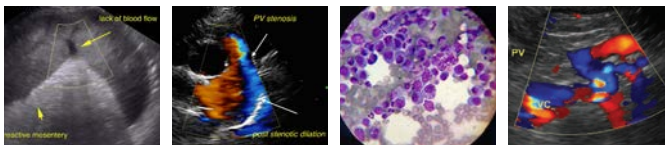
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Beau Meza

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
11 Years

WEIGHT
5.07 kg

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

IMAGING PERFORMED BY
Dr. Patti Mayfield

HOSPITAL NAME
Emergency Vet Hospital

REFERRING VET
Dr. Patti Mayfield

INVOICE
46190

DATE
3/27/23

PRESENTING CLINICAL SIGNS

Patient was found recumbent this morning; V/D noted. Patient was reportedly normal last night. Indoors only, no known toxins in the home No PPH Treatments: Heat support Normosol 35ml/hr with Dextrose 5% additive and KCl40mEq/L additive Cerenia 5mg IV q24hr Unasyn 152 mg IV q 8hr Enrofloxacin 25.3 mg IV q 24hr 10:30am- Central line placed. BP --> difficult to monitor, best doppler measurement is 50mmHg Unable to obtain urine for USG - bladder continues to be too small. Dobutamine CRI started at 2mcg/kg/min. Ondansetron 2.5 mg IV q 12hr Pt has vagal event and regurgitates. Oxygen flow by as pt appears almost ready to code. Blood gas--> Severe metabolic acidosis with inadequate respiratory compensation. Hyperkalemic. pH 7.01, pCO2 63 mmHg, HCO3 14.5, BE -17.1. K 9.2mmol/L Acidosis is due to severe hyperlactemia 12.8. Blood glc monitored hourly. Normalized at 10am to 104 then falls again at noon to 56mg/dL. Third 6mL 25% dextrose bolus and continue 5% dextrose in bag. Add Calcium Gluconate 10% 5mL as IV bolus to manage hyperkalemia 5mL of 8.4% Na HCO3 IV to manage hyperkalemia and severe metabolic acidosis

Abnormal PE/Chem/CBC/UA Results: Patient is laterally recumbent, comatose, profound hypothermia, hypotension, smells of diarrhea. Blood: CHEM: -- BG: 46 (L) -- CREAT: 3.0 (H) -- Na: 171 (H) -- K: 2.5 (L) -- PHOS: 13.8 (H) -- LIPA: 2788 (H) Radiographs: -- Thoracic: Unremarkable -- Abdominal: Diffuse gas/fluid distention of stomach and entire GIT, consistent with inflammatory condition. No noted FB/obstruction. CBC: -- HCT: 60% (H) -- PMN: 1750/uL (L)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was subnormal in size. Minor anechoic urine present. No sediment or calculi. No evidence of inflammatory urinary bladder criteria. No urinary bladder tumors. Urethra normal 2.0 cm.

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. The right kidney measured 4.5 cm.

Adrenal Glands

Both adrenal glands were overtly normal in size, position, and shape. The left adrenal gland measured 0.46 cm. The right adrenal gland measured 0.52 cm.

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.

Liver

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. Overall normal subjective hepatic vascular volume. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

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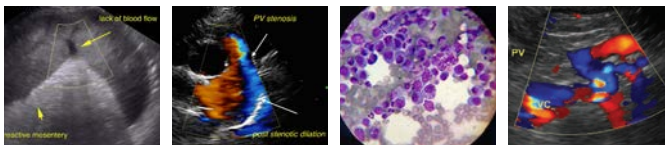

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Gastrointestinal

The stomach presented moderate distention with retained anechoic fluid. Overtly normal gastric wall layering without evidence of mechanical pyloric outflow obstruction.

The intestinal walls demonstrated intact wall layering and maintained 1:3 muscularis / mucosa ratio. The mucosa exhibited mild decreased echogenicity with occasional mucosal speckling. A generalized mild ileus pattern consisting of mild fluid accumulation in the intestinal lumen was present without obstruction or foreign material. No evidence of loss of intestinal wall layering or visualized obstructive mural pathology.

The colon presented sonographically unremarkable wall layering. If the colon exhibited generalized mild to moderate distention with non-formed liquid fecal matter, consistent with patient history, to the level of the colorectum.

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 inflammation. No overt evidence of neoplasia.

Free Abdomen

No omental masses or peritoneal effusion.

Intermittent, mildly prominent to enlarged mesenteric nodes were present. The lymph nodes were mildly prominent and isoechoic to mildly non-homogeneous compared to adjacent omentum.

ULTRASONOGRAPHIC FINDINGS

- Acute gastroenteritis pattern with moderate generalized gastrointestinal hypomotility – subjectively non-obstructive.
- Pancreatitis – subjective mild to possibly moderate.
- Intermittent mild benign/reactive mesenteric lymphadenopathy – mild reactive hyperplasia or mild lymphadenitis secondary to inflammatory bowel episode probable.
- Sonographically normal kidneys

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall, appearance of the gastrointestinal tract is consistent with acute inflammatory criteria with considerations including dietary indiscretion, inflammatory bowel episode, gastroenterotoxic insult, infectious disease, occult infiltrative neoplasia (less likely), or other. No overt evidence of gastrointestinal obstructive pattern without overt indication for immediate surgical intervention.

Pancreatitis as a contributing factor may be suspected if evidence of cranial abdominal or subxiphoid discomfort on palpation. Correlation with GI panel to include PLI, TLI, cobalamin and folate warranted. Empirically, continued aggressive supportive care and gastrointestinal support +/- plasma expanders and continued therapy for shock/sepsis with close monitoring would be reasonable.

Although extremely rare in cats and considered unlikely, occult Addison's disease (given the overall clinical presentation) could be an extremely unlikely consideration in this patient. A physiologic dose of corticosteroids could be considered and may prove beneficial.

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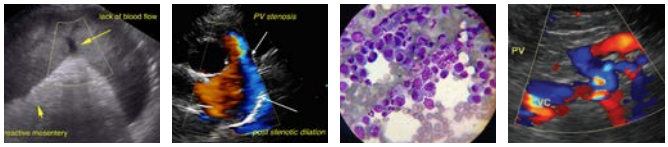

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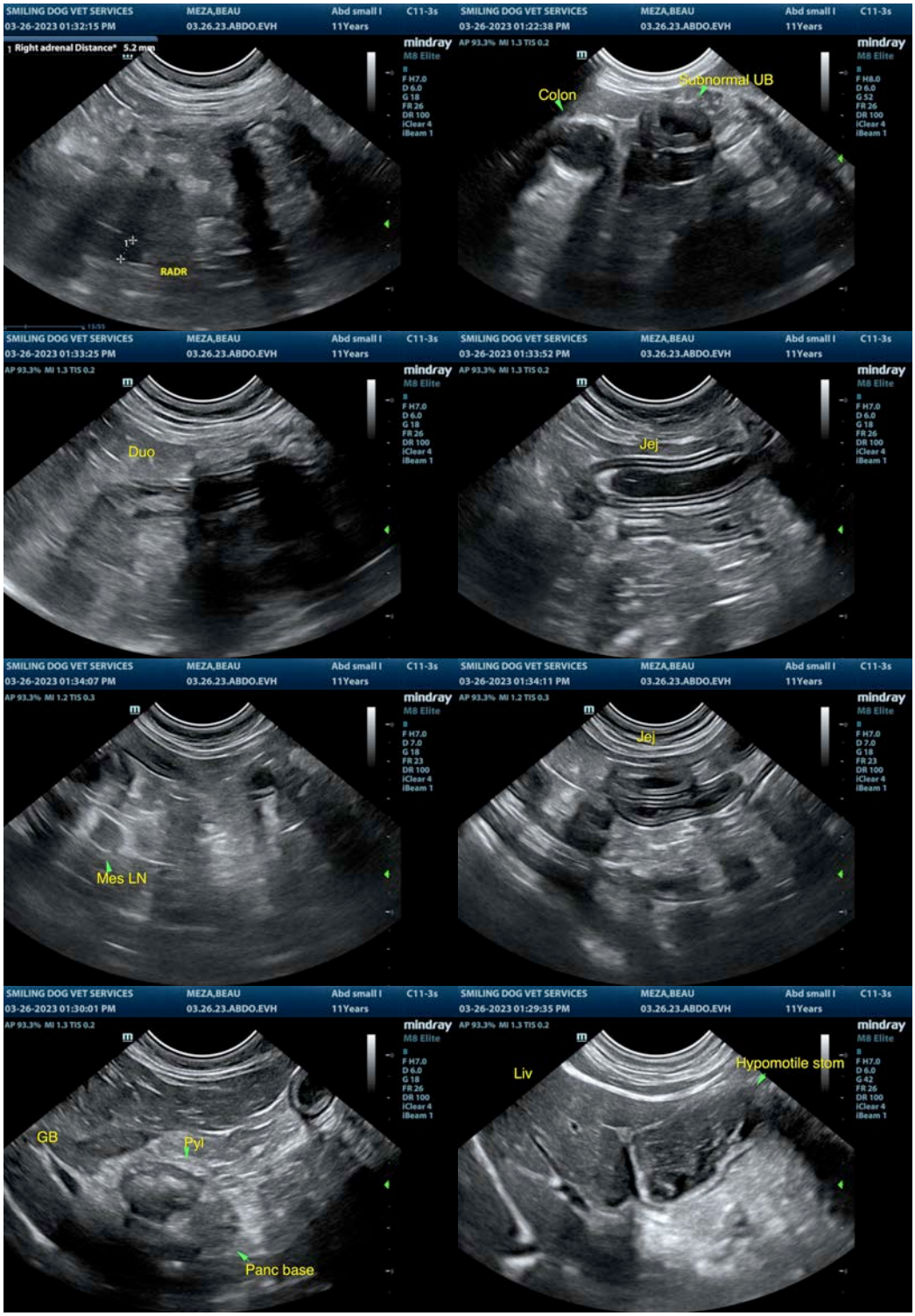

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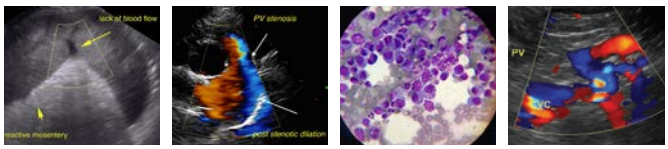

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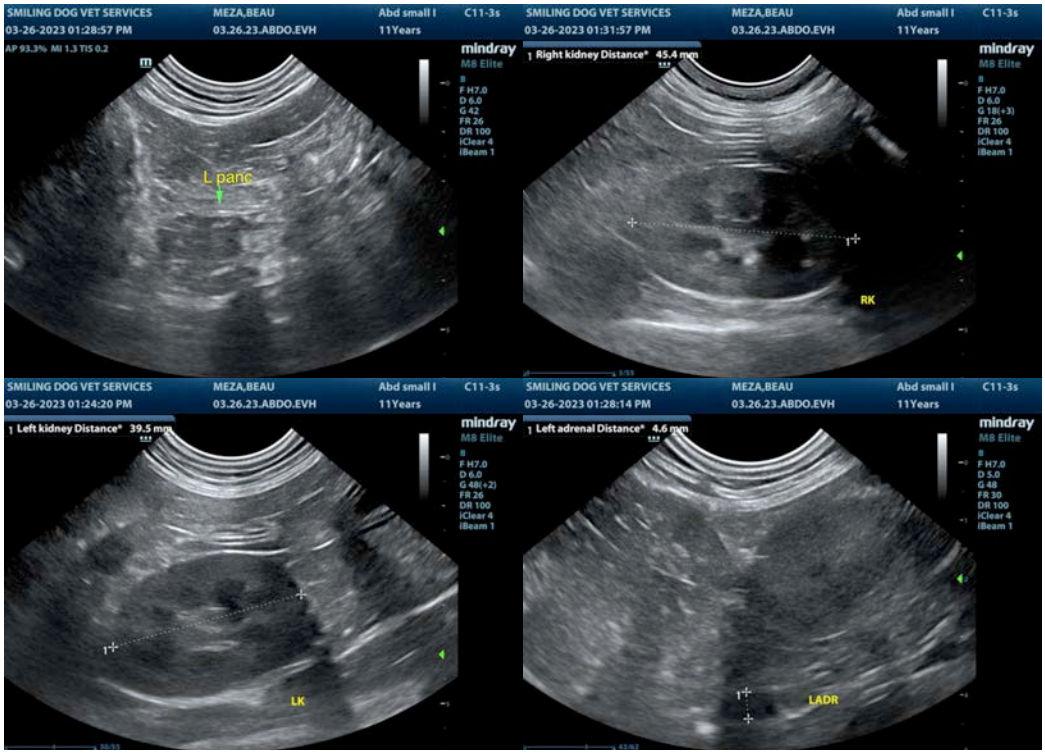

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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