



PATIENT PRESENTING CLINICAL SIGNS

Danger Coop

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

9 years

History: Hospitalized for severe azotemia and potential SIRS/Sepsis; Night 2 of current treatment. Initially presented 12PM 9/15 (thursday) as transfer from pDVM; - Vague history of DM and glargine administration PRN at home; - vomiting/diarrhea since Sunday (9/11/22) with collapse; - OP treatment w/pDVM but continues to decline; Hx if IBD possibly and was restarted on prednisone; had been on onsiar this past week also. Current treatments: - LRS 137 mL/kg/d - KCL 40 mEq/L - Dextrose 1.25% - Metoclopramide 1.5 mg/kg/d - Unasyn 30 mg/kg IV q8 hours - Maropitant 1 mg/kg IV q24 hours - Pantoprazole 0.5 mg/kg IV q12 hours - Metronidazole 12 mg/kg IV q12 hours - Dex-SP 0.15 mg/kg IV q24 hours PRN - Methadone 0.2 mg/kg IV q6 hours PRN - Recovery CRI 25% RER via NG tube - Aspirate NG tube q2 hours

Abnormal PE/Chem/CBC/UA Results: PE: Moribund/obtunded, laterally recumbent upon arrival. Emaciated. 9/15 pDVM CBC: -- WBC 4.22, -- NEUTROPENIA (NEU 1.45), -- LYMPHOPENIA (LYM 0.57), -- MONOCYTOSIS (MONO 2.10), -- THROMBOCYTOPENIA (PLT 66k) 9/15 pDVM Chemistry: -- SDMA 88, -- CREA THTM, -- BUN >130, -- PHOS >16.1, -- HYPERPROTEINEMIA (TP 9.1), -- AST 132, -- TBil 3.0, -- CHOL 255, -- Na 148, -- HYPERKALEMIA (K+ 7.7), -- Cl 105 9/15 pDVM UA: USG 1.023 9/16 In-house blood work: - 5PM Chem 17/Lytes: -- GLU 268, CREA 1.7 (IMPROVED, NORMAL), -- BUN 78 (IMPROVED, H), -- PHOS 8.9 (IMPROVED, H), -- K+ 3.0 (IMPROVING, L), -- Cl 110 (static, L) 9/17/22: 5AM: Clinical condition static; - BG: 301 - LYTEs: Na 155, K+ 3.4, Cl 111 - PCV/TS: 27%, 7.0 g/dL, icteric - CBC: WBC 2.03, NEU 0.35, LYM 0.82, MONO 0.75, - EOS 0.06, - PLT 97k Urine Culture/Sensitivity: pending

WEIGHT

2.82 kg

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** was over distended with suspended debris at the time of the sonogram. The urethra was dilated, yet without pathology up to 3.0 cm beyond the cystourethral junction.

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

The **kidneys** were mildly swollen. The corticomedullary definition was maintained. Slightly increased cortical echogenicities are non-specific. This is a non-specific finding and not specifically pathological. The left kidney measured 3.67 cm. The right kidney measured 3.7 cm.

IMAGING PERFORMED BY

Dr. Mayfield

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 0.4 cm. The left adrenal gland measured 0.32 cm.

HOSPITAL NAME

Emergency VH

REFERRING VET

Dr. Mayfield

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. The spleen measured 0.87 cm.

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Liver

Danger Coop

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

There was some residual chyme and gas was noted in the **stomach**, yet not pathological. This is consistent with end post prandial presentation. Transit of chyme into the small intestine was normal. Curvilinear patterns were maintained throughout the GI tract. No evidence of pathology. The small intestine appeared to be dilated with chyme. The mesenteric lymph nodes were unremarkable and essentially normal at 3.0 mm in width.

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Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

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ULTRASONOGRAPHIC FINDINGS

Suspect distal small intestinal obstruction beyond the field of view.

Full stomach and transiting chyme.

Mildly swollen kidneys.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The Prednisone may be suppressing more significant GI Presentation. Structurally the liver appears normal therefore, the bilirubin elevation should be rechecked to ensure this is not artifactual or possible related to hemolytic disease. Urination history should be evaluated in this patient. At the time of the sonogram the bladder was over distended as was the pelvic urethra. Full CNS examination is warranted. Systemic toxin or infectious agent is suspected if there is no history of obstruction present.

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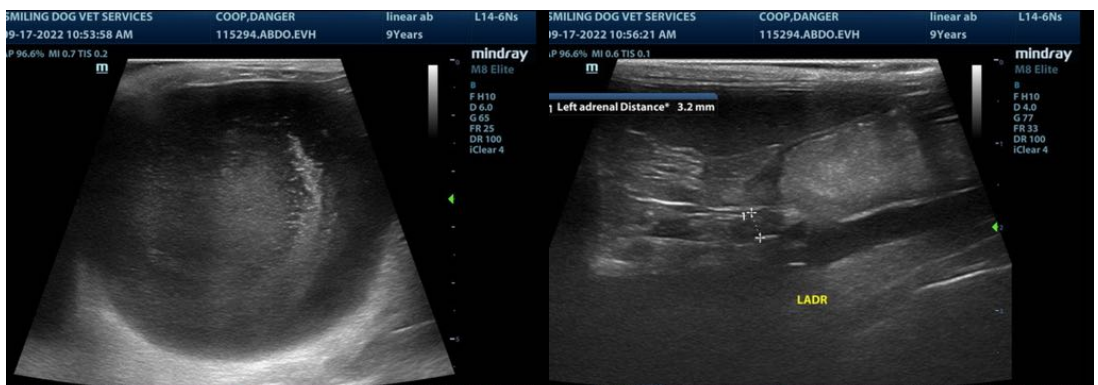
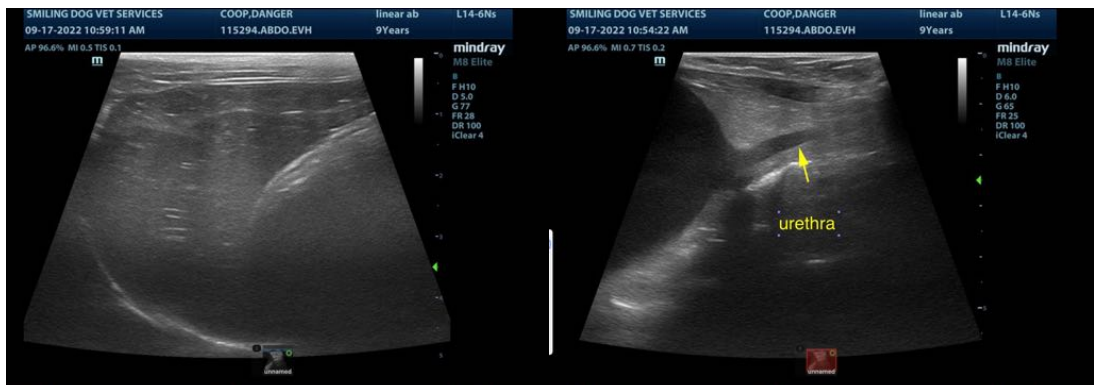
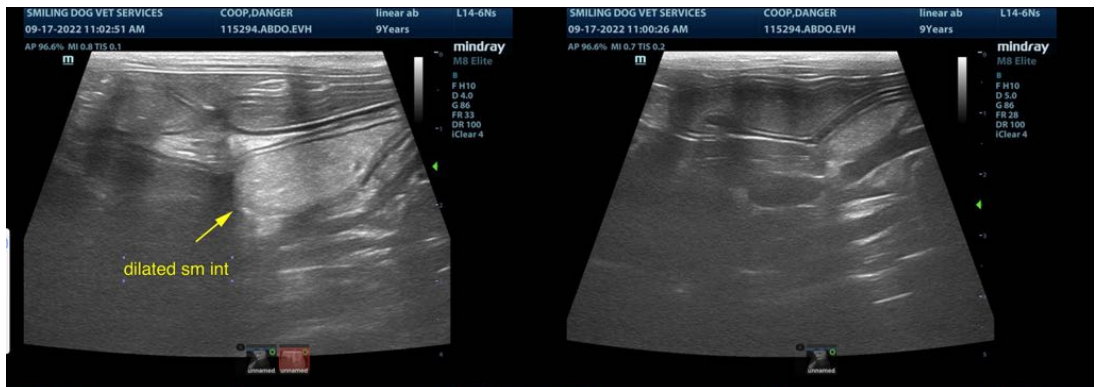
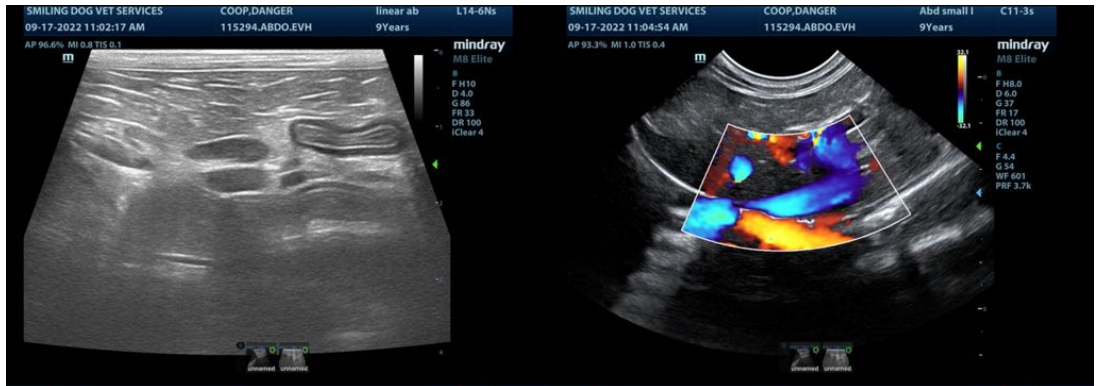
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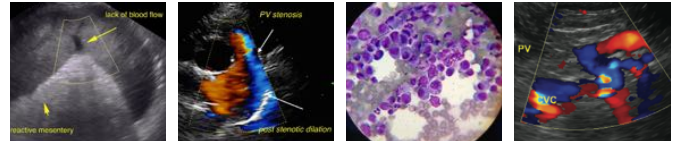
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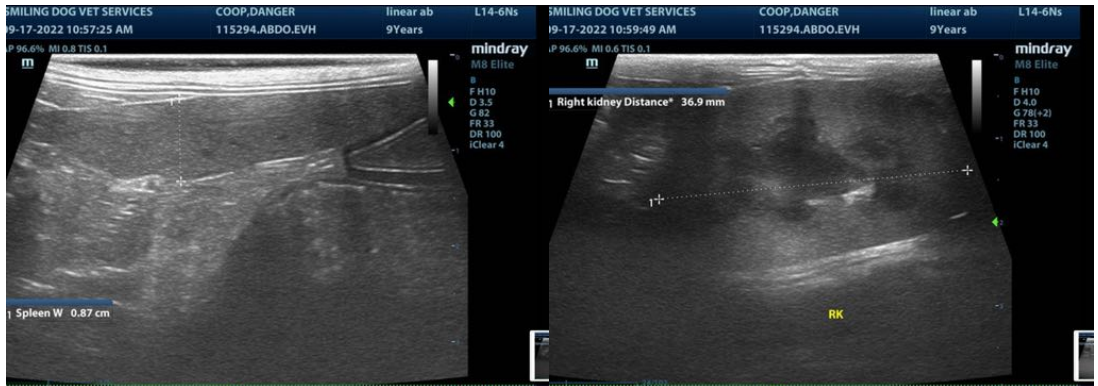
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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