



**PATIENT**

Chester Moffat

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

8 years, 11 months

**WEIGHT**

9.92 lbs.

**INTERPRETED BY**

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

**IMAGING**

**PERFORMED BY**

Amanda Crook -  
SDEP Certified  
Clinical Sonographer

**HOSPITAL NAME**

Rivers Edge Pet  
Medical Center

**REFERRING VET**

Dr. David Gray

**INVOICE**

12357

**DATE**

10/4/21

**PRESENTING CLINICAL SIGNS**

Weak and vomiting, not eating; has been in hospital since 10/2 on IVF and supportive care. Current Medications: Cerenia, Unasyn, Buprenorphine

Abnormal PE/Chem/CBC/UA Results: See attached - See trend since first labwork 10/2 today, low albumin and WBC, BUN was elevated and has normalized. 10/4: CBC Neutro \* 0.27, Monocytes \* 1.55, Eosinophils 0.15, Calcium 6.8, Potassium 3.1, Chloride 109, Total Protein 5.3, Albumin 2.1, ALP 13, Amylase 497, FELV/FIV neg/neg. 10/2 UA: Orange in color, USG 1.050, Bili 3, Urobili 4, WBC 1, RBC 16, suspect presence of cocci,

**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 3.9 cm in length. The right kidney measured 4.5 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 0.44 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.43 cm width.

**Spleen**

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present. A solitary, mildly expansive, nonhomogeneous to mineralized nodule was present in the splenic tail, measuring 1.0 cm in diameter. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age-related remodeling with minor potential for inflammatory or neoplastic disease.

**Liver/ Gallbladder**

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 mild gallbladder debris, likely secondary to fasting / anorexia or mild nonclinical cholestasis. The cystic and common bile ducts were normal.



**PATIENT**

Chester Moffat

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

8 years, 11 months

**WEIGHT**

9.92 lbs.

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Amanda Crook -  
SDEP Certified  
Clinical Sonographer

**HOSPITAL NAME**

Rivers Edge Pet  
Medical Center

**REFERRING VET**

Dr. David Gray

**INVOICE**

12357

**DATE**

10/4/21

**Gastrointestinal**

The stomach presented as severely distended with retained anechoic fluid. No evidence of retained ingesta, foreign material, or mechanical pyloric outflow obstruction. The visualized gastric walls were unremarkable. The gastric body wall measured 0.18 cm width.

The small intestine exhibited segmental, mild to moderate mural hypertrophy and indistinct wall layering with segmental mild to moderate ileus, subjectively primarily involving the upper small intestine. Concurrent segments of small intestine were empty with intact wall layering and maintained 1:3 muscularis / mucosa ratio, suspected to be in the mid to distal small intestine. Normal appearing small intestine measured 0.22 cm wall width. Segments of intestine exhibiting mild to moderate mural hypertrophy and ileus measured up to 0.35 wall width.

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

**Pancreas**

The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia.

**Free Abdomen**

Generalized primarily peri intestinal echogenic mesentery along with intermittent minor mesenteric lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). Mild peritoneal free fluid was present.

Transdiaphragmatic view of the caudal thorax revealed concurrent pleural free fluid without overt evidence of caudal thoracic masses or lymphadenopathy.

**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

- Severe hypomotile stomach
- Segmental acute enteropathy and associated mild to moderate ileus - acute enterotoxin insult, infectious enteritis, dietary indiscretion, occult parasitism (if patient outdoor), occult neoplastic infiltrative enteropathy, or other, possible
- Pancreatitis
- Associated generalized yet primarily peri intestinal reactive mesentery - potential for peritonitis
- Mild peritoneal and concurrent pleural free fluid
- Nonspecific, mineralized, caudal splenic nodule - hyperplasia, hematopoiesis, chronic splenitis, previous infarction, mineralized granuloma, or neoplasia possible



**PATIENT**

Chester Moffat

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

8 years, 11 months

**WEIGHT**

9.92 lbs.

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Amanda Crook -  
SDEP Certified  
Clinical Sonographer

**HOSPITAL NAME**

Rivers Edge Pet  
Medical Center

**REFERRING VET**

Dr. David Gray

**INVOICE**

12357

**DATE**

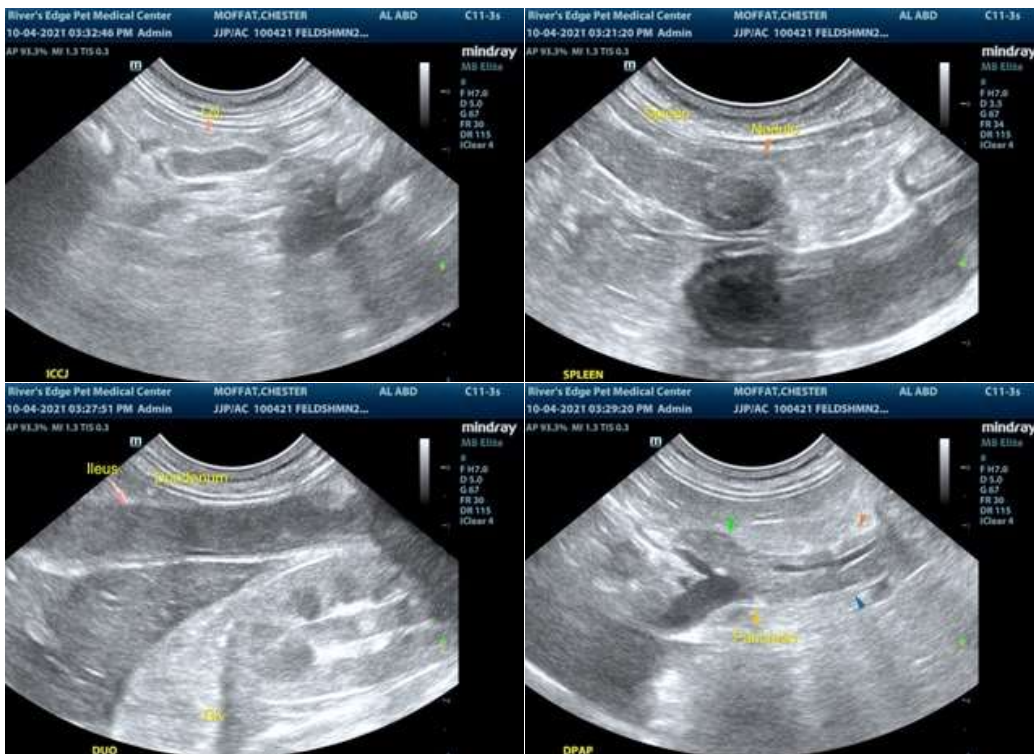
10/4/21

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

This patient is at risk of sepsis, given the current neutrophil level (<1.0). Recommend increased antibiotic spectrums i.e., Metronidazole +/- Enrofloxacin in combination with current Unasyn.

The peritoneal and pleural free fluid may indicate non-septic (increased vascular permeability, decreased hydrostatic pressure, vasculitis, etc.) or septic /inflammatory effusion. Further assessment including effusion analysis, cytology +/- C/S if evidence of inflammatory cells is recommended.

Plasma expanders may be indicated if decreasing protein levels. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Exploratory laparotomy with gastrointestinal biopsies considered essential may be indicated pending clinical response to further supportive care or If persistent gastric and segmental intestinal ileus pattern is noted. Overt evidence of mechanical obstruction was not definitively evident, yet given the segmental Intestinal fluid dilation In combination with empty small intestine and degree of gastric fluid dilation, the possibility of non-visualized partial obstruction cannot be definitively excluded.





## PATIENT

Chester Moffat

## SPECIES

Feline

## BREED

DSH

## SEX

Neutered Male

## AGE

8 years, 11 months

## WEIGHT

9.92 lbs.

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Amanda Crook -  
SDEP Certified  
Clinical Sonographer

## HOSPITAL NAME

Rivers Edge Pet  
Medical Center

## REFERRING VET

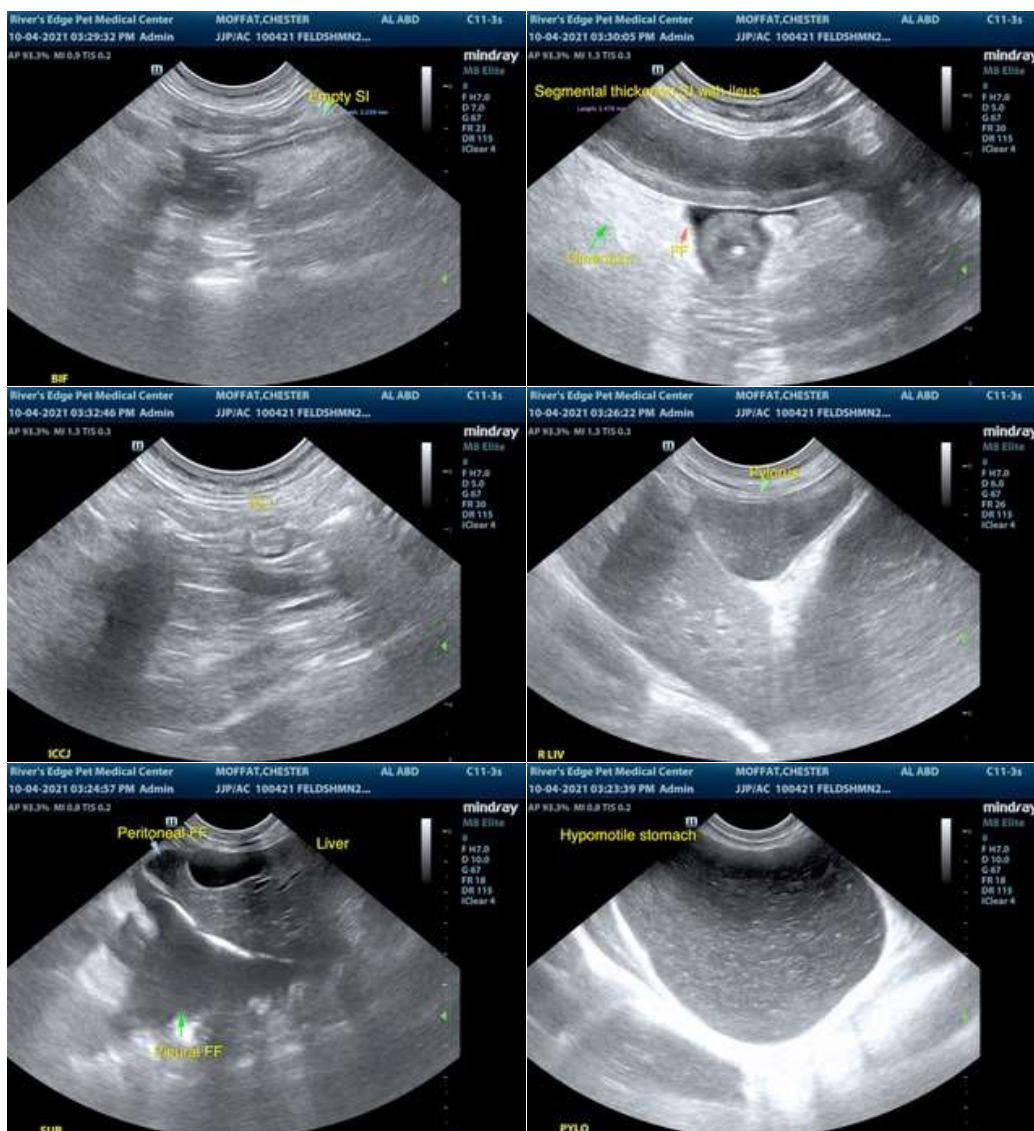
Dr. David Gray

## INVOICE

12357

## DATE

10/4/21



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.

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