



PATIENT PRESENTING CLINICAL SIGNS

Clifford Lacasse
History: Presented at our hospital for vomiting, anorexia. Owner noted blood in urine about 14 days ago. Drooling. Previous Health Concerns: dental with extractions 1 year ago Current Medications: Amoxi 50 mg Q 24 hr (owner had at home gave for 7 days-last given on 1/1); sq fluids 60 ml Q 24 hr for 10 days Appetite/When did they eat last: not eating for 5 days

SPECIES

Feline

Abnormal PE/Chem/CBC/UA Results: Oral-Nasal-Throat: missing some teeth, remaining teeth very clean, hard swallowing during exam Radiograph: cranial organomegaly, loss of detail in cranial abdomen chem:total protein 8.9 H., globulin 5.5 H, ALT 208 H, GGT 30 H, total bilirubin 1.2 H (plasma hemolyzed) cbc:mono 0.05 L, mono 0.6% L epoc:potassium 3.4 L, chloride 131 H, ica ++ 0.97 L, lactate 3.56 H urinalysis: blood 3+ (250, hemolyzed), protein 3+ (300), pH 6.0, USG 1.044, leukocytes 3+ (500) wbc none, rbc 0-1/hpf, casts none, epithelial cells 0-1/hpf, crystals none, bacteria none

BREED

DSH

SEX

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Neutered Male

Urinary System

AGE

12 Years

The urinary bladder was normal in size and tone with potential focal to intermittent areas of mild apical and dorsal mural hypertrophy, exhibiting potential for minor atypical polypoid like luminal lesions were present. Moderate nondependent to dependent particulate sediment which may indicate cellular or crystalline debris or potential mucus present. No calculi or overt urinary bladder masses noted. The urethra was normal to a depth of 2.0 cm. Aortic trifurcation was normal.

WEIGHT

3.9 kg

Both kidneys were normal in size and margination. Both kidneys exhibited maintained 1:3 cortex to medulla ratio with mild nonuniform increased cortex echogenicity. Moderate loss of corticomedullary border demarcation and pinpoint areas of dystrophic mineral were present. No evidence of pyelectasia. The left kidney measured 4.3 cm in length. The right kidney measured 4.5 cm in length.

INTERPRETED BY

Adrenal Glands

R. McKenzie Daniel,
DVM, DABVP
(Canine and Feline)

No overt pathology in the area of the left adrenal gland.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.41 cm width.

IMAGING PERFORMED BY

Erin Wicks

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted. The spleen measured 0.86 cm in width.

HOSPITAL NAME

Shores VEC

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Liver

Dr. Lupole

The liver exhibited potential for mild generalized enlargement with maintained symmetrical capsule contour. Subtle reduced hepatic parenchyma echogenicity compared to the spleen and falciform fat, exhibiting moderate coarse echotexture.

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The gallbladder was non-distended. No evidence of gallbladder wall inflammation or thickening with anechoic content. The gallbladder and cystic duct presented mildly dilated in size with primarily anechoic content. The common bile duct was dilated and tortuous. The common bile duct measured 0.25 cm diameter. This was not consistent with post hepatic obstruction.

DATE

1/18/22

Gastrointestinal



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The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. The stomach exhibited intact wall layering with subjective mild prominent wall layering in the area of the antrum and pylorus with mild retained anechoic and antrum fluid. The pylorus wall measured 0.35 cm width. Mild to moderate gas was noted in the fundus and body.

SPECIES

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The small intestine presented intact wall layering and primarily maintained 1:3 muscularis/mucosa ratio. Segmental propensity for subtly prominent muscularis layer in the small intestine yet no evidence of mural hypertrophy or loss of intestinal wall layering. No overt pathology in the area of the duodenal papilla. The duodenum wall measured 0.32 cm. The jejunum wall measured 0.20 cm.

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DSH

Normal visible colon wall layers were present with apparent formed feces in lumen. The ileocolic wall measured 0.32 cm.

SEX

Neutered Male

Pancreas

The pancreas was normal in size and contour with mildly hypoechoic to nonhomogeneous parenchyma compared to adjacent peripancreatic omentum.

Free Abdomen

AGE

12 Years

No evidence of significant lymphadenopathy or effusion. Omentum was of uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

WEIGHT

3.9 kg

- Moderate dependent to nondependent urinary bladder sediment, potential for minor areas of apical to dorsal cystitis or atypical polyps
- Bilateral chronic renal changes- no overt pyelonephritis
- Hepatopathy- subjectively acute
- Mild nonobstructive proximal common bile duct dilation
- Suspect mild pancreatitis
- Gastritis pattern with mild gastric stasis. Correlation with a spec FPL or GI panel would be ideal to assess for occult concurrent small intestinal disease or potential triad disease in this case, especially if evidence of weight loss.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urine culture and sensitivity on sterile urine sample recommended to rule out underlying urinary tract infection.

REFERRING VET

Dr. Lupole

Although nonspecific, the appearance of the liver may suggest acute hepatitis/cholangiohepatitis with nonobstructive cholestasis given the ALT/GGT elevation as well as mildly elevated total bilirubin. No overt evidence of posthepatic obstruction. Vacuolar hepatic changes possible while occult hepatic neoplasia cannot be definitively excluded. Assuming normal clotting status, hepatic FNA, using a 25-gauge needle, could be considered for screening cytology and potential identification of inflammatory cell type (if present).

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Empirically, hospitalization with acute cholangiohepatitis/pancreatitis therapy with as needed gastrointestinal support and assessment of clinical response recommended.

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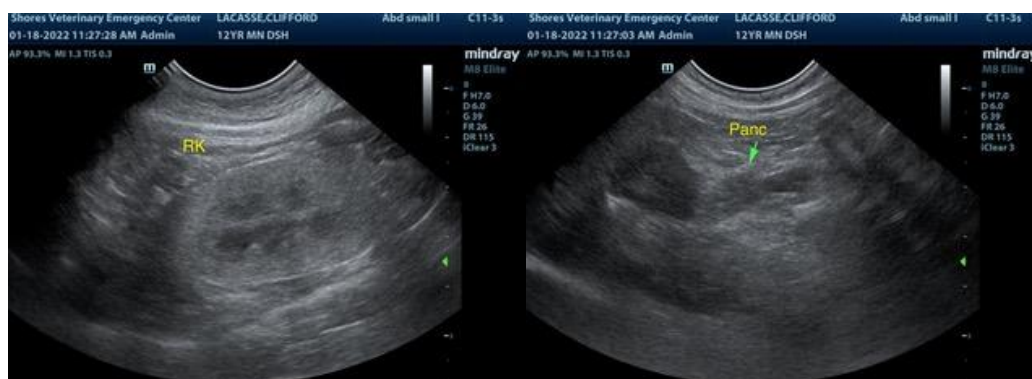
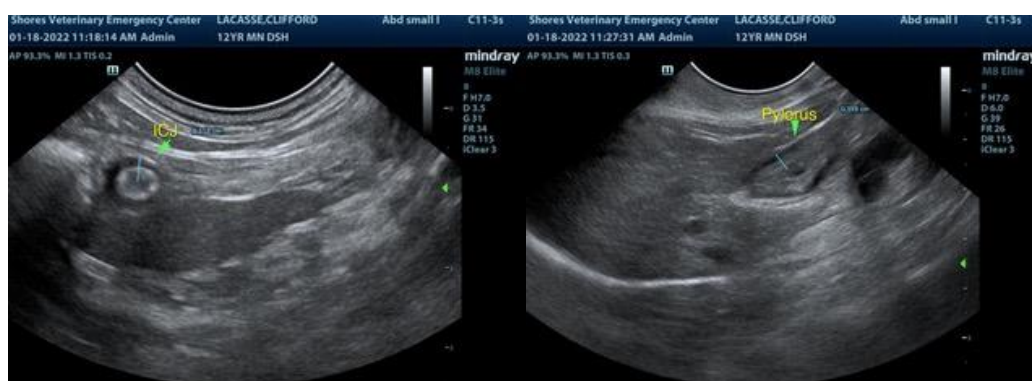
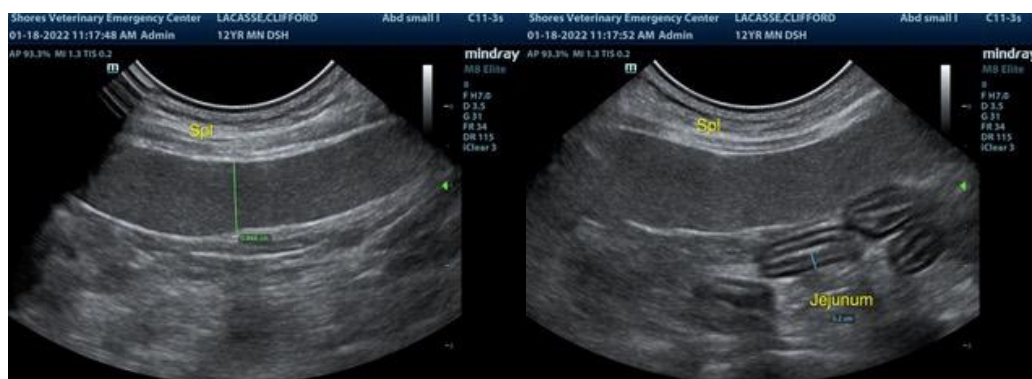
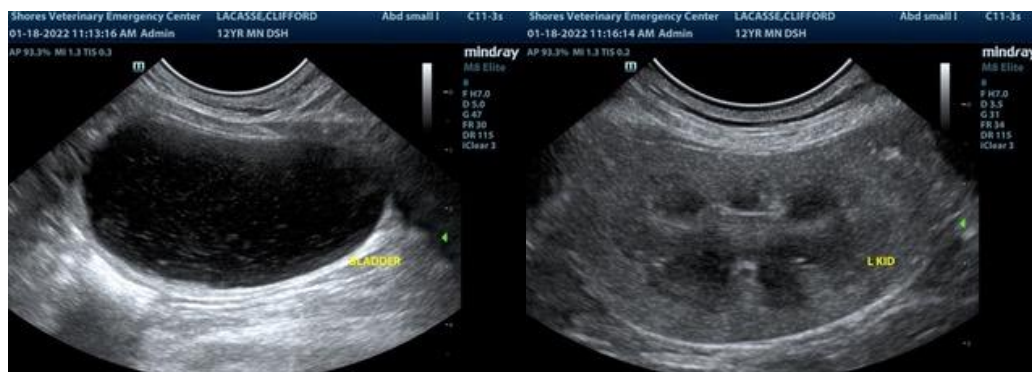
Dr. Lupole

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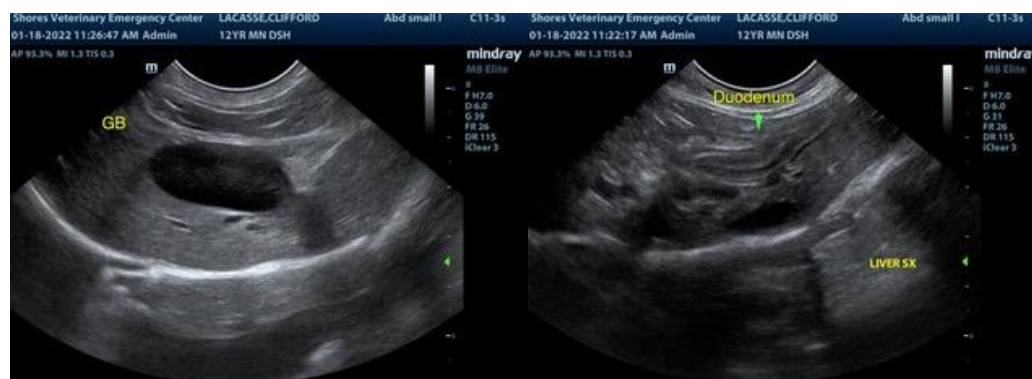
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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