



PATIENT

Mellow Sampsell

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

5 Years

WEIGHT

3.9 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Erin Wicks

HOSPITAL NAME

Shores VEC

REFERRING VET

Dr. Lupole

INVOICE

40722

DATE

8/25/22

PRESENTING CLINICAL SIGNS

Presented at our hospital for wheezy is normal for her, 2 weeks ago went to rDVM for distemper vaccine, 5 days ago getting lethargic, 3 days ago decreased eating, now not eating, sleeping all day, skin tent seems dehydrated, temp of 105F at home. O is concerned about potential ovarian retention with the tense abdomen Previous Health Concerns: FIV+, teeth extracted due to ulcerative stomatitis, hepatomegaly, immune mediated dz, liver flukes, UTI Current Medications: gabapentin, Cerenia

Abnormal PE/Chem/CBC/UA Results: Temp 104.2 Abdominal: thickened bowel; very tender cranial abdomen Genitourinary: small bladder- seems tender to palpate- easily expresses urine with blood clots Cbc: NR Chem:8.3; globulin 5.8 Epc:K+ 3.5 lactate 3.69 glucose 170 Rads: empty bowel/stomach; small amount of stool in colon Ua: rods, wbc. Rbc spgrav: 1050

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 (3.79 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 (3.71 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 (0.42 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The area of the left adrenal gland is examined without evident pathology.

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

Liver is subjectively enlarged (swollen contour). Mild parenchymal remodeling with diffusely mildly coarse architecture and increased portal markings is present. No focal nodules or masses are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. The cystic and common bile duct are tortuous and mildly distended, measuring 0.50 cm, with some echogenic luminal contents, but no visible cause of obstruction. There is no evidence of effusion or inflammation.



PATIENT	<i>Gastrointestinal</i>
Mellow Sampsell	The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.
SPECIES	
Feline	The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). 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.
BREED	
DSH	The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.
SEX	<i>Pancreas</i>
Spayed Female	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.
AGE	<i>Free Abdomen</i>
5 Years	There is no evidence of free peritoneal effusion noted in these images.
WEIGHT	There is no apparent lymphadenopathy noted in these images.
3.9 kg	
INTERPRETED BY	ULTRASONOGRAPHIC FINDINGS
Beth Johnson, DVM DACVIM	<ul style="list-style-type: none"> • Hypoechoic hepatomegaly – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered. • Gallbladder debris with a tortuous, distended cystic and common bile duct also containing echogenic debris. These findings combined with the hypoechoic hepatomegaly are suggestive of a cholangitis/cholangiohepatitis, but can also be present with historical or resolved cholangitis or cholangiohepatitis, and therefore should be interpreted in combination with supporting clinical signs such as cranial abdominal discomfort and/or laboratory changes such as increased liver enzymes, etc.
IMAGING PERFORMED BY	<u>INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS</u>
Erin Wicks	Differentials for this patient’s decreased appetite and malaise, based on these ultrasound images and the history provided, include the reported urinary tract infection, as well as possibly cholangitis/cholangiohepatitis, potentially compounded by this patient’s FIV status, etc. While both conditions can result in abdominal discomfort, the marked degree of pain described in this patient seems inconsistent. Therefore, recommendations include further evaluation of possible orthopedic and/or especially neurologic sources of pain.
HOSPITAL NAME	In the meantime, treatment recommendations include fluid therapy, antiemetics, gastroprotectants, and broad-spectrum antibiotics in addition to pain management. Nutritional support is also critical to prevent concurrent hepatic lipidosis and can be attempted with an appetite stimulant, or, if necessary, feeding tube placement.
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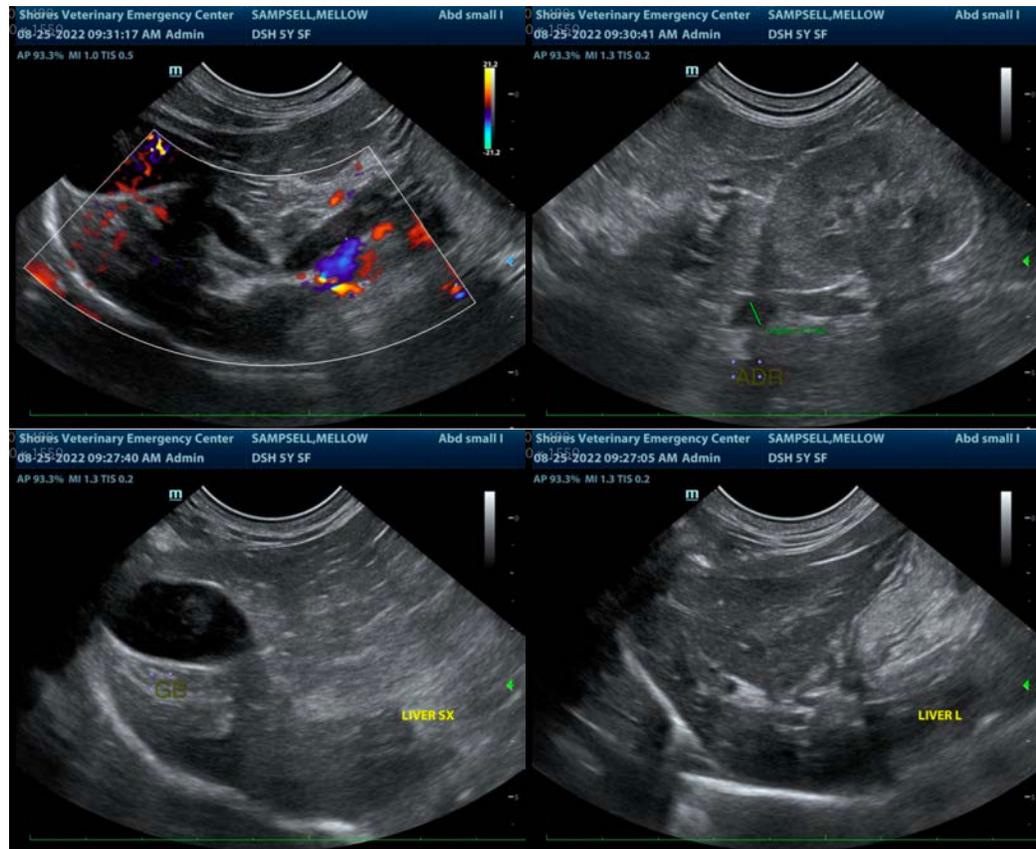
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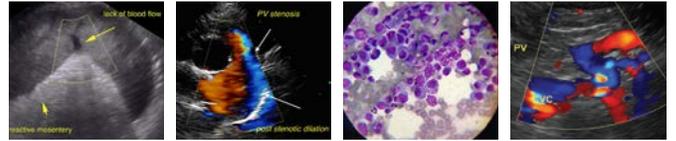
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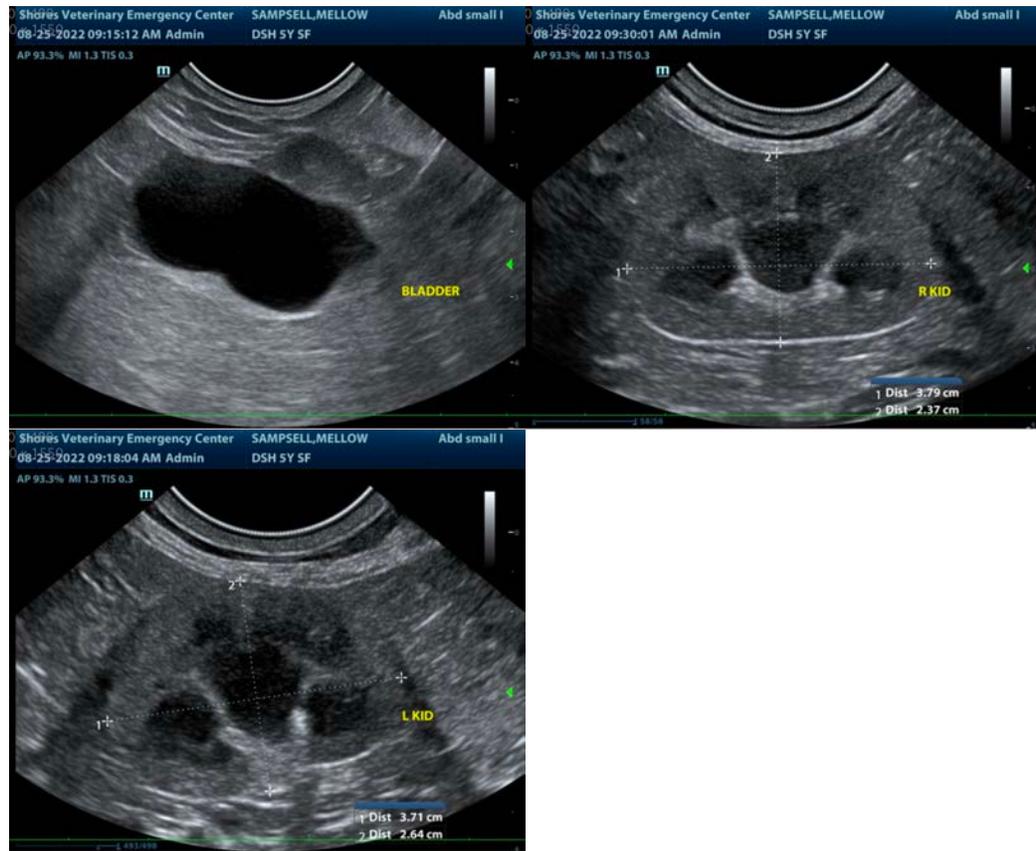
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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