



PATIENT

Hanna Suarez

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

2yr

WEIGHT

8.5lb

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr Gabriel Ferrer
DVM

HOSPITAL NAME

Pulse: Pet Ultrasound
Services

REFERRING VET

Dra. Alma Alicea

INVOICE

13653ag

DATE

05/01/2023

PRESENTING CLINICAL SIGNS

Hanna is a 2.5 y/o F/S DSH that presented to the Emergency clinic on 4/27 with hx of lethargy and anorexia for several days. Found to have fever (103.7), severe hyperbilirubinemia, thrombocytopenia at presentation. started on fluids 12ml/hr, famotidine 0.4 cc iv bi, cerenia 0.4 cc iv sid, dex SP 1 cc iv bid, doxycycline 3.8 iv sid assuming infectious cause. 4/28 - She continues to be lethargic, no fever. no v/d. tense, painful abdomen. severely icteric. continued plan as per yesterday's instructions. 4/29 - Hanna is brighter. icterus seems slightly better. abd. pain improving (more comfortable). still no appetite. problems: fever (improved) icterus anorexia thrombocytopenia hperbilirubineimai abd. pain r/o infectious, inflammatory, neoplasia, pancreatitis, etc continue simbadol 0.24mg/kg sq sid, continue famotidine 1mg/kg iv sid, continue cerenia 1mg/kg iv sid, continue doxycycline 10mg/kg IV SID, once place E-tube change oral, continue dex SP to 0.25mg/kg iv sid. - 0.23 cc IV SID, cotninue baytril 5mg/kg iv sid, continue fenbendazole 50mg/kg po sid x 5 days, continue mirtazapine 2 clicks EOD, 4/27 -vit b 12 0.5 cc sq once, Esophageal tube - to be placed today, recheck CBC today, recheck cata 17 today

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 uroliths or 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. A caudomedial left kidney infarct and a cranio-lateral right kidney infarct were present. 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 3.7 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 0.33 cm width at.

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 0.85 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.



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The proximal common bile duct was dilated and tortuous without overt post hepatic obstruction. The proximal common bile duct measured 0.2 cm diameter. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content with mild echogenic debris. No peripheral gallbladder inflammation.

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Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with subjective mild gas distension and no signs of ileus, obstruction or foreign material.

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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 ileus, obstruction or foreign material. The duodenum wall measured 0.20 cm width. The jejunum wall measured 0.22 cm width. The ileocolic junction wall measured 0.25 cm in width.

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

Pancreas

AGE

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The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

WEIGHT

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No omental masses or peritoneal effusion was present.

Intermittent mildly prominent to enlarged 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 1.2 cm x 0.35 cm.

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ULTRASONOGRAPHIC FINDINGS

- Sonographically unremarkable liver.
- Non-distended gallbladder with mild sludge.
- Non-obstructive proximal common bile duct dilation-suggestive of cholangitis.
- Structurally unremarkable GI tract.
- Intermittent minor benign/reactive mesenteric lymph nodes-likely minor hyperplasia or reactive lymphadenitis suspected secondary to inflammatory bowel episode.
- Mild heterogenous pancreas.
- Bilateral small renal cortical infarcts.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No sonographic evidence of significant visceral pathology i.e., post hepatic obstructive criteria, neoplasia, poverty IBD pattern etc. was present. Potential of low grade pancreatitis or inflammatory enteropathy episode, both of which may present sonographically normal is possible.

REFERRING VET

Dra. Alma Alicea

Assessment for evidence of cranial abdominal/subxiphoid discomfort on palpation which may allude to chronic active pancreatitis is recommended. Recheck retroviral status could be considered if not recently done. No overt indication for immediate surgical intervention.

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Continued GI supportive care with potential conservative empirical therapy for cholangitis/possible low grade pancreatitis would be reasonable.

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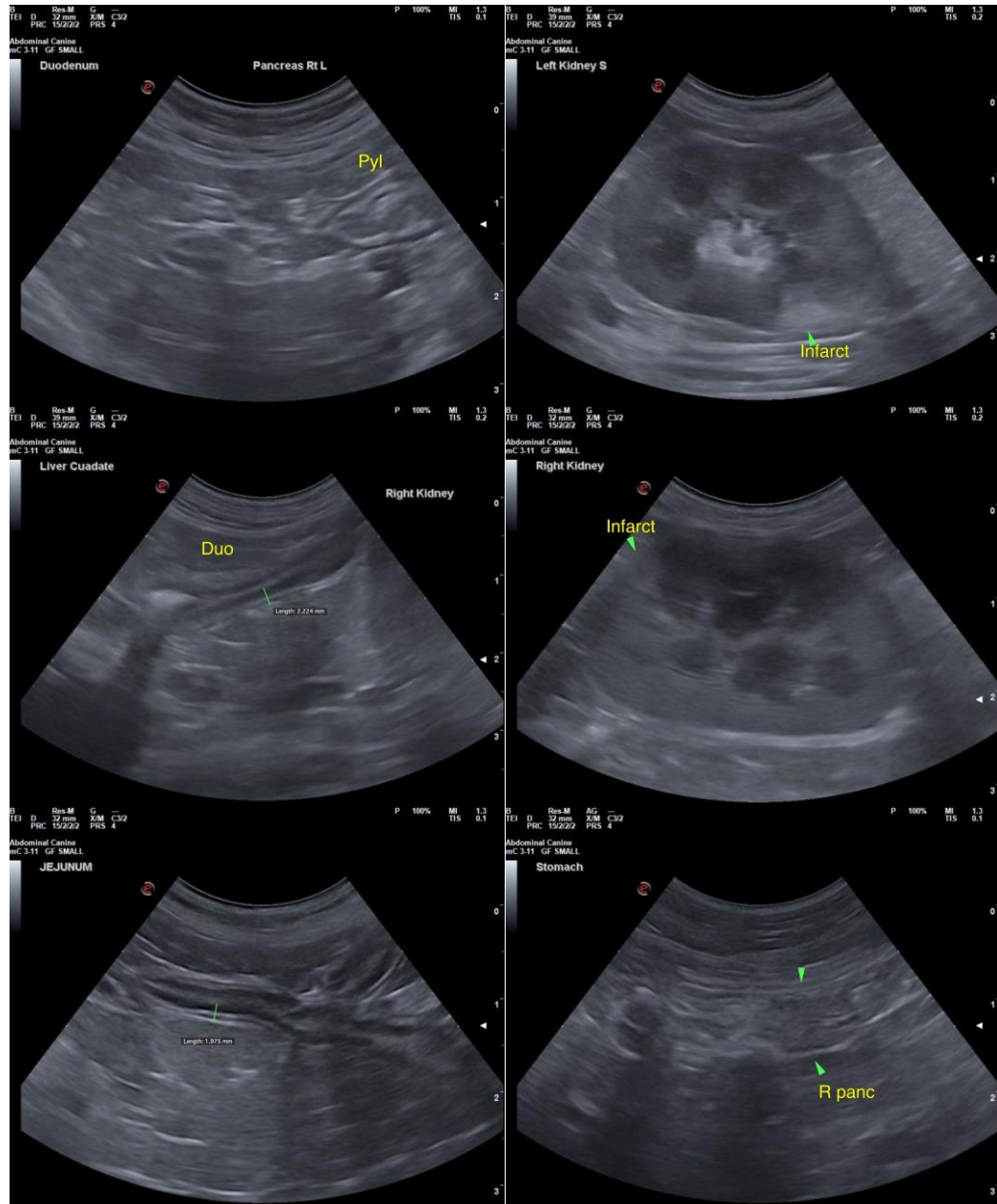
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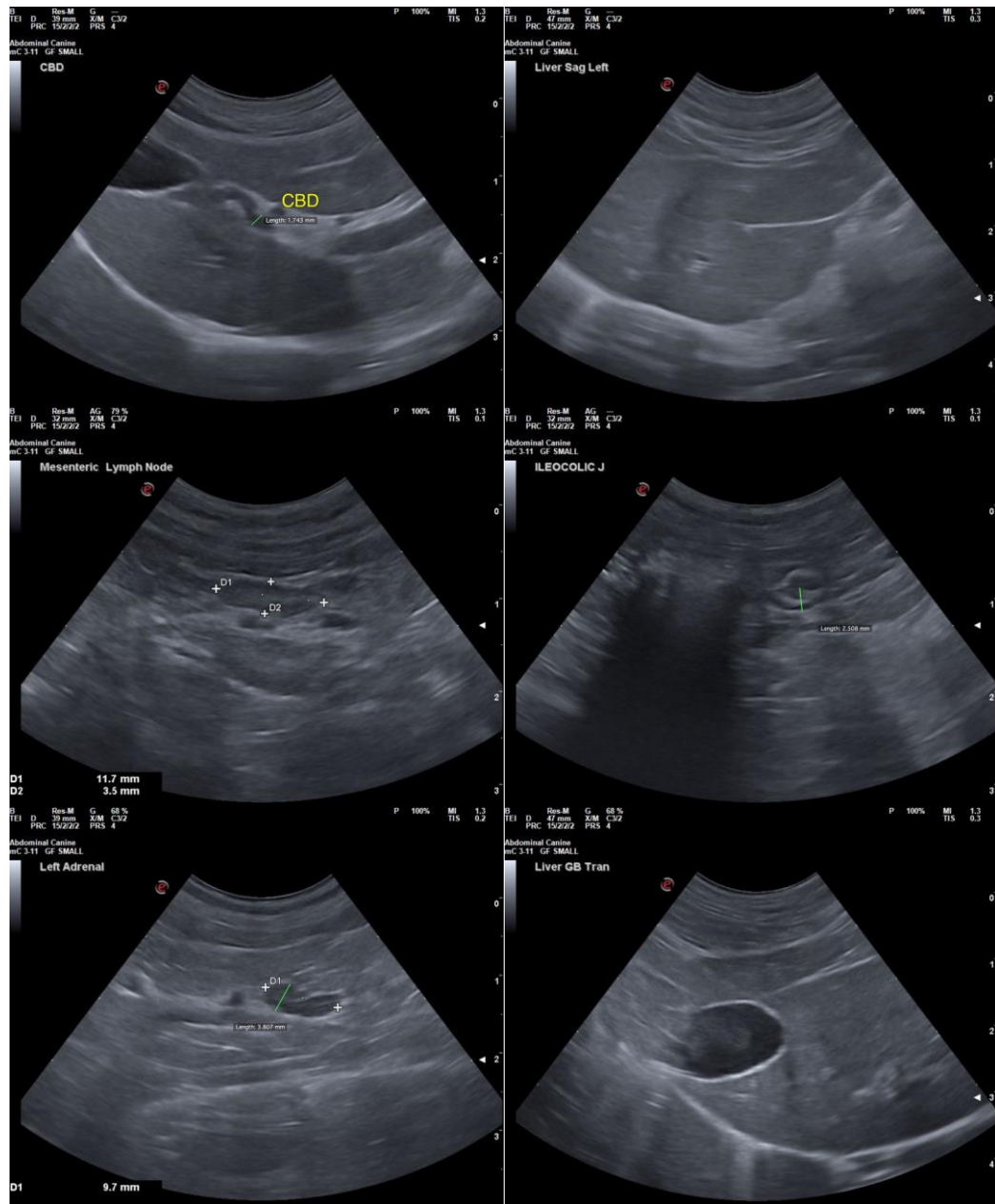
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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