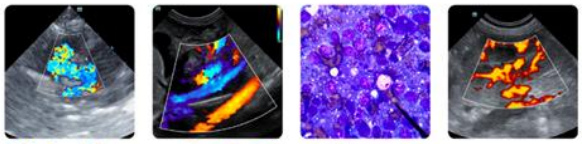


PATIENT

Ryan Noll

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

15.5yr

WEIGHT

3.67kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary Emergency Center

REFERRING VET

Logan Law

INVOICE
24053

DATE
03-01-26

PRESENTING CLINICAL SIGNS

- 2/27 vomiting and hyporexia. ate in the morning, then vomited. For evening P did not initially eat. owner gave famotidine and cerenia. P then did eat in the evening. 2/28 morning anorexia and lethargic. O gave denamarin advanced, laxatone and Miratraz. P started becoming drooly and and was crying out. history of constipation, gastritis, and elevated liver values, heart murmur. outpatient treatment of sq fluids, cerenia, dex sp, and enema. To recheck if concerns.
- recheck 2/28 evening: very lethargic, seems weak and uncomfortable. P was not offered food since earlier discharge. Hasn't had any vomiting. Did produce some soft stool after receiving enema earlier today. Owner reports that P was having an increased respiratory rate at home which is abnormal for him and they think his abdomen looks distended. admitted for supportive care: iv fluids w/ KCL, buprenorphine, cerenia, metronidazole, ondansetron, carafate, proviable and cisapride. NG tube was placed 3/1 at 1 am.
- concern for severe constipation/obstipation (improving) - r/o megacolon, dehydration, hypokalemia-induced ileus; Gastrointestinal ileus; Severe hypokalemia - r/o chronic GI losses, decreased intake, renal losses; Azotemia - r/o prerenal dehydration, chronic kidney disease; Elevated liver enzymes - r/o hepatic lipidosis, cholestasis, hepatitis; Elevated ProBNP - r/o hypertrophic cardiomyopathy, false elevation secondary to azotemia
- Abnormal PE/Chem/CBC/UA Results: PE 12/28 PM: 3/4 moderate pain, uncomfortable on abd palp, nauseated; tachypneic; abd tense/hard to palpate chem 3 pm: BUN 32.2 H, Glob 5.1 H, Gluc 166 H, ALT 841 H, ALP 96 H, Tbili 2.4 H epoc 3pm: K 2.5 L, Lact: 4.54 H epoc 9 pm pH 7.1 L, K 2.8 L, Ica++1.58 H, Lact 5.09 H, BUN 34 H, Creat 1.99 H epoc 3/1 4 am: Na 147 L, K 3.0 L, Ica++ 1.55 H, Lact 3.33 H, BUN 43 H, Creat 2.66 H proBNP: 932.8 abnormal rads: Revealed gastric distension with gas and distension of the intestines and colon. Colon was completely obstructed with feces. multifocal mineral opacity ingesta repeat rads: fluid distended stomach, small radiopaque particles, gas and fluid filled loops of SI, possible mass effect ventral to stomach 3/1

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no evidence of urine/lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

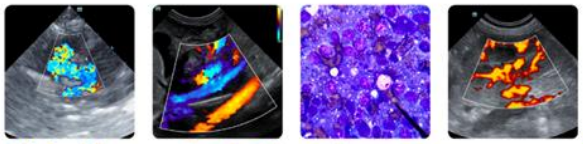
Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 3.8 cm in length. The right kidney measured 4.6 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.42 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.45 cm width.

Spleen



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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.

Liver/Gallbladder

The liver was subjectively mildly enlarged. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. Focal lobar biliary tree mineralization with mildly dilated lobar biliary tree. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was mildly distended in size with mildly prominent isoechoic wall without evidence of edema. Gravity dependent to non-dependent non-organized debris was present in the gallbladder. The proximal common bile duct was dilated and tortuous without overt post hepatic obstruction.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained a moderate amount of shadowing gastric ingesta and lumen gas with no signs of obstruction or foreign material.

The small intestine presented normal intact visible wall. The lumen of the small intestine contained segmental intestinal gas and ingesta to the level of the colon.

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

Pancreas

The pancreas was normal in size with asymmetrical contour and non-homogenous mildly hypoechoic parenchyma with prominent pancreatic duct.

Free Abdomen

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Hepatopathy with lobar biliary tree mineral / small calculi
- Mild inflamed gallbladder with nonobstructive bile duct dilation
- Shadowing gastric ingesta and segmental intestinal gas
- Mild chronic / chronic active pancreatitis
- Chronic renal changes
- Normal adrenal glands
- Empty visible distal colon

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Acute or acute on chronic cholangiohepatitis is favored given biliary tree mineral / calculi and evidence of mild biliary tract inflammation. The gastric ingesta is nonspecific and may suggest delayed gastric emptying although no visible signs of intestinal obstruction. Monitoring of gastric emptying / ingesta is

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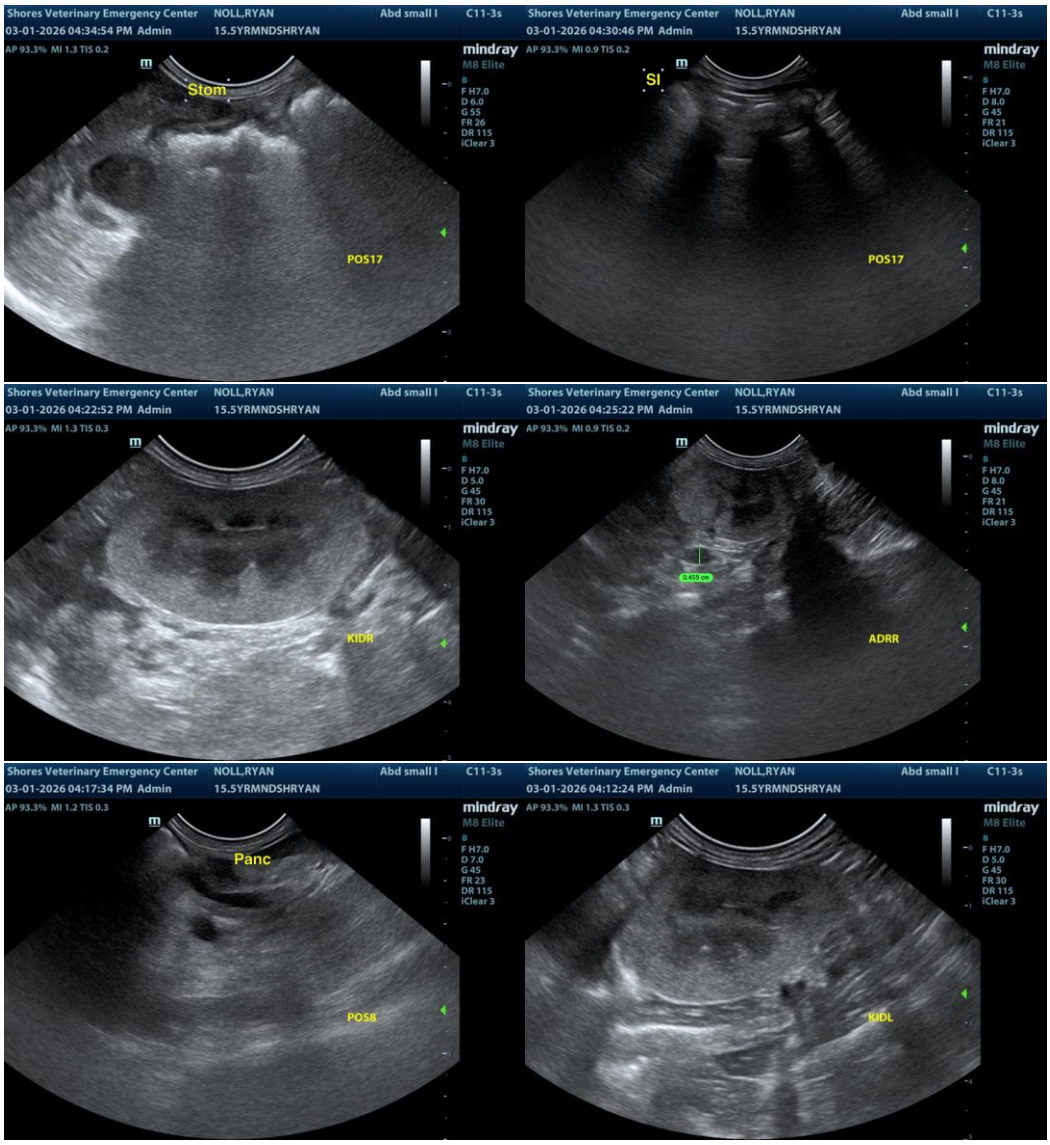
recommended. Further assessment may include consideration for GI panel and liver FNA cytology. Empirical therapy for cholangiohepatitis, pancreatitis and GI support with monitoring would be reasonable. Recheck if persistent gastric ingesta or progressive hepatopathy / azotemia.



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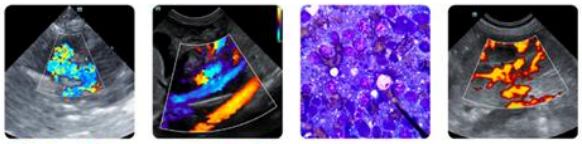

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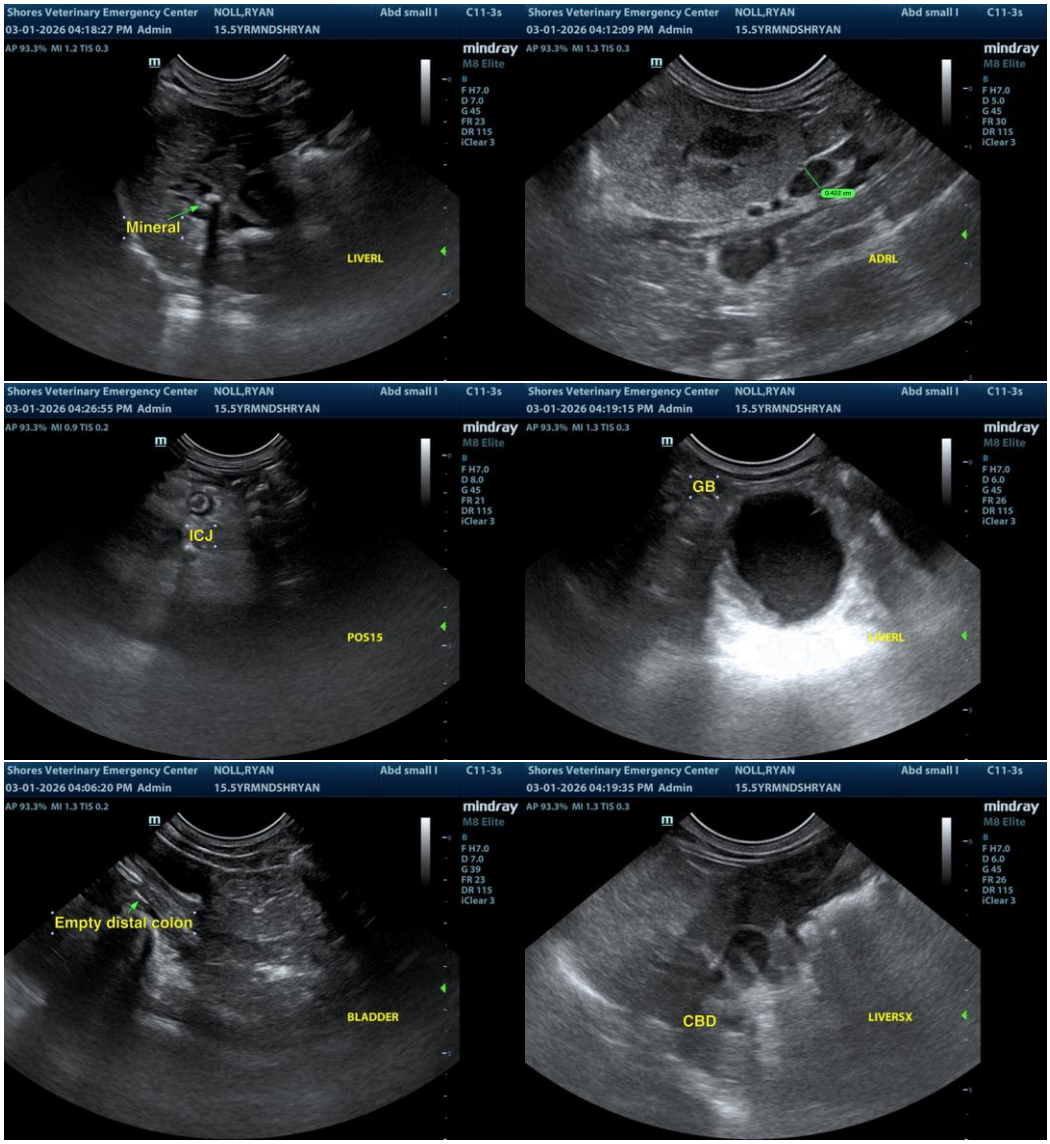

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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