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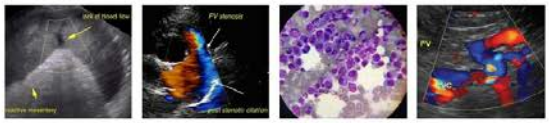

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Bix Allen

SPECIES

Feline

BREED

DLH – Flame Point

SEX

Neutered

AGE

3 Years 1 Month

WEIGHT

9 Pounds

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Sierra Oaks VS

REFERRING VET

Dr. Fossum

INVOICE

33361

DATE

12/8/21

PRESENTING CLINICAL SIGNS

S: Exam: owner reports acting "off" for 1 week (maybe 10-14 days) : decreased appetite, low energy unsure when last bm was owner reports vomited once this morning owner usually gives 1/4 tsp of miralax bid. Multiple cats in house hold indoor only -JA No c/s/dDiet: blue buffalo limited ingredient 1/3 can bid (5oz cans); O changed to all canned a few months ago---previously on 1/4 can BID and dry. O: BCS BAR, MM= pink, CRT<2s; mild dehydration Oral: Mild focal tartar and gingivitis PM's Eyes: No discharge, corneas clear OU, deeper structures WNL Ears: Clean, pinna WNL, no debris or discharge, TMs WNL N/T: No nasal discharge CV/Resp: No murmurs, normal rate and rhythm, eupneic, lungs auscult clear GI/GU: Abdomen: as previously, firm fecal mass ~ in transverse colon. Very hard, but not as large in diameter as previously noted prior to addition of Miralax. Neuro/MS: No obvious lameness or neurologic signs INT : Not as well-groomed ---especially perineum---not awful. LN WNL Rectal: A: History of palpable fecal material transverse colon on every exam since became our patient 6/2020. Addition of Miralax provided more consistent elimination of stools. O has not seen evidence of defecation recently. May have issue with motility or infiltrative bowel process---IBD? Neoplasia? Appetite not as exuberant---used to be wanting to get into other cats' food---now they are trying to get into his because he is slow to consume but O thinks mostly finishes. She has ordered special microchip activated feeding station for Bix. Wt loss---1/4 of BW since last visit ~ 1 year ago. Rule out metabolic issues, etc.
Abnormal PE/Chem/CBC/UA Results: rads done after AUS- radiologist suspects hair ties- Lab: ALT= 122 Other chemistries, T4, CBC, U/A= wnl Mild elevation ALT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (3.62 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.82 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.27 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect.

Spleen

The spleen is normal/large in size (1.3 cm in width measured at the hilus), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

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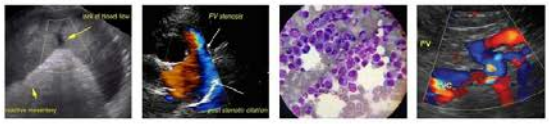

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Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is mildly heterogenous in echotexture with subtle, indistinct focal mottling. The gall bladder appears somewhat thick-walled. Adjacent to the gall bladder are two smaller luminal structures most consistent with dilated thickened bile duct. One duct is visualized with soft tissue opacity material within. This is most consistent with a thickened gallbladder, dilated bile duct and a bile plug. This area does not appear inflamed or completely obstructed. Other differentials would be a cystic lesion.

The gallbladder lumen is moderately distended. The wall of the gall bladder appears mildly thickened, measuring 0.22 cm. Luminal contents are primarily anechoic. The adjacent bile duct appears somewhat dilated and tortuous, and there is soft tissue density material within a section, most consistent with a mucus plug. Due to altered orientation of the liver with the enlarged stomach, I cannot rule out this as a cystic lesion, but this structure most likely represents bile duct.

Gastrointestinal

The stomach contains a large volume of heavy shadowing intraluminal material. The wall of the stomach appears to measure at a normal thickness of <0.36cm with some variability. The distinction of the gastric wall layers is adequate. No lesions associated with the gastric wall are visualized.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. The duodenum measured as normal (between 0.13-0.38cm in wall thickness) and the jejunum measured as normal (between 0.15-0.36cm.) Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

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.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. Prominent mesenteric lymph nodes are noted measuring 0.48 cm and 0.42 cm. The omentum is of slightly increased echogenicity.

Other

A brief view of the heart was submitted. No significant pericardial effusion was seen.

PRIMARY FINDINGS

- Gastric distension with shadowing foreign material– The nature of this foreign material is uncertain. Differentials such as hair ties and gorilla glue have been considered.
- Prominent, thick-walled gallbladder with dilated duct and likely bile plug – The nature of this lesion is not 100% clear. Correlate with bloodwork findings and recommended continued monitoring. Consider further evaluation at the time of gastrotomy.

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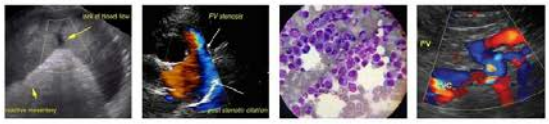

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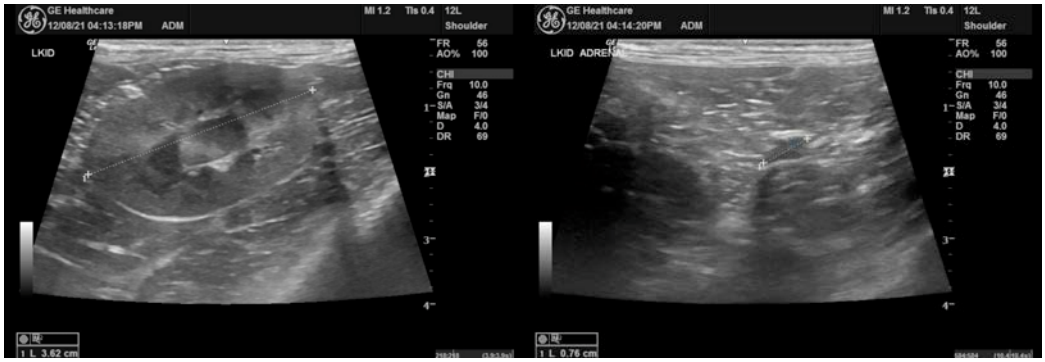
SECONDARY FINDINGS

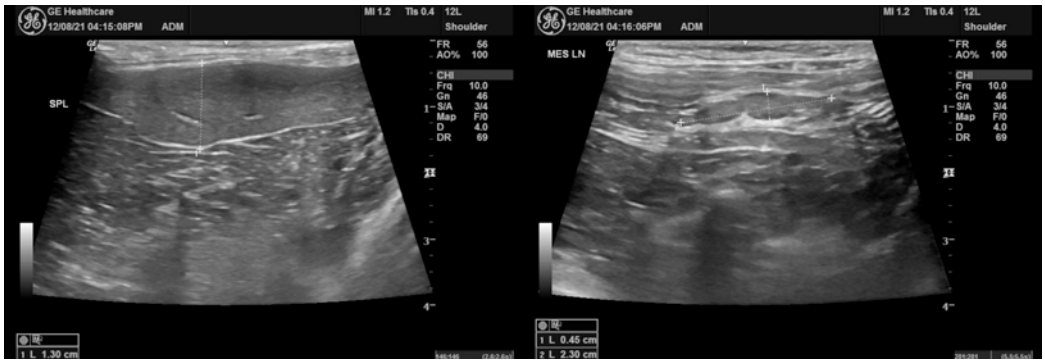
- Large spleen – The spleen appears to have normal shape and echogenicity. This could be normal for a larger cat. Recommend monitoring.

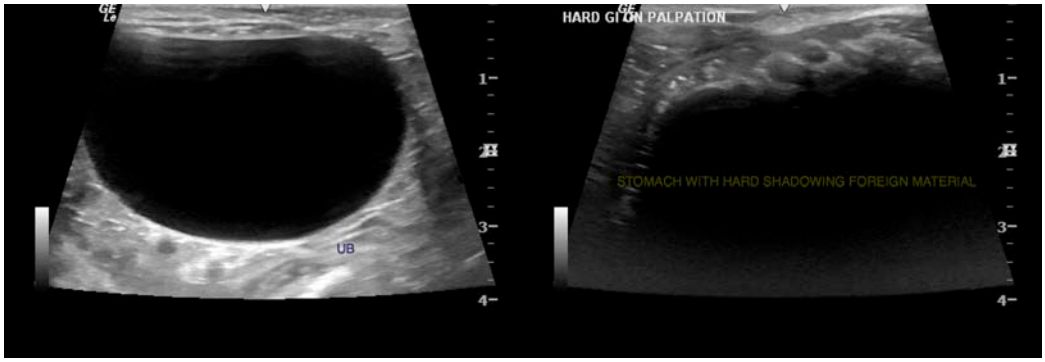
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a large volume of gastric foreign material present. Based on the symptoms described, it is likely that the most effective means to evaluate this further would be gastrotomy. Alternately, you could visualize this material with endoscopy, but it is unlikely to be easily removed in this fashion.

There are some changes in the liver most consistent with possible gallbladder/bile duct thickening and sludge. Recommend referral to a veterinary surgeon for gastrotomy and consider evaluation of this lesion at surgery. Starting ursodiol would be a consideration. Liver biopsy could be considered at the time of surgery due to the elevated ALT, or this could be reactive secondary to the gastric foreign material.







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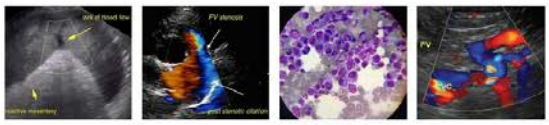

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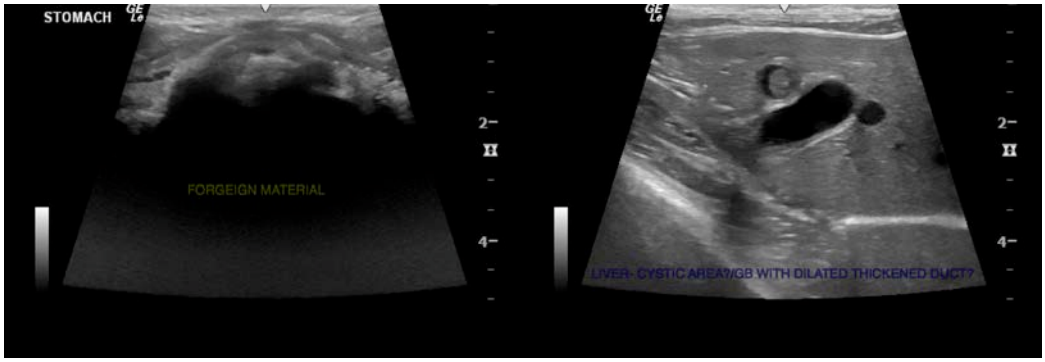

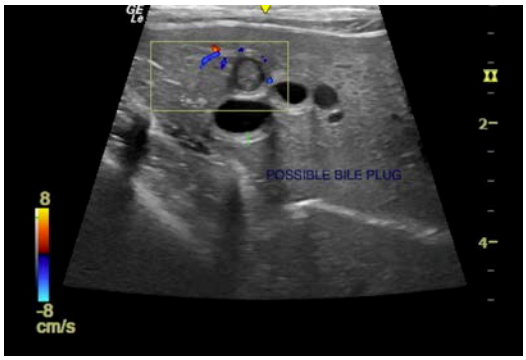

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

kathleen.sennello@sonopath.com