



<b>PATIENT</b>	<b>PRESENTING CLINICAL SIGNS</b>
Hobbes Brasier	Presented 8/4 for 2 days of anorexia & vomiting. Indoor only. No known ingestion of foreign material or toxin exposure. Hx of surgery for GI obstruction in 2015.
<b>SPECIES</b>	Abnormal PE/Chem/CBC/UA Results: Baseline labs: CBC: HCT 59.8%, Lym 0.87k, Eos 0.08k, rest wnl. Chem10: Glu 171, TP 9.8, Alb 3.4, Glob 6.4, rest wnl. EPOC: iCa 0.96, Cl 106, Glu 167, K 3.3, Na 144, LAC 6.98, HCT 54% Abdominal rads: Stomach contains gas, formed stool and gas in colon. Small intestine contains fluid & gas, no pathological distention noted. No obstructive pattern in small intestine. 8/5/22 6am - Recheck EPOC: iCa 0.64, Glu 158, K 4.0, Na 141, LAC 4.17, pH 7.484, HCT 47% Placed NGT after US, removed 122 mL pale green gastric fluid.
Feline	
<b>BREED</b>	
DSH	<b>ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN</b>
<b>SEX</b>	<b>Urinary System</b>
Neutered Male	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.
<b>AGE</b>	The right kidney is normal in size (3.8 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.
8 Years 11 Months	The left kidney is normal in size (4.0 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.
<b>WEIGHT</b>	<b>Adrenal Glands</b>
10.6 Pounds	The adrenal glands are unable to be well visualized in these images.
<b>INTERPRETED BY</b>	<b>Spleen</b>
Beth Johnson, DVM DACVIM	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.
<b>IMAGING PERFORMED BY</b>	<b>Liver</b>
Dr. Couser	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.
<b>HOSPITAL NAME</b>	<b>REFERRING VET</b>
Willamette VH	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.
<b>REFERRING VET</b>	<b>Gastrointestinal</b>
Dr. Couser	The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is markedly distended with anechoic fluid, with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.
<b>INVOICE</b>	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). However, the proximal bowel is fluid dilated up to the level of an abnormal appearing intraluminal structure with an acoustic shadow, followed by empty normal bowel. This is consistent with an obstructive pattern.
40187	
<b>DATE</b>	
8/5/22	



**PATIENT**

Hobbes Brasier

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

**Pancreas**

**SPECIES**

Feline

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.

**BREED**

DSH

**Free Abdomen**

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

**SEX**

Neutered Male

There is no apparent lymphadenopathy noted in these images.

**AGE**

8 Years 11 Months

**ULTRASONOGRAPHIC FINDINGS**

- **Obstructive pattern in the small bowel**, characterized by dilated bowel leading up to an unidentifiable object with acoustic shadow, followed by empty bowel. The top differential is a foreign body. However, a foreign body cannot be guaranteed, especially given the history of foreign body removal and the change that there could be bowel adhesions combined with the marked hypocalcemia, which could be causing ileus, etc.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

**WEIGHT**

10.6 Pounds

Recommendations include patient stabilization, primarily addressing hydration status and hypocalcemia, followed by an exploratory laparotomy for suspect foreign body removal.

As stated above, while foreign body is the top differential given the characteristic obstructive pattern in this bowel, a foreign body cannot be guaranteed, and therefore client should be prepped for possible negative exploratory.

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

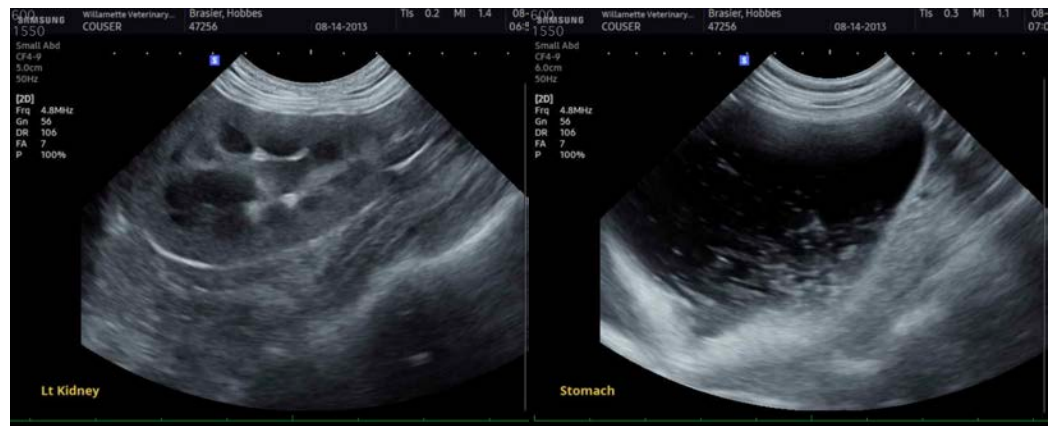
If a more conservative approach is elected, then aggressive medical management and supportive/symptomatic therapy of gastrointestinal signs, hydration status, as well as electrolyte abnormalities should be addressed with recheck abdominal imaging following continued fasting in 12-24 hours.

**IMAGING PERFORMED BY**

Dr. Couser

**HOSPITAL NAME**

Willamette VH



**REFERRING VET**

Dr. Couser

**INVOICE**

40187

**DATE**

8/5/22



**PATIENT**

Hobbes Brasier

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

8 Years 11 Months

**WEIGHT**

10.6 Pounds

**INTERPRETED BY**

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**REFERRING VET**

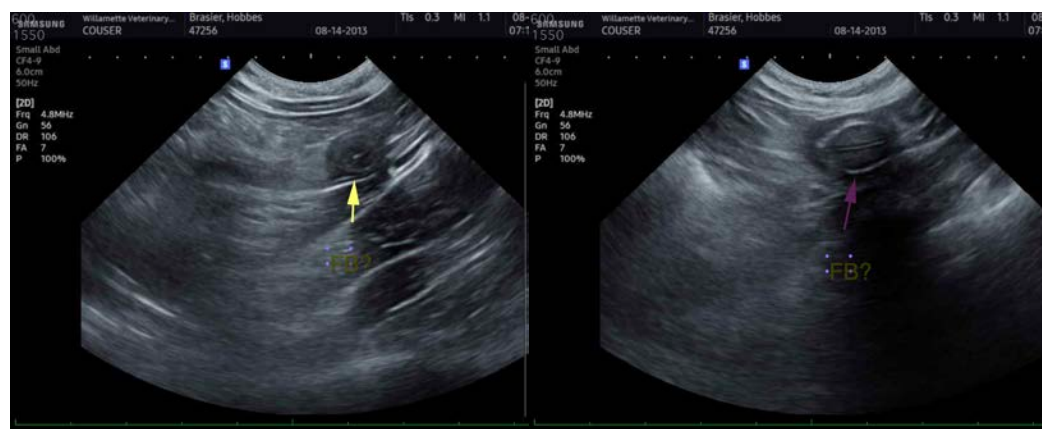
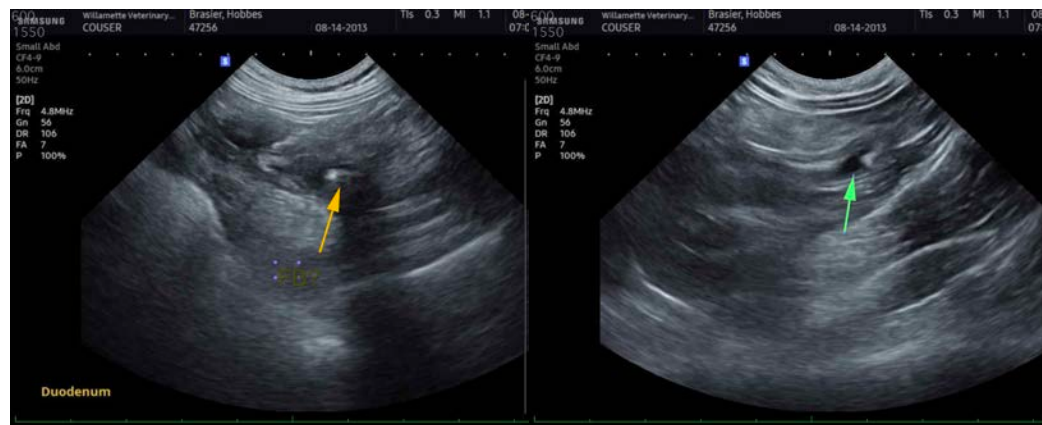
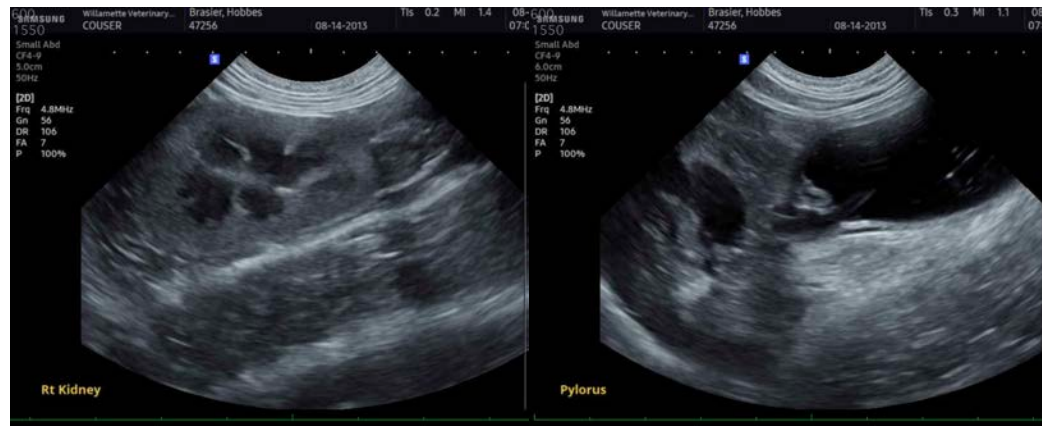
Dr. Couser

**INVOICE**

40187

**DATE**

8/5/22



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**

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