in March 2022 Email recent labs, radiographs and this form to: SVSimagingMI@gmail.com Reviewed differential for ALT elevation and vomiting- rule-out fb, intestinal inflammation, pancreatitis, primary hepatopathy/cholangiohepatitis, toxin. Recommended initial diagnostics AUS- O consented, reviewed torb for sedation - O consented, confirmed O will be home to monitor P tonight. results likely to be received tomorrow CBC Chemistry PT/PTT- reviewed risk for coag deficiencies with liver disease, certain toxins- PT- 16.4 (13-20s) APTT- 114.9 (96-124s) Bile acids testing (confirmed P is fasted since yesterday afternoon) Fecal parasite screening- need sample Informed O AUS **Please see attached records and labs

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately 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.

The right kidney is normal in size (3.67 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.

The left kidney is normal in size (4.13 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

The right adrenal gland is normal in size (0.38 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.36 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

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen is markedly distended with anechoic fluid. There is no visible evidence of foreign material or infiltrative disease present in these images. No evidence of obstruction, although obstruction cannot be definitively ruled out.

The visible small intestines are normal in wall thickness and layering. Bowel is diffusely mildly fluid distended without evidence of an obstructive pattern, plication and/or visible foreign material. Small intestinal hyperperistalsis is noted.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. The colon is distended with echogenic fluid.

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.

Free Abdomen

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

There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- **Gastroenteritis with gastric stasis –** Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other. Given the diffuse fluid dilation, gastroenteritis/ileus is considered the top differential. An obstruction cannot be definitively ruled out, but is considered less likely given the diffuse nature of the dilation in these images.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patient's neutropenia, increased liver enzymes, and diffuse ileus, differentials include infectious disease or potentially exposure to a toxin while outdoors versus other. Infiltrative neoplasia such as a lymphoma can't be ruled out, but is considered less likely.

Recommendations include a fecal exam as well as a fecal enteropathogen PCR panel to Texas A&M GI Laboratory for further evaluation of possible infectious disease.

A fine needle aspirate of the liver is recommended if patient's coagulation status is appropriate, which I believe it reportedly was, especially if medical management does not result in improvement of the ALT.

In the meantime, supportive/symptomatic medical manage with fluid therapy, antiemetics, gastroprotectants, and promotility agents such as Metoclopramide could be considered. Hepatic nutraceuticals and broad-spectrum antibiotics are also recommended. Nutritional support is also critical to prevent/manage concurrent hepatic lipidosis. Therefore, appetite stimulants, and/or if indicated, feeding tube placement is also recommended.

If clinical signs do not resolve and/or persist, recheck imaging of the ileus for another investigation of possible emerging obstruction not visible today, is recommended. If this patient does not improve, a diagnosis is not obtained, and neutropenia persists, bone marrow cytology could also be considered.

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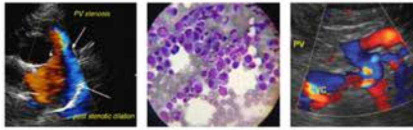

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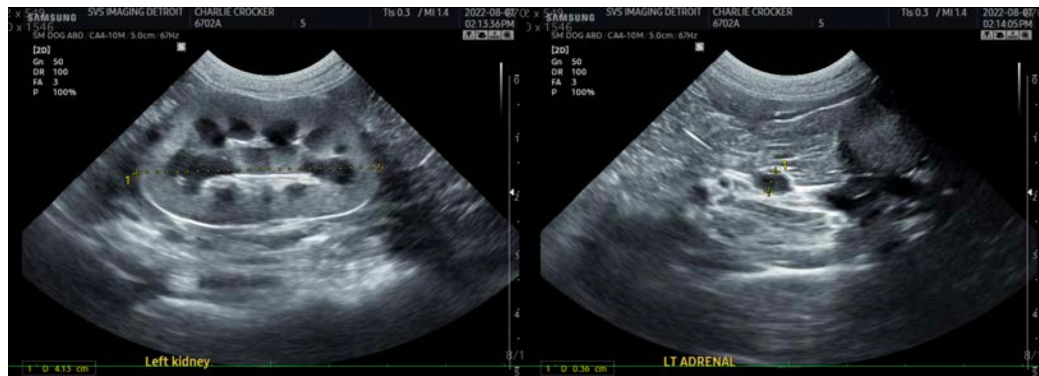

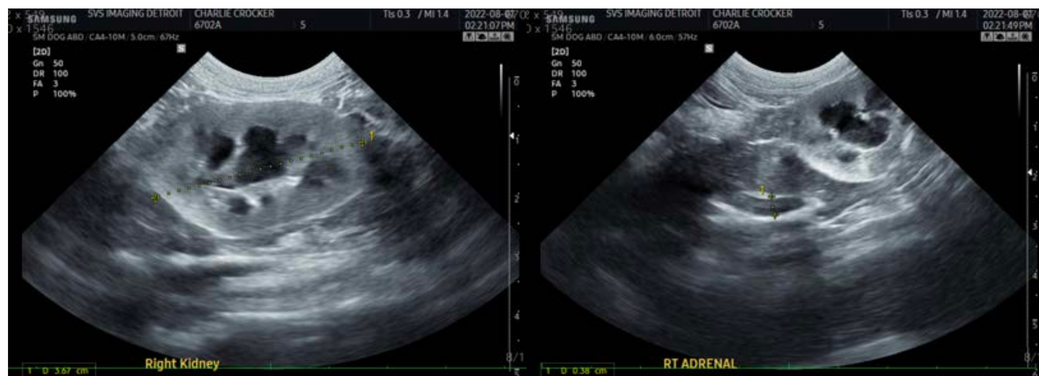

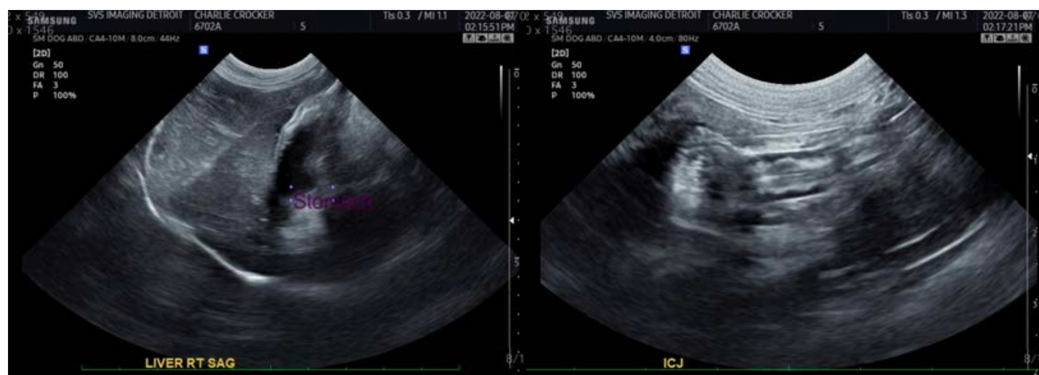

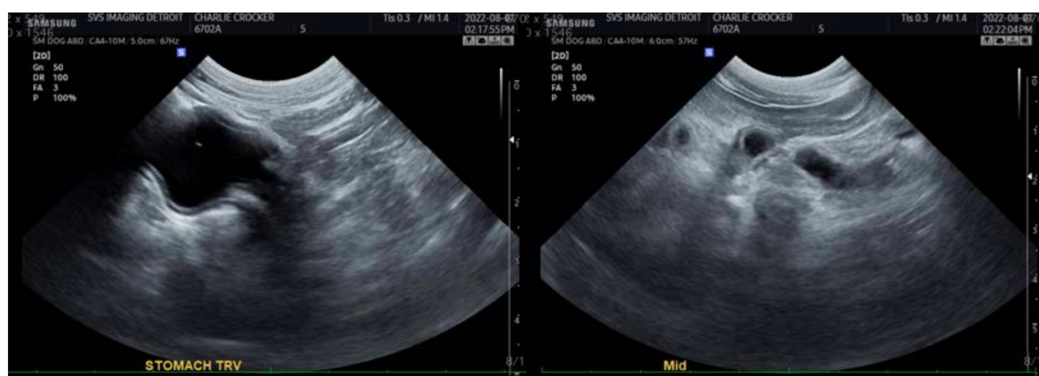

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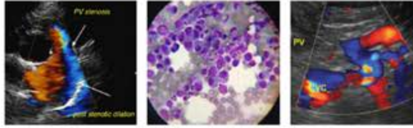

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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