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Clinical Sonography & Telecytology
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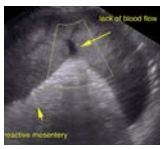
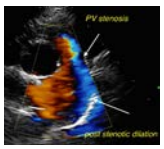
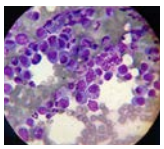
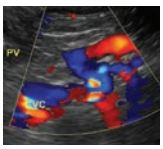

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1-800-838-4268 info@sonopath.com

PATIENT

Patch Guyton

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

17 Years

WEIGHT

4.7 kg

INTERPRETED BY

Jessica Midence, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Dr. Laura de Cordon

HOSPITAL NAME

Mason Dixon Animal Emergency Hospital

REFERRING VET

Dr. Laura de Cordon

INVOICE

45048

DATE

2/10/23

PRESENTING CLINICAL SIGNS

Patch was seen as a transfer after receiving SQ fluids and a bolus of dextrose. He had been anorexic for 48 hours and he was continuing to get insulin SQ. When the family found him 2/9 evening he was collapsed and couldn't move.

Abnormal PE/Chem/CBC/UA Results: BG: 349 363 BP: 90 Phos: 3.4 was 2.1 Mg: 3.8 was 5.6 EPOC: HCT: 25 Gluc: 274 BUN: 43 was 112 K: 3.1was 2.8 -Distended abdomen-possible gas distended stomach - Eating -Hematuria with bacteriuria on UA - Hypermagnesemia-improving -Hypokalemia

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is distended with a large volume of echogenic urine. There is a significant amount of dependent aggregated debris that is hyperechoic but does not shadow. This amorphous debris likely contains crystal/mineral, given how intensely hyperechoic it is, though there is no shadowing. It could be consistent with pyuria.

The left kidney is normal in size, shape and architecture with smooth peripheral margins and measures 3.65 cm. There is moderately decreased corticomedullary distinction and normal echogenicity. The renal pelvis shadows strongly. Though no stones are seen discretely, diverticular mineralization is suspected. There is a small amount of pyelectasia measuring 0.37 cm. This could be consistent with IV fluid therapy but could also be seen with pyelonephritis. There is no evidence of perirenal inflammation, infarcts, or hydroureter.

The right kidney is normal in size, shape and architecture with smooth peripheral margins and measures 4.2 cm. There is moderately decreased corticomedullary distinction and normal echogenicity. The renal pelvis shadows strongly. Though no stones are seen discretely, diverticular mineralization is suspected. There is no evidence of pyelectasia, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal in size (0.45 cm). The left adrenal gland has normal shape and it is normal in appearance and echogenicity.

The right adrenal gland is normal in size (0.52 cm). The right adrenal gland has normal shape and it is normal in appearance and echogenicity.

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.

Liver

The liver is generally enlarged and heterogeneous. This is likely secondary to the diabetes. No overt evidence of inflammatory, 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 distended. The wall is a normal thickness and smooth. The gallbladder contains a small to moderate volume of non-dependent echogenic debris. The cystic and common bile ducts are normal/not visible.

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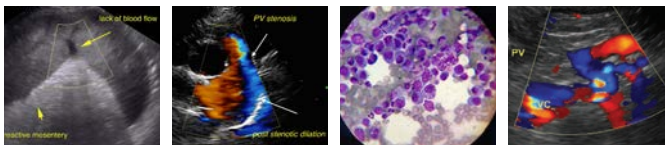

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Gastrointestinal

The gastric lumen is empty. The stomach wall is of normal wall thickness with some variability due to rugal folds. There is normal gastric wall layering. There are no masses or focal lesions observed and the pyloric outflow tract appears patent.

The small intestines are diffusely thickened. Most loops measured up to 3.0 mm (normal is up to 2.4 mm). There is mild blurring of layers and the mucosa is hyperechoic in certain segments. Some segments are empty while others are moderately to severely dilated with ingesta. There is both hyper- and hypoperistalsis depending on the intestinal loop. There is also scant effusion.

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

There was scant effusion around the intestines. There were a few prominent hypoechoic mesenteric lymph nodes, suspected to be reactive. The omentum is of normal uniform echogenicity.

PRIMARY FINDINGS

- Acute gastroenteritis with ileus, chronic enteropathy is possible
- Significant aggregated hyperechoic bladder debris

SECONDARY FINDINGS

- Gallbladder sludge – may be normal/incidental but could also represent bacterial cholangitis.
- Mild chronic kidney changes with diverticular mineralization and left renal pyelectasia – consistent with pyelectasia versus IV fluids.

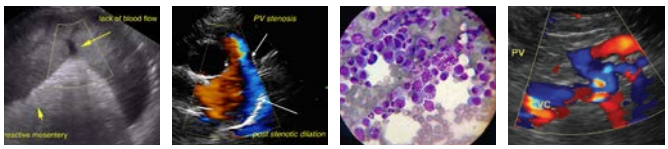
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most significant changes on this exam are related to the ileus of the small intestines. The intestines measure thick diffusely and there is subtle mild loss of layering. This is consistent with acute gastroenteritis, but chronic enteropathy can appear similar. There were associated reactive lymph nodes as well as scant peritoneal effusion.

The changes to the bladder could be incidental to the presenting complaint, but given the azotemia and urinary tract infection, consider culture and ongoing treatment for pyelonephritis. Once the patient is improved, a lower urinary tract diet could be considered temporarily if not contraindicated in this patient.

There is pyelectasia of the left kidney, which could be consistent with pyelonephritis, though there were not other signs of pyelonephritis (such as perirenal inflammation).

The liver changes are secondary to the diabetes. The gallbladder could be investigated further. If the



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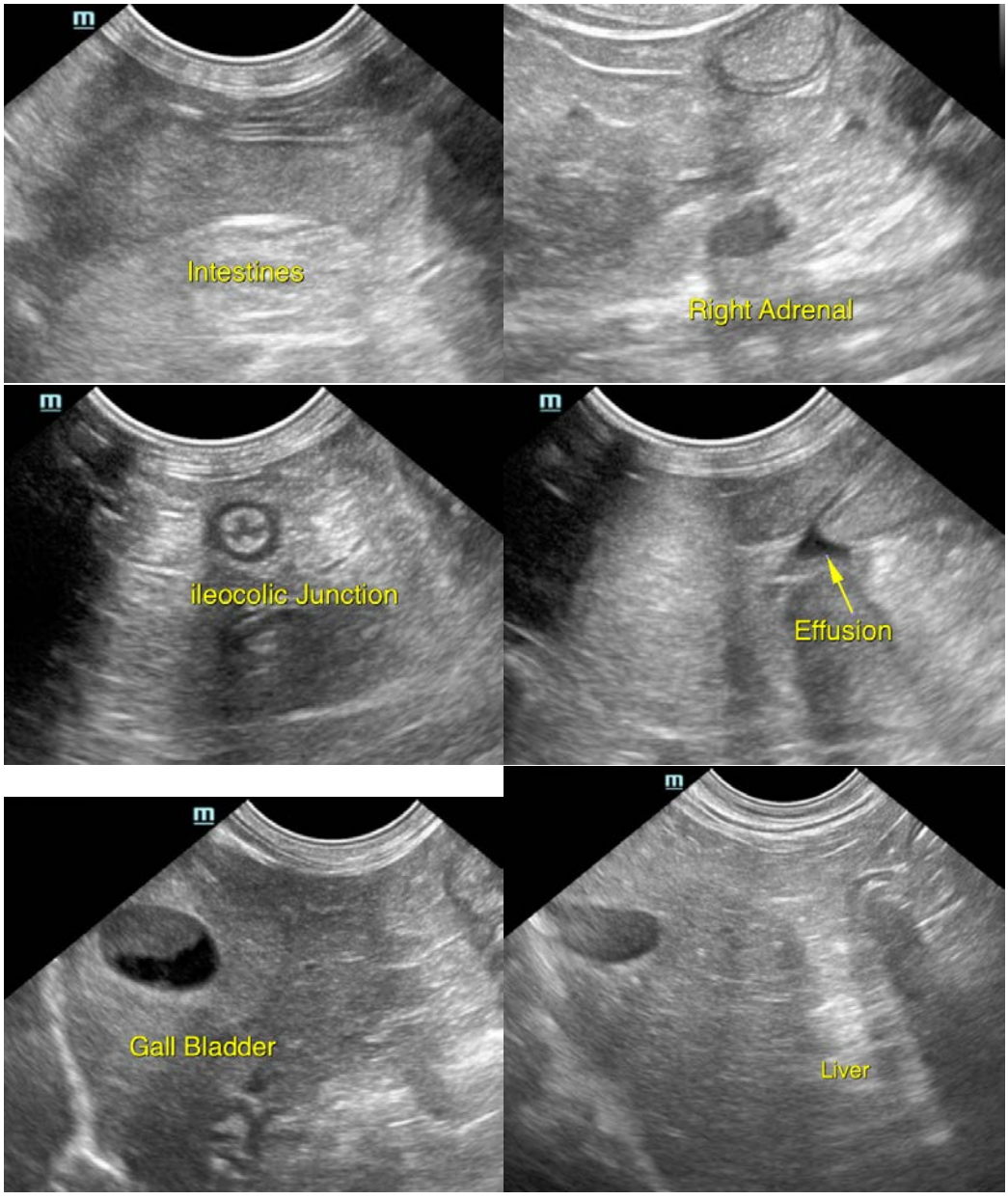
patient fails to improve, consider a cholecystocentesis for cytology and culture of bile.

Consider ongoing treatment for infection (urinary tract +/- biliary tract), gastroenteritis, and ileus. If the patient continues to have ongoing issues with appetite after this illness, then consider a workup for chronic enteropathy.



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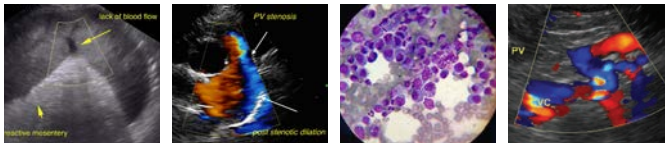

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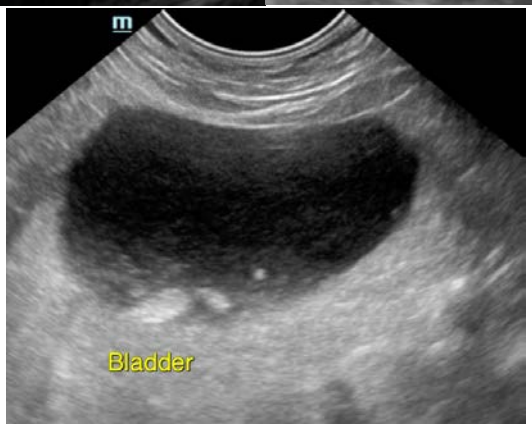

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Jessica Midence, DVM, DACVIM (SAIM)

info@SonoPath.com