



PATIENT

Chloe Tummon

SPECIES

Feline

BREED

Domestic Long Hair

SEX

S- Spayed Female

AGE

7y

WEIGHT

4.84 kg

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

JSS

HOSPITAL NAME

King Hopkins Pet
Hospital

REFERRING VET

Dr. Tamara
Dzikewicz

INVOICE

15777

DATE

1/3/23

PRESENTING CLINICAL SIGNS

Chloe is a 7 yo SF DLH that presented today for the concern of vomiting since this morning with hairball, fell over and shaking shortly after, reduced appetite. hx of vomiting hairballs and food lately no known hx of seizures BM- O is unsure Diet: RC FEL T/D, wellness canned From Radiology Services Report (8650878-15/Radiograph Consult - Stat), on Jan 2, 2023: "- The small amount of gastric soft tissue material is nonspecific and may represent food and/or foreign material. No evidence of gastrointestinal obstruction is seen at this time; however, recent vomiting may mask an obstructive pattern and the possibility is not entirely excluded. In the absence of overt evidence of obstruction, consider gastroenteritis, inflammatory bowel disease and/or pancreatitis as most likely causes for the patient's clinical signs.

RECOMMENDATIONS: At this time, medical management for gastroenteritis and pancreatitis is advised, and recheck 3 view thoracic radiographs could be considered in 6-8 hours to rule out the presence of an emerging or masked gastrointestinal obstruction. Alternatively, an abdominal ultrasound may also be advantageous. "

Abnormal PE/Chem/CBC/UA Results: ProCyte Dx - January 2, 2023 2:52pm Test Results Ref Interval
RETIC 53.4 K/ μ L 3.0 - 50.0 HIGH

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 4.0 cm in length. The right kidney measured 3.8 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.38 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.51 cm width.

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.



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Liver/ Gallbladder

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The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size containing primarily anechoic content with minor, non-dependent, echogenic, luminal gallbladder debris. No evidence of gallbladder or peripheral gallbladder inflammatory criteria was noted. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty without evidence of gastric distention secondary to retained ingesta, fluid, or foreign material. The gastric body wall width measured 0.23 cm.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of small intestinal mechanical / metabolic ileus, obstruction, or foreign material. The duodenum wall measured 0.22 cm width. The jejunum wall measured 0.22 cm width. The ileocolic wall measured 0.29 cm width.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The parenchyma of the left limb, body, and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease were evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

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ULTRASONOGRAPHIC FINDINGS

- Sonographically unremarkable abdomen
- Sonographically unremarkable gastrointestinal tract / pancreas
- Mild incidental gallbladder debris

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of visceral pathology, specifically gastrointestinal or pancreatic pathology, as well as no evidence of current gastrointestinal hairballs as an obvious cause of the patient's recent vomiting and reduced appetite. Previous hairball, structurally insignificant inflammatory gastroenteropathy, and low-grade to chronic pancreatitis, both of which may present as sonographically normal, dietary intolerance / food allergy, occult parasitism, if the patient is indoor/outdoor or if clinically applicable, are all potentials. If evidence of weight loss, a GI panel to include PLI/TLI/Cobalamin/Folate for further assessment of the pancreas and occult gastrointestinal disease, may be considered. Empirically, as-needed gastrointestinal support, dietary therapy which may include a canned hydrolyzed trial and as-needed hairball therapy with an assessment of clinical response would be reasonable.



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Radiographic or sonographic reassessment could be considered if persistent clinical signs despite empirical gastrointestinal and dietary therapy.

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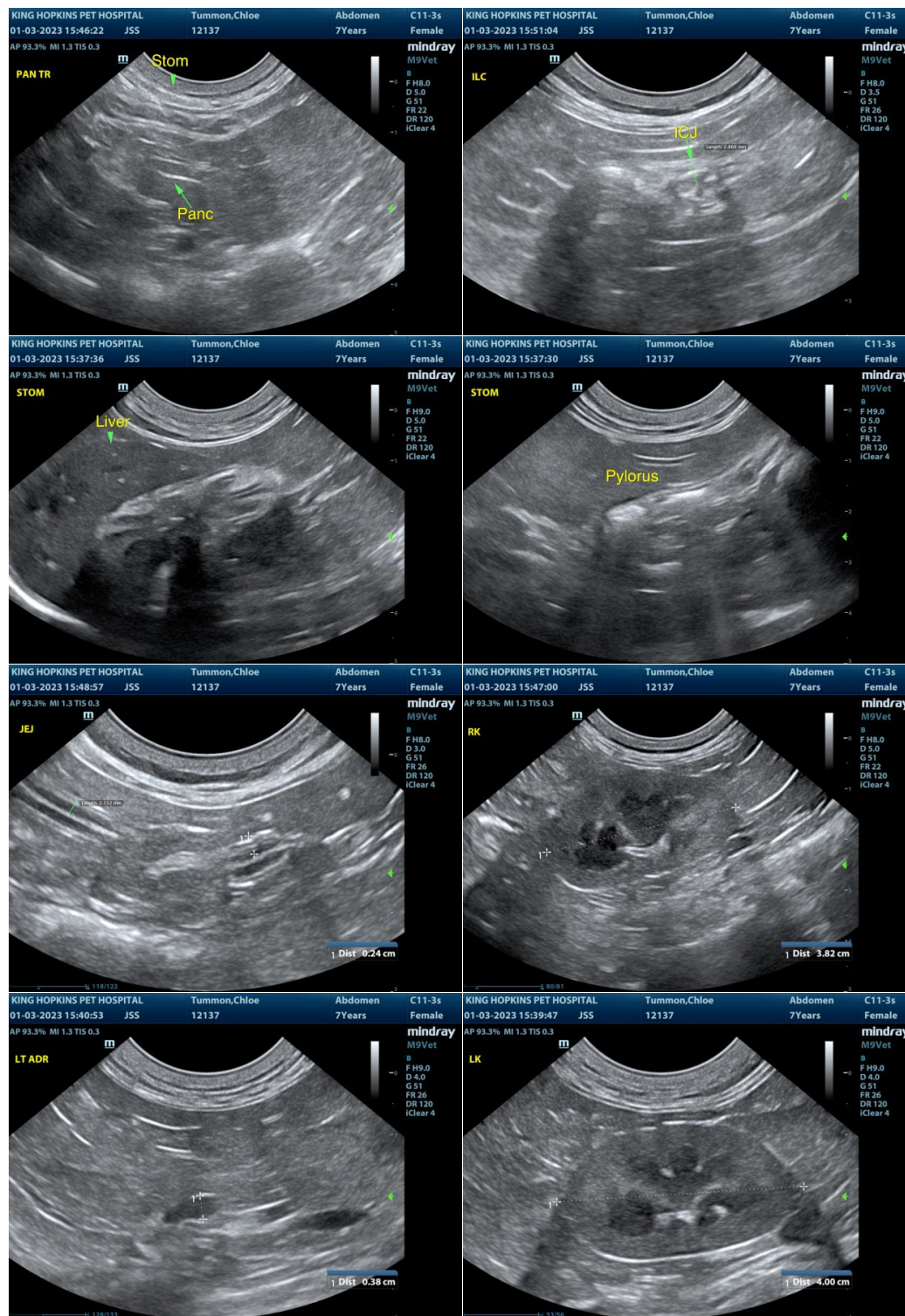
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
info@SonoPath.com