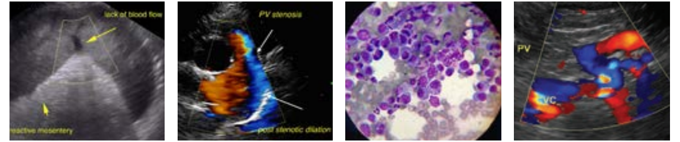

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1-800-838-4268 info@sonopath.com

PATIENT

Mya Lines

SPECIES

Feline

BREED

Burmese

SEX

Spayed Female

AGE

7

WEIGHT

2.8 kg

INTERPRETED BY

Jessica Midence, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Dr. Callihan

HOSPITAL NAME

Pacific Crest Mobile

REFERRING VET

Dr. Groff/Chuckanut Feline

INVOICE

45036

DATE

2/10/23

PRESENTING CLINICAL SIGNS

Mya was examined at AEC on 02/05/23 for acute vomiting, lethargy, and anorexia over a 24-hour period. She was noted to have an increased respiration rate with some lung crackles. Issues started with the vomiting on Saturday, prior to that she was normal. She received an injection of Cerenia and was sent home with sucralfate, Elura, and recommended adding canned pumpkin with her food. Mya has not improved since her visit with AEC. O does not think P vomited for 24hrs after getting the Cerenia injection but has vomited quite a bit since it wore off. She has been hiding, has had some labored breathing--O notes that her throat was moving with every breath, she has not eaten within the past 2.5-3 days, today she drank a little water after vomiting. She has vomited after getting her elura, and after syringe feeding. Energy/appetite/water consumption decreased. 2/7/23 to BBVSH for increased insp effort; 3 view thoracic rads showed gas filled esophagus, normal heart, mild bronchointerstitial infiltrates but overall no concern for cardiac or respiratory disease. She was hospitalized overnight on fluids and GI support, improved some but had not eaten yet when she was discharged PE: marked upper airway congestion, really struggled to get this ultrasound done w light sedation as she does not move air without active effort. I positioned her in all different ways to try and move GI air and get visualization but still very limited. CBC normal Chems: -gluc 268 -Total Ca 7.1 (ref 7.8-11.3) -mild hypochloremia 106

Abnormal PE/Chem/CBC/UA Results: PE:cleft lip (does not extend beyond) marked upper airway congestion, really struggled to get this ultrasound done w light sedation as she does not move air without active effort. I positioned her in all different ways to try and move GI air and get visualization but still very limited. CBC normal Chems: -gluc 268 -Total Ca 7.1 (ref 7.8-11.3) -mild hypochloremia 106

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder mucosa, trigone, and visible urethra are normal in thickness and there is no evidence of mucosal irregularities. The bladder lumen is distended with anechoic urine and bladder thickness is considered normal for volume of urine. No masses, inflammatory changes or calculi are observed.

The left kidney is normal in size (3.13 cm), shape and architecture with slightly irregular contour, consistent with prior renal infarct. There is normal corticomedullary distinction and normal echogenicity. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal in size, shape and architecture with smooth peripheral margins and measures 3.29 cm. There is normal corticomedullary. distinction and normal echogenicity. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

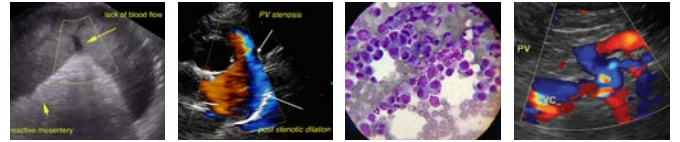
While the adrenal glands were not directly visualized, the area of the adrenals was visualized and no abnormalities were seen.

Spleen

The splenic echotexture is homogeneous with parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule is smooth with no irregularities. The splenic vasculature is normal without signs of congestion or thrombosis. The spleen measured 0.54 cm.

Liver

The liver is subjectively normal in size with normal contours, structure, with smooth peripheral margins. The echogenicity appears normal with normal portal markings. No overt evidence of inflammatory,



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infiltrative or regenerative pathology is evident. The visible portions of the vasculature and biliary tract appear normal. No pathological hepatic lymphadenopathy observed.

The gallbladder lumen is moderately distended. The wall is a normal thickness and smooth. Large volume anechoic bile present, consistent with the reported anorexia of the patient. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach was significantly distended with a large volume of fluid and gas. The stomach was hypomotile with fluid pooling. The pyloric outflow tract was difficult to visualize definitively, though no discrete foreign body or pyloric outflow obstructions were visualized, and the duodenum was empty. The stomach wall measured normal in thickness and there was a mild amount of hyperechoic inflammation around the stomach.

The duodenum measured thick at 2.8 mm (normal is up to 2.4mm), and in some video loops the duodenum was very mildly corrugated. Some sections of small intestinal bowel were normal, while other sections had a very subtle thickening of the muscularis layer and a mildly hyperechoic longitudinal mucosal stripe, consistent with mucosal fibrosis. The ileum measured normal, though there were mildly enlarged lymph nodes around the ileocolic junction that measured <5.0 mm and are considered reactive. The ileum also had a mildly hyperechoic longitudinal mucosal stripe, consistent with mid mucosal fibrosis.

The ileocolic junction was visualized and had normal intact wall layering and is subjectively of normal thickness.

Sections of colon are visualized with formed fecal material and gas shadowing distally. The colon measures normal. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The area of the pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid. The visible pancreatic duct was normal.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. Mild lymphadenomegaly was noted around the ileocolic junction, suspected to be reactive. The omentum is of normal uniform echogenicity.

PRIMARY FINDINGS

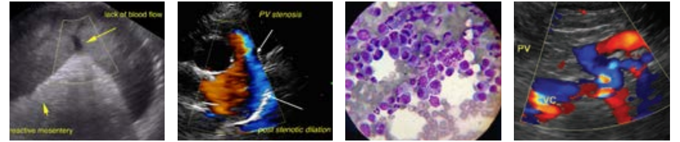
- Gastric hypomotility versus gastric atony with a large volume of fluid
- Subtle changes to the intestines – suggestive of chronic enteropathy and mid mucosal fibrosis.

SECONDARY FINDINGS

- Chronic degenerative changes to the left kidney – considered an aging change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a significant amount of fluid pooling within the stomach, and while a pyloric outflow tract obstruction could not definitively be ruled out by this examination given intraintestinal gas, one was not discretely seen and is not necessarily suspected based on this exam. There were also subtle changes within the small intestines consistent with a more chronic enteropathy. Consider longer, more



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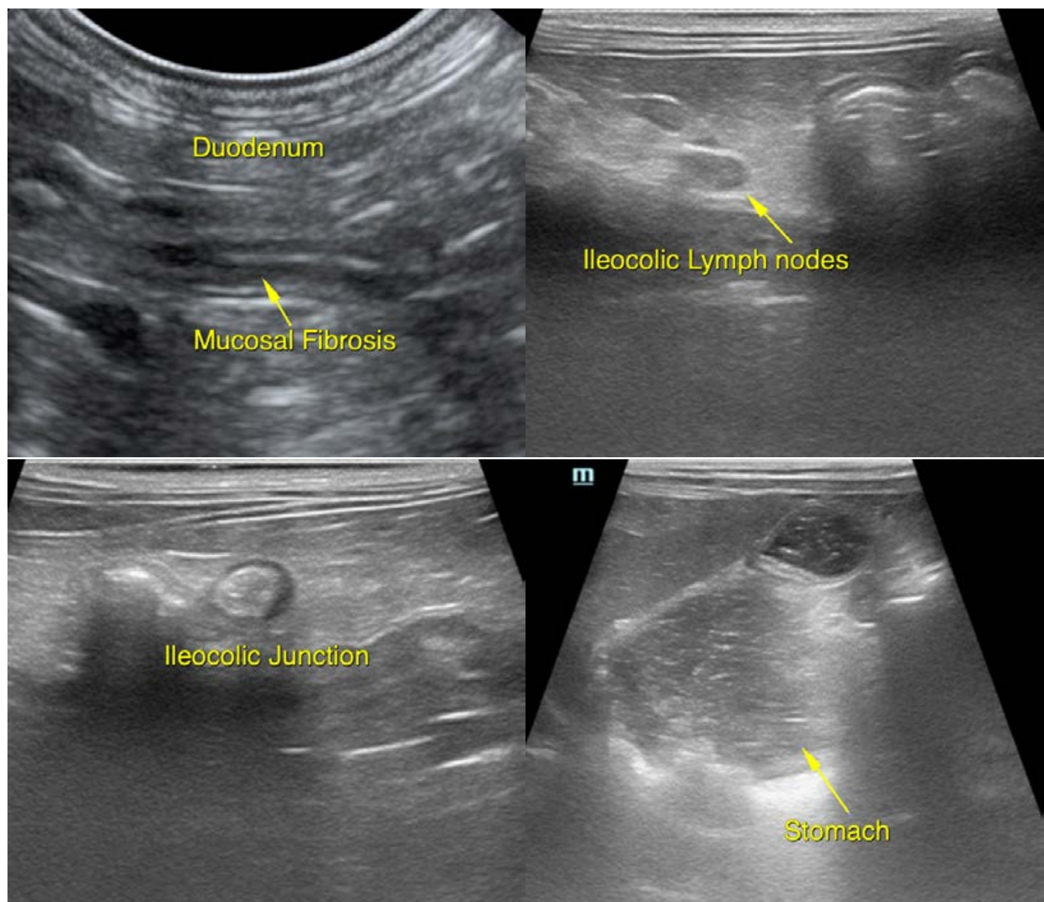
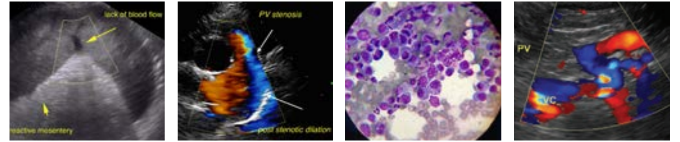
aggressive gastroprotectants (e.g., prokinetics, polypharmacy antiemetic therapy) and repeat imaging (either radiographs or ultrasound) to continue to evaluate for possibility of a pyloric outflow tract obstruction. Also consider a nasogastric tube to decompress the stomach.

If these therapies fail, consider endoscopic evaluation of the stomach +/- biopsies for acute onset of underlying chronic enteropathy.

In regard to the respiratory changes, if the patient has significant congestion, stertor, or even laryngeal disease causing stridor, this would cause significant aerophagia, which can contribute to abdominal discomfort from the significant amounts of gas, esophageal dilation, and poor appetite.





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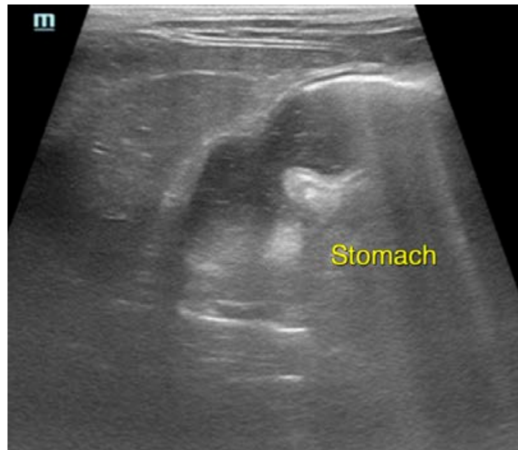

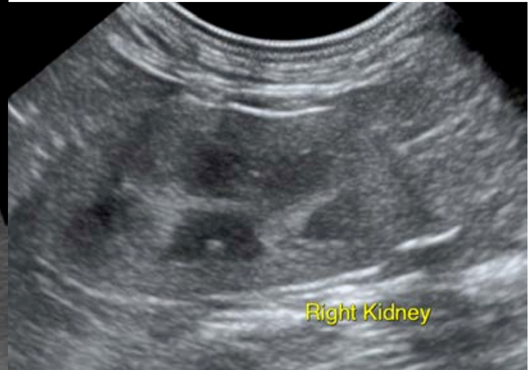

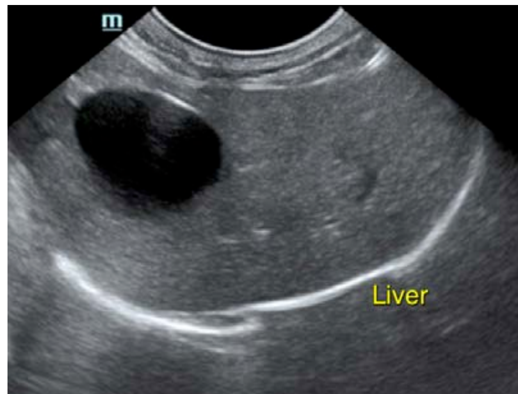

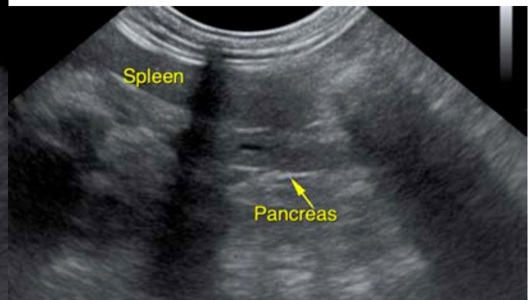

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Jessica Midence, DVM, DACVIM (SAIM)

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