



PATIENT PRESENTING CLINICAL SIGNS

Tigger Butler

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

15 years

WEIGHT

6.9 kg

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Callihan

HOSPITAL NAME

Animal Emergency
Care

REFERRING VET

Dr. Baker

INVOICE

42574

DATE

11/24/22

History: S: Tigger has been lethargic and vomiting since yesterday but may have also been intermittently vomiting for a week or more. He has been diabetic for several years and received 6 units of Prozinc insulin at 7:30-8am today. He did eat breakfast with his insulin but vomited the food later. Indoor only. Multiple cats in household. Last vet visit with rDVM was this past summer. Owners give Laxatone occasionally for intermittent constipation. A: Obtunded, non-ambulatory, dehydrated Diabetes Mellitus Overweight P: Placed IV catheter. BG: Low on glucometer. 0.5mg/kg 50% Dextrose (diluted 2:1) IV over 15 minutes (3.5ml dextrose) Cerenia 0.69ml IV BG (post Dextrose bolus): 124 Rec full labwork +/- abd rads and hospitalization on IV fluids and dextrose drip Owners approve estimate - Care Credit approved Started LRS at twice maintenance (23ml/hr) with 5% dextrose drip Give Gabapentin 100mg PO TID - first dose at 1pm CBC: Mild neutrophilia (13.66) Chem: Moderate azotemia (BUN 79 & Creatinine 3.3) Hypoglycemia 59. Mild amylase elevation (1874). Hypokalemia (2.3) UA: USG: 1.014, pH 6.0, hematuria and proteinuria, epithelial cells and unclassified crystals BG on glucometer: 61 Patient became too fractious to handle. Gave 0.14ml Butorphanol IM. 2:52pm BG 86 4:03pm: BG 138 Added 60mEq/L KCL (added 28ml at 2mEq/ml of KCl to 934ml remaining fluids in bag) Abnormal PE/Chem/CBC/UA Results: O: T = 98.7 F (soft stool on thermometer), P = 140 bpm, R = 50 b/min. BP: 96. Glucose on admit was too low to read Azotemia BUN 79, Cr 3.3; hypokalemia 2.3 CBC: neutrophilia, USG 1.014; microscopic hematuria, proteinuria, quiet sed FNA of intestinal mass (abscess?) taken and did have purulent appearance, sheets of degenerate neuts and other inflammatory appearing cells, other questionable cells possibly malignant appearing (submitting for cytology and C/S if owners consent)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal.

A 0.4 cm calculus was noted in the caudal pole of the right **kidney**. The right kidney revealed microinfarcts and measured 3.66 cm. The left kidney revealed similar changes to the right with mild pyelectasia and cortical infarcts. The left kidney measured 4.0 cm.

Adrenal Glands

Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The right adrenal gland measured 0.5 cm. The left adrenal gland measured 0.4 cm.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes was noted.



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Liver

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The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

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Gastrointestinal

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Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. An undifferentiated intestinal/mesenteric lymph node mass was noted and measured 3.6 x 3.0 cm. The mass appears to be jejunal. The tissue is undifferentiated. Part of it appeared to derive from the intestinal wall; however, regional lymph node involvement is likely an issue. The ileocecal junction was free of pathology.

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Pancreas

The **pancreas** was enlarged, irregular and hypoechoic in the left limb.

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ULTRASONOGRAPHIC FINDINGS

Mesenteric lymph node/intestinal mass.

Concurrent pancreatitis.

IMAGING PERFORMED BY

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Kidneys appear to have moderate to end stage degenerative disease. Pre renal and renal component of the azotemia is likely an issue.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

FNA of the mass is indicated. Clean resection may be difficult in this patient. Screening FNA of the intestinal mass and pancreas is warranted for staging purposes. If neoplastic pathology is limited to the intestine/lymph node then exploratory surgery can be considered with potential resection and anastomosis. The prognosis is guarded long term regarding the kidneys alone.

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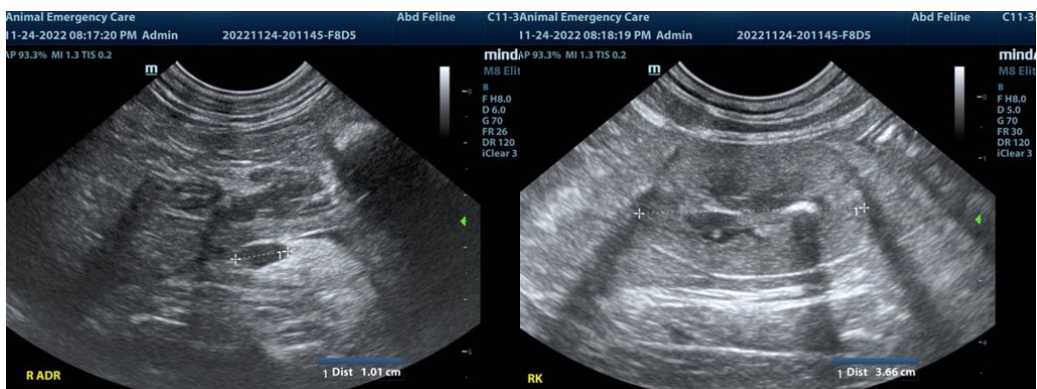
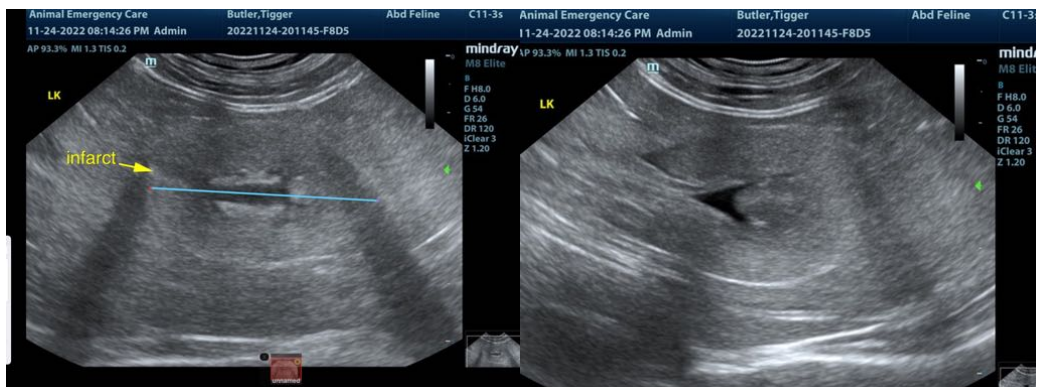
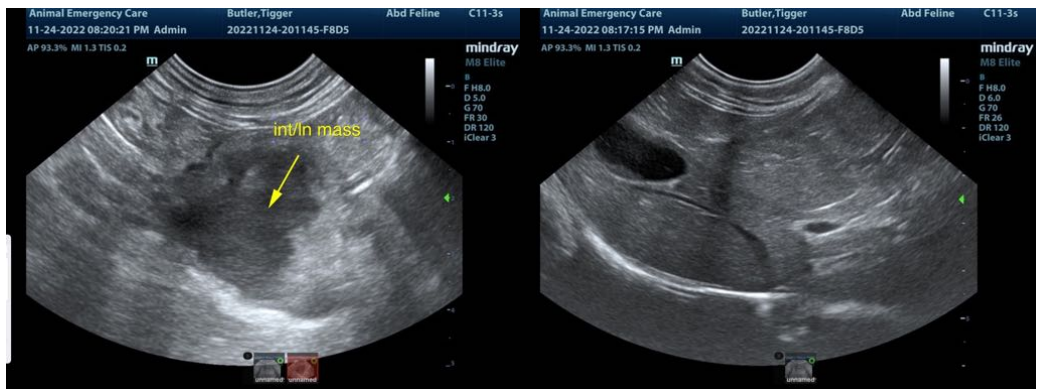
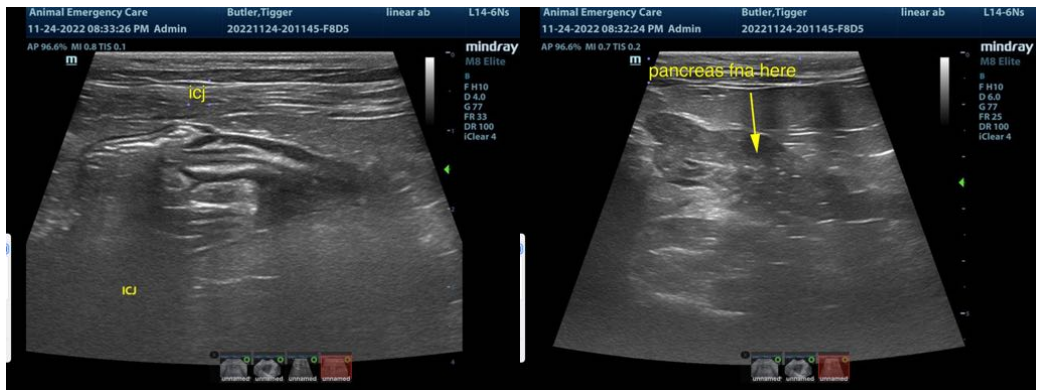
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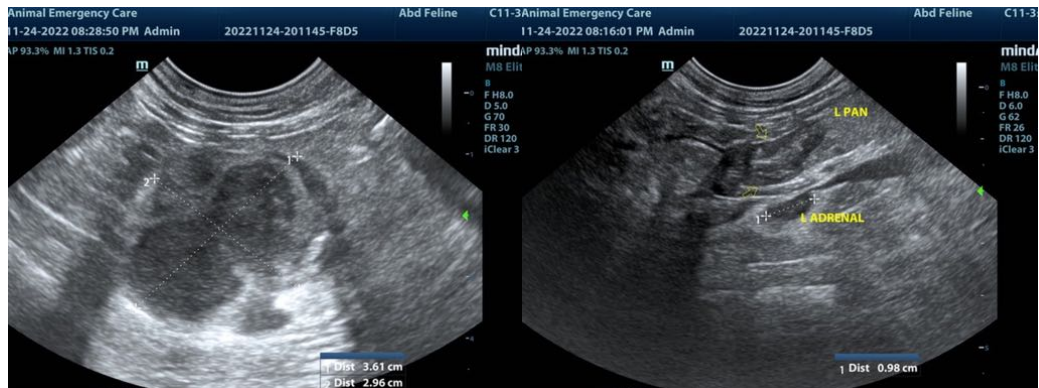
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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