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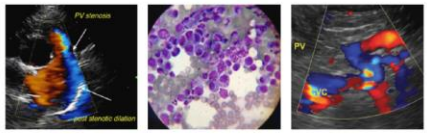
SVS Mobile Imaging CT 262 - 366 - 5970
fredgromalak@gmail.com



SonoPath
Clinical Sonography & Telecytology
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PATIENT
Wulfgar Alucard
52666C

SPECIES
Feline

BREED
DSH

SEX
M/N

AGE
15y

WEIGHT
6.42 kg

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

IMAGING PERFORMED BY
Tom McNeill

HOSPITAL NAME
SVS Imaging CT

REFERRING VET
Madison Veterinary Specialists-Dr. Strauss

INVOICE
15135

DATE
10/7/22

PRESENTING CLINICAL SIGNS

Patient presented yesterday for acute onset of vomiting. Over the course of the day, approximately 6-8 piles of vomit, some of it including food and some more bilious in nature. Pt then started vomiting while walking and engaging with owner, and seemed to be choking on it. He is indoor only (the condo does not have a door access to the outside he can escape from) and does not have access to any toxins, flowers, and does not get into anything. Historical IRIS Stage 2 CKD - treated with renal diet

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder was mildly distended in size with no evidence of obstruction to urinary outflow. The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Moderate, nondependent, particulate sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

The area of the aortic trifurcation was free of pathology.

Normal renal size with asymmetrical margination were present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. The left kidney measured 4.1 cm in length. The right kidney measured 4.3 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 0.37 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.35 cm width.

Spleen

The spleen was normal in size and contour with subtle parenchyma heterogeneity and intermittent, discrete, nondisruptive, hypoechoic nodules. The nodules are likely consistent with lymphoid hyperplasia, hematopoiesis, or similar with no overt suspicion of splenic neoplastic criteria which is thought unlikely. An example of splenic nodule measured 0.3 cm diameter.

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 with minor nonorganized echogenic debris. The cystic and common bile ducts were normal. Suspect focal nonobstructive discrete mineral at the level of the duodenal papilla. No evidence of gallbladder or peripheral gallbladder inflammation was noted.

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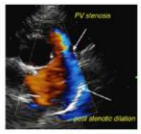
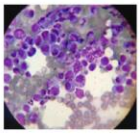
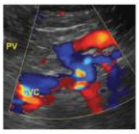

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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate nonshadowing ingesta /chyme most consistent with post prandial presentation without signs of ileus, obstruction or foreign material. The stomach was otherwise normal. No evidence of mechanical pyloric outflow obstruction was noted. 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 mechanical / metabolic ileus, obstruction, or foreign material. The duodenum wall measured 0.24 cm width. The jejunum wall measured up to 0.27 cm width. No overt pathology was noted at the level of the ileocolic junction.

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

Pancreas

The pancreas exhibited generalized yet variable asymmetrical enlargement including asymmetrical capsule contour. Mild hypoechoic irregular to discretely nodular parenchyma with evidence of minor peripancreatic hyperechoic mesentery. No overt evidence of neoplasia.

Free Abdomen

Intermittent 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). An example of a lymph node measured 2.7 cm x 0.53 cm. No overt free fluid was present.

ULTRASONOGRAPHIC FINDINGS

- Moderate urinary bladder sediment
- Nonspecific chronic renal changes exhibiting increased cortex echogenicity
- Irregular hypoechoic to nodular pancreas - pancreatitis likely, unlikely potential for emerging pancreatic neoplastic criteria
- Overtly normal gastrointestinal tract with moderate retained gastric ingesta / chyme
- Intermittent benign / reactive mesenteric lymph nodes - potential minor reactive lymphadenitis secondary to inflammatory bowel episode
- Minor gallbladder debris, suspect focal nonobstructive mineral at the level of the duodenal papilla, no evidence of post hepatic obstructive criteria

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S if evidence of inflammatory cells is recommended.

In light of documented NPO, suspect some degree of metabolic gastric stasis or hypomotility potentially secondary to inflammatory bowel episode or likely pancreatitis. Correlation with a Spec fPL or A GI panel to include Cobalamin/Folate levels to rule out occult small intestinal disease could be considered.

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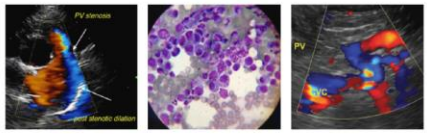

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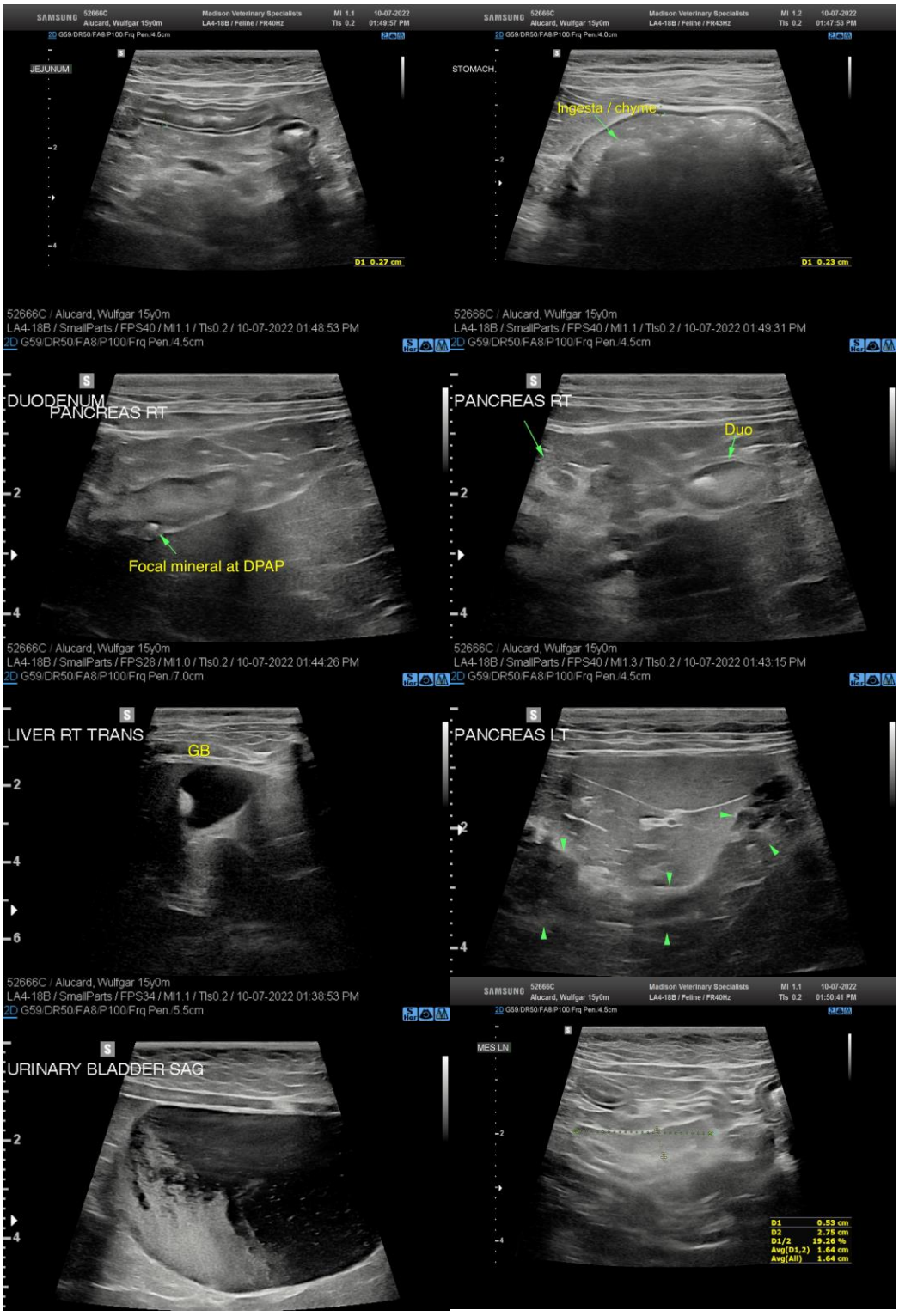
Empirical therapy for pancreatitis with as-needed GI support and assessment of clinical response would be reasonable. Recheck sonogram if clinically indicated.



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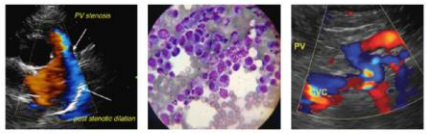

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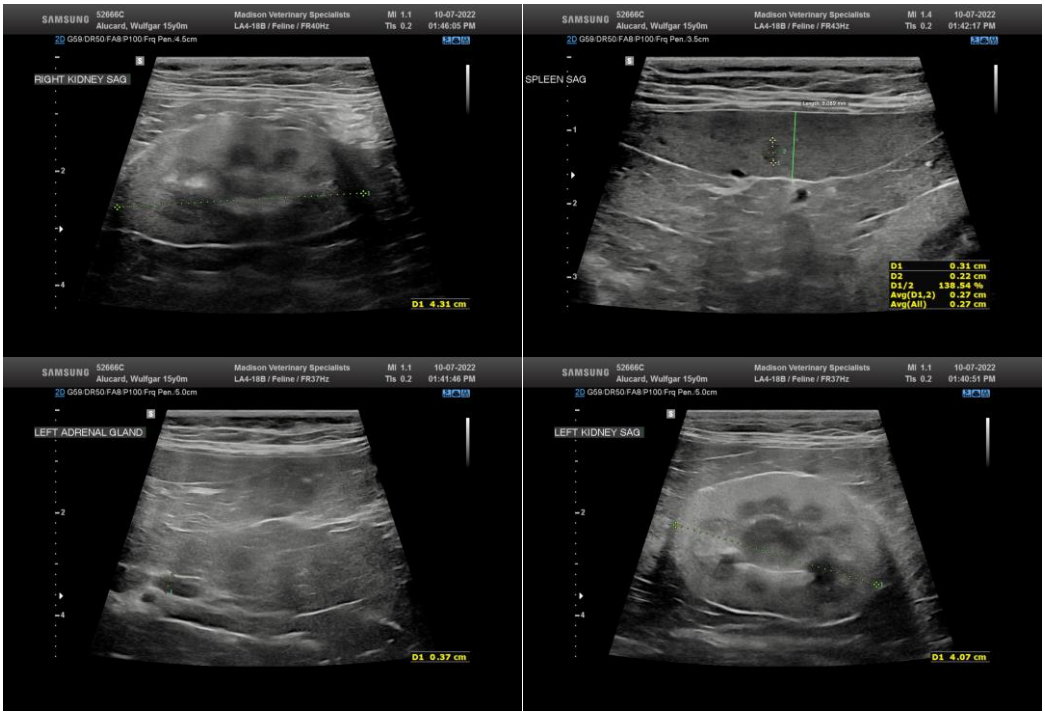

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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