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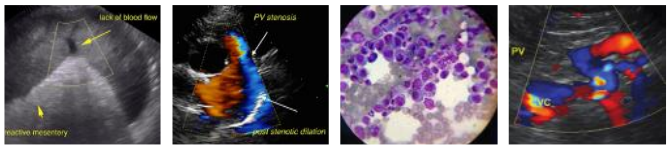
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Fig Roach

SPECIES

Feline

BREED

Oriental shorthair

SEX

FS

AGE

8mo

WEIGHT

2.9kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Bennett

HOSPITAL NAME

Wilvet South

REFERRING VET

Bennett

INVOICE

13475ag

DATE

04/15/2023

PRESENTING CLINICAL SIGNS

Presented for approx 1 week duration lethargy, hyporexia, gagging/hard swallowing, & occasional vomiting. Also has been PU/PD and sneezing with mild nasal discharge. No diarrhea. O feels like she has lost approx. 1/2 pound since spay surgery 6 weeks ago. 2 other cats in household (unrelated), both are asymptomatic. Prior history: Adopted 2 months ago from breeder in the UK. Spayed at rDVM 6 weeks ago. No pre-op blood work done at that time because P was acting very normal. P is reportedly up to date on vaccines.

Abnormal PE/Chem/CBC/UA Results: Exam: QDR, lethargic. Fever 103.7. Pale MM. No oral ulcers or FB. Crusty mucoid nasal discharge on nares. Thoracic auscultation WNL. Abdominal palpation- prominent intestinal loops, no palpable FB or dilated loops. Thin body condition. FeLV / FIV / HWT: all negative CBC: HCT 41.5%, WBC 27.31k, Neut 20.09k, suspect bands, Mono 1.03k, rest WNL. Chem10: Glu 232, Crea 1.9, BUN 62, rest WNL (TP 8.1, Alb 3.7, Glob 4.5). EPOC: pH 7.3, BE -8.3, Na 142, K 1.8, Cl 106, iCa 1.18, LAC 6.15, BUN 69, Crea 1.99, Glu 245, rest NSF. UA (free catch): USG 1.014, pH 7.0, Pro 30, quiet sediment.

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 minor non-dependent particulate sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and adequate 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 3.5 cm in length. The right kidney measured 3.9 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 0.38 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.34 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. The spleen measured 0.77 cm in width at the level of the hilus.

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 thin walls and primarily anechoic luminal content with minor incidental debris. No evidence of gallbladder or peripheral gallbladder inflammation was present. The cystic and common bile ducts were normal.

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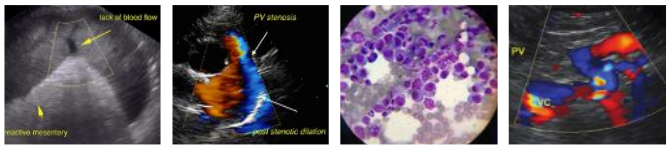

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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate retained anechoic fluid and pockets of luminal gas with no signs of ileus, obstruction or foreign material.

The duodenum exhibited intact subjective mildly prominent wall layering. The jejunum and ileum were sonographically unremarkable. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

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

Pancreas

The l 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

No omental masses or peritoneal effusion was present.

Mildly prominent mesenteric lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of subtle perilymphatic inflammation was evident. An example of lymph node size was 1.4 cm x 0.32 cm.

ULTRASONOGRAPHIC FINDINGS

- Pancreatitis with regional mild reactive omentum.
- Hypomotile stomach with likely concurrent duodenitis.
- Intermittent mild benign/reactive mesenteric lymph nodes-mild hyperplasia, reactive lymphadenitis or immunologic immaturity.
- Overtly normal bilateral kidneys.
- Minor urinary bladder sediment.

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. Baseline UPC may be considered if persistent proteinuria in light of relatively quiet urinary bladder sediment or if no evidence of inflammatory debris. The kidneys did not appear to be end stage without sonographic evidence of dysplasia or pyelonephritis. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. No evidence of GI obstructive pattern or foreign material.

No overt evidence of intra-abdominal neoplastic or FIP criteria. Three view chest radiographs are recommended if not done to assess for occult thoracic pathology. Empirically hospitalization with IVF, empirical therapy for pancreatitis with as needed GI support and monitoring of clinical and renal response is recommended.

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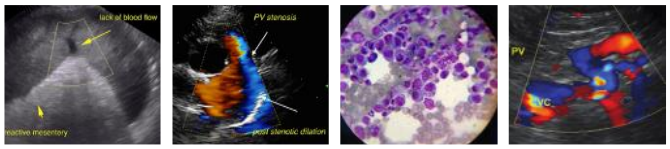

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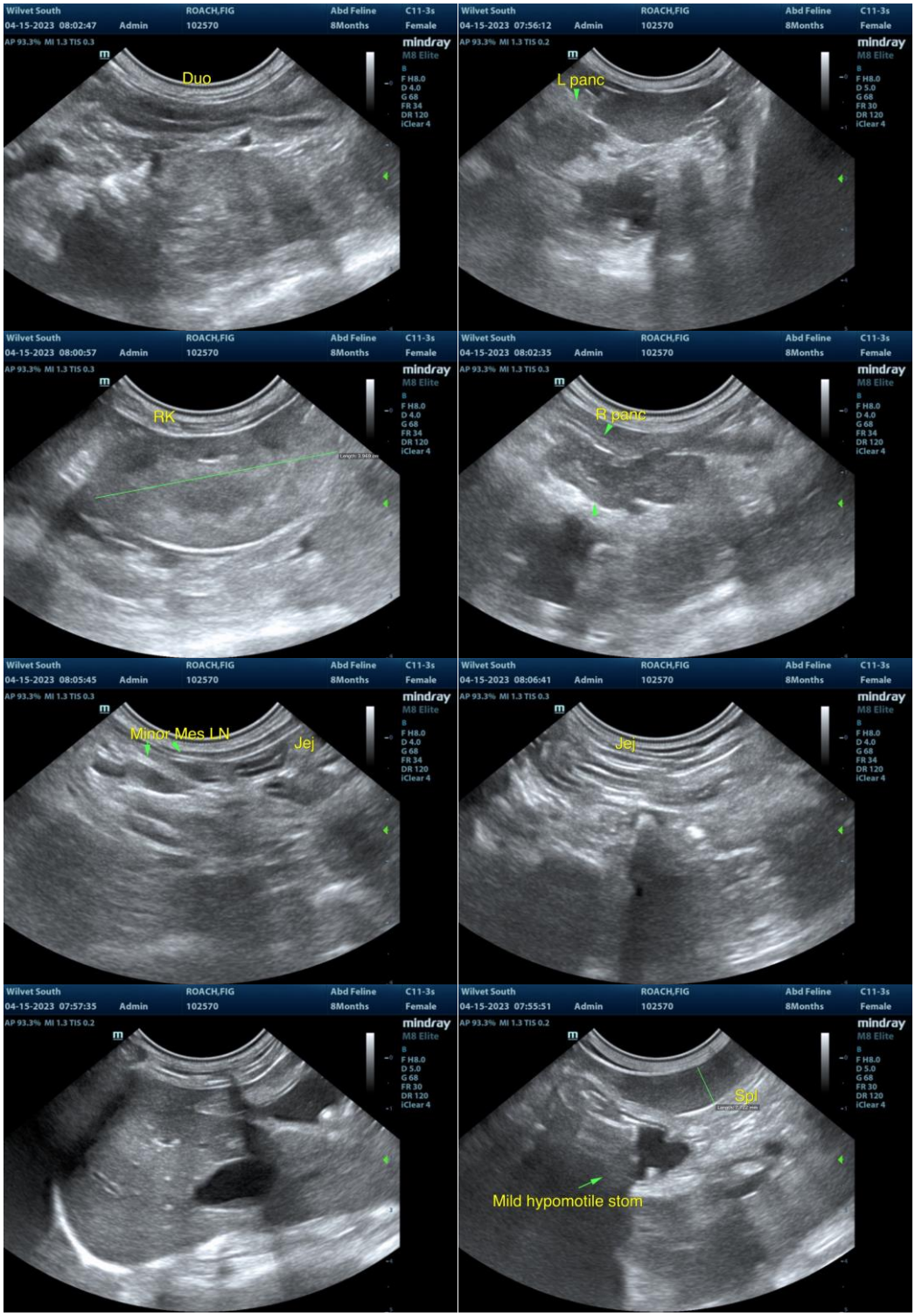

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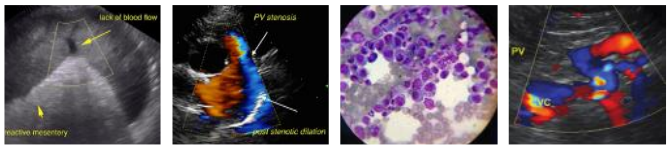

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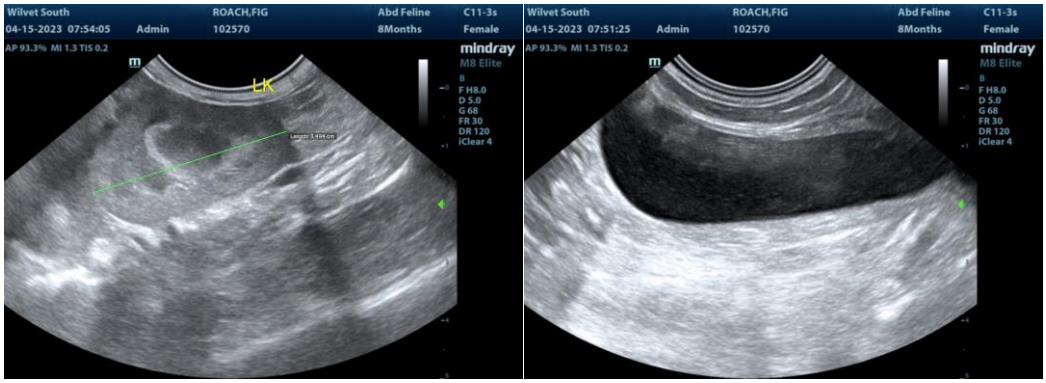

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
mac.daniel@sonopath.com