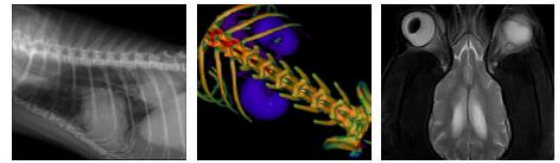
SonoPath Teleradiology

EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com™
1-800-838-4268 info@sonopath.com

PATIENT

Silas Woodard

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

3 Years

INTERPRETED BY

Heike Rudorf, DVM, Dr. med. Vet., DipECVDI DVR

HOSPITAL NAME

Northshore VH

REFERRING VET

Dr. Karla Schultz

INVOICE

22140

DATE

4/20/23

PRESENTING CLINICAL SIGNS

History: P presented to ER clinic for hyporexia/vomiting/lethargy on 4/16 pm, he had gotten into trash the day prior. P febrile (103.6), mild nasal d/c, on rads slightly distended stomach with no obvious foreign material. Started OP care with SCFs, cerenia, amoxi/clav. P returned 4/17 late night for persistent lethargy and vomiting. Exam = worsened fever (106.2), sedated orogastric tube passed to remove 25 mL brown/chunky material, AUS suspicious for plastic in stomach, started unasyn, transferred 4/18 to our hospital for possible endoscopy. Started with further work up of fever prior to anesthesia- in house labs showed profound neutropenia, bilirubinemia, elevated AST. Proceeded with IVFs, unasyn IV, cerenia IV. Added metro IV 4/18 d/t persistent fever despite 24h unasyn, p willing to eat starting 4/19 pm. Oral doxycycline suspension started 4/19 with persistent fever and persistent profound neutropenia. Temperature normalized 4/19 pm. Recheck 4/20: p eating, temp is normal, neutrophils slightly improved. Rads taken to track possible foreign material/obstruction originally suspected 4/17.

Abnormal PE/Chem/CBC/UA Results: CBC 4/20: neutropenia (currently 200 per uL), mild thrombocytopenia (126K) chem 4/20: persistent stress hyperglycemia (162), normalized electrolytes (Na, K, Cl were low 4/18), improved increased AST (216 prev 385), increased ALT (178), normalized t bili (0.8 prev 3.1), GGT and ALP have been normal throughout u/a 4/18: USG 1.020, bilirubinuria, suspected bacteriuria FeLV/FIV/HW 4/18: neg x3 pending: -urine culture -FUO panel

RADIOGRAPHIC STUDY OF THE ABDOMEN

18.4

The body condition score is 6/9 with smooth alternating layers of fat and soft tissue opacity.

The bony structures are within normal limits.

The abdominal detail is good; diaphragm and abdominal wall are intact.

The liver is located just within the costal arch and the caudo-ventral lobe is pointed.

The spleen appears physiological.

The stomach contains a small amount of air; distribution and size of the small intestinal loops appear physiological. Colon and rectum contain a small amount of fecal matter.

With 3x L2, the renal length is bilaterally just above the normal range of 2-2.5x the length of L2. They also appear plump and wide in the latero-medial direction without an obvious indentation of the renal pelvis on the VD view. The bladder is located in the abdominal cavity and contains a small amount of homogeneous fluid opacity.

The sublumbar region appears physiological.

19.4

The bladder shadow is large.

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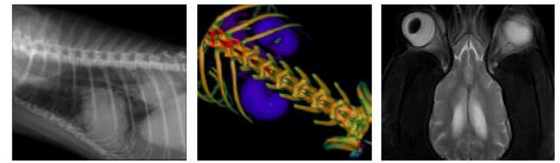

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20.4

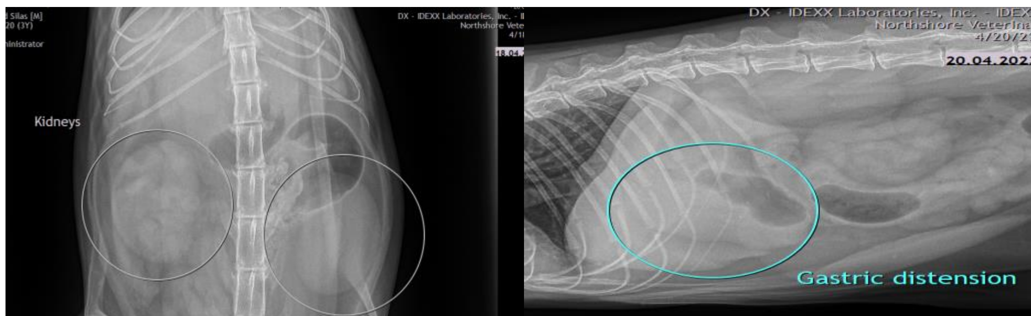
The stomach is distended by a large amount of fluid and some air. The bladder is moderately filled.

RADIOGRAPHIC DIAGNOSIS

- Bilateral renomegaly, mild
- Varying gastric distension

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

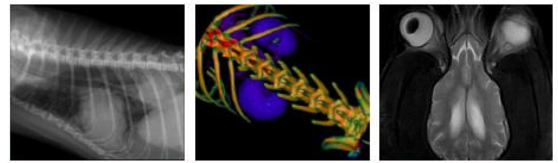
I can see no radiopaque foreign body but I cannot rule out a radiolucent foreign body on the last images. However, I agree with your evaluation of the stomach. It is unusual for cats to eat foreign objects; linear structures such as wool are more likely and will cause a degree of ileus. However, over the three-day period I have not been able to identify an ileus, intestinal plication or intestinal gathering which go along with a linear foreign body. Elevation of bilirubin in blood and urine could be due to hepatic disease (e.g. hepatic lipidosis, cholangiohepatitis), bile duct obstruction as well as due to pancreatitis or lymphoma (e.g. gastric wall and kidneys). I recommend repeating the abdominal ultrasound to look specifically for these diseases. This examination will allow re-checking the gastric contents. Gastric and duodenal ulcerations can only be detected during endoscopy thus I would keep this option open if the vomiting does not cease despite initial response to treatment.



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.

Heike Rudorf, DVM, Dr. med. vet., DipECVDI, DVR
dr.h.rudorf@gmail.com



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