



PATIENT

Tadia Diehl

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

2 Years

WEIGHT

3.39 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Patti Mayfield, DVM

HOSPITAL NAME

Highland VH

REFERRING VET

Rachel Poet, DVM

INVOICE

15230

DATE

5/16/22

PRESENTING CLINICAL SIGNS

History: Pt presenting for AUS. Pt has been doing well at home. Had a bowel movement yesterday at 4 pm. Pt is on probiotics and Miralax daily. Confirmed Pt has been fasted for the last 12 hours and no water in the last 2 hours. AA Report from Highland Vet Clinic: Symptoms Adopted from Brightside. History of urinary infections and dysuria, difficulties with voiding. Intermittent vomiting. Stool issues. Blood spots occasionally after defecating. Possible PPH of diaphragmatic hernia and repair at shelter. Gallop arrhythmia previously documented, but subsequent to that, patient received full GA (without indication of arrhythmia) for dental extractions/cleansing. Patient did well for GA ~ 1 month ago. Historic marked distention of the urinary bladder and possible missing R kidney, as it is not palpable. -- Diet Z/D diet canned and piece chicken and Z/D kibble -- Medications/Preventatives - Famotidine 2.5 mg BID, Miralax, hairball gel, cranberry comfort, fortiflora, cobalequin

Abnormal PE/Chem/CBC/UA Results: PE: -- Markedly distended bladder, albeit slightly soft and able to express, however with only dribbling efforts (historic finding for >1 year). Mild pain on expression. Unable to palpate R kidney. -- Regularly irregular arrhythmia, no murmur appreciated -- Mild lumbar pain ECG: Normal complexes with intermittent VPC's and increased R-R interval -- Previous blood work was unremarkable (within 1 month) -- Previous ECG during GA in April was unremarkable -- Last UA was unremarkable (~ 1 month ago)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was distended in size with subjective normal tone. Primarily anechoic urine was present with mild nondependent particulate sediment. The sediment may indicate a mild cellular debris/protein, crystalline debris or potential mucus. Within the area of the trigone, a thinly walled cystic appearing structure in the area of the ureteral papilla, potentially extending caudally into the area of the urinary bladder neck, measuring approximately 2.5 cm in diameter, was present. Anechoic fluid, similar in appearance to adjacent urine was present. No overt evidence of regional inflammation around the urinary bladder or proximal urethra, which exhibited normal structure and tone to a depth of 2.0 cm. Aortic trifurcation was normal.

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 pyelectasia. The left kidney measured 3.7 cm in length. The right kidney measured 4.5 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 0.30 cm.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.35 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. The spleen measured 0.93 cm.



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Liver

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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. The cystic and common bile ducts were normal.

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Gastrointestinal

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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material. The stomach appeared to be in correct location caudal to the liver. The gastric body wall measured 0.25 cm.

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The small intestine exhibited intact wall layering with subjective maintained 1:3 muscularis/mucosa ratio. Segments of small intestine were noted cranial and ventral to the liver. No overt evidence of mechanical/metabolic small intestinal ileus or obstructive pattern, as well as no loss of intestinal wall layering. The small intestinal wall measured 0.22 cm.

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

Pancreas

WEIGHT

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The area of the pancreas base and the proximal right pancreatic limb exhibited subjective mild prominent size with maintained symmetrical capsule contour and subtle hypoechoic parenchyma compared to adjacent nonreactive or inflamed peripancreatic omentum.

Free Abdomen

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No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

IMAGING PERFORMED BY

Patti Mayfield, DVM

- Distended urinary bladder with mild nondependent particulate sediment
- Suspect ureterocele
- Sonographically unremarkable small bowel with segments of small bowel cranial and ventral to the liver- suspect potential entrapped sections of sonographically unremarkable small bowel secondary to previous hernia repair given the patients history.
- Possible low-grade to mild pancreatitis

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Rachel Poet, DVM

The possibility of an unspecified fibrous tissue band noted within the area of the trigone is possible yet based on sonographic presentation, a ureterocele as a contributing factor to the patients chronic history of urinary bladder distention is suspected. Additional imaging, such as contrast urography or ideally, CT with contrast for further assessment and potential surgical planning is recommended. Likewise, further assessment of the suspected entrapped segments of small bowel, cranial and ventral to the liver, could be obtained, although the segments of small bowel were not overtly pathologic and not likely a clinical issue at this stage. If surgery is elected, repair of segments of bowel, cranial and ventral to the liver +/- gastrointestinal biopsies could be considered.

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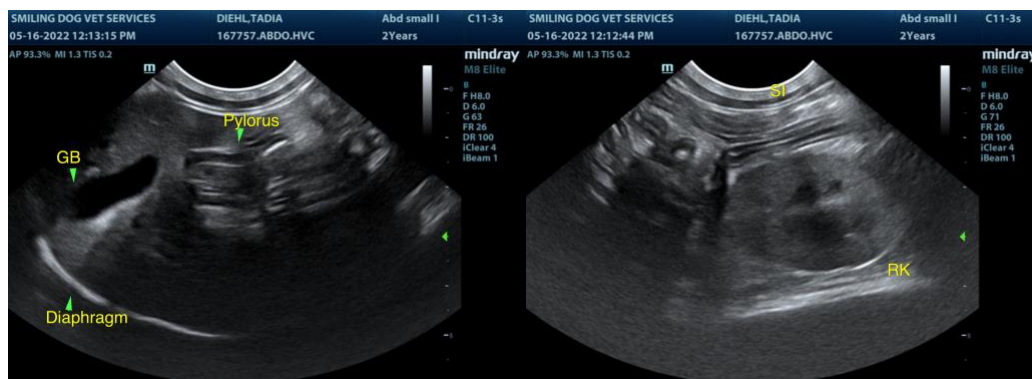
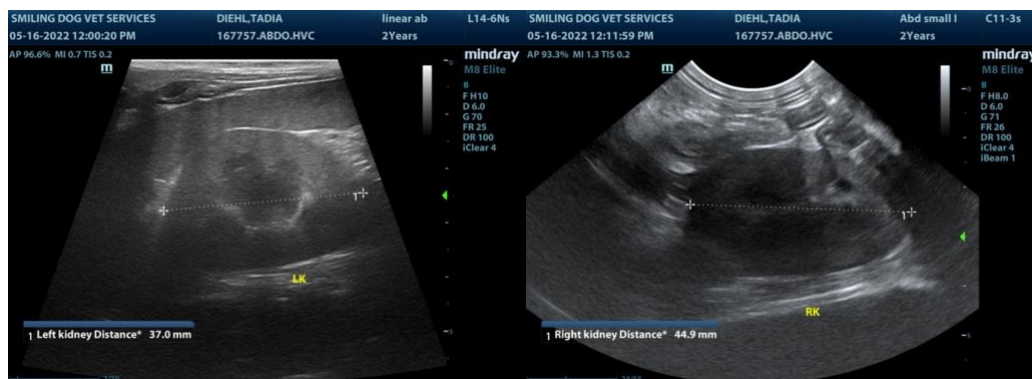
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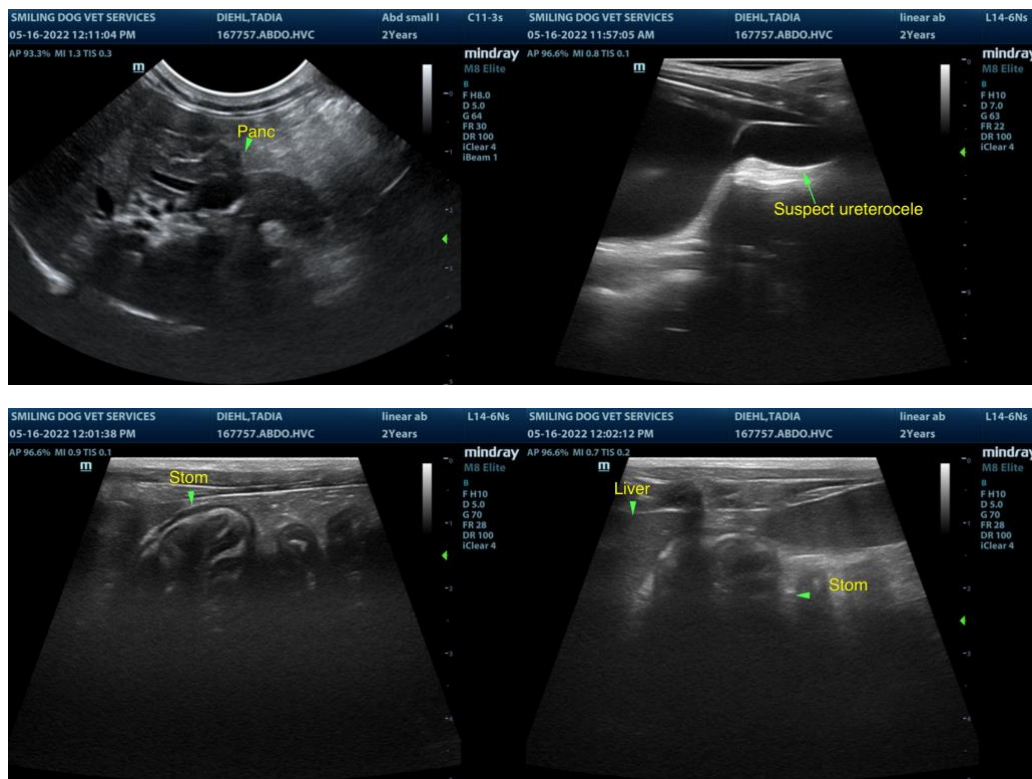
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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