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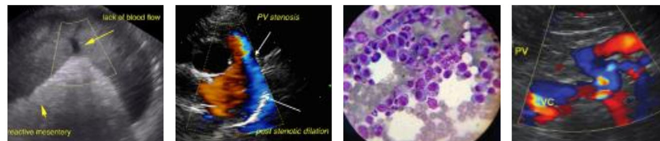
Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT

Bella Allen

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

10yr

WEIGHT

9.93lb

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Rivera

HOSPITAL NAME

DPC Veterinary Hospital

REFERRING VET

Dr. Rivera

INVOICE

13756ag

DATE

05/08/2023

PRESENTING CLINICAL SIGNS

Date: 4/11/2023 Reason for Visit: vomiting, lethargic History: 10 y/o s,f dsh presents for throwing up since friday/sat. Would throw up once a day, now suspects that it might be more, O has seen little piles around the house. V was watery and unchewed food. Was slightly lethargic but thinks it due to age. Still mostly active. Has recently introduced temptations as a treat. C/S/V/D: no c/s/d, V+ E/D/U/D: wnl Diet: dry food blue buffalo FAS Score: 5, not friendly at all Current Medications (dose and frequency):Tomlyn Heartworm Prevention / Flea Prevention: none Known Allergies and Medical Conditions: Microchip ID: / No microchip Date: 5/8/2023 Rechecking: FROM EXCESSIVE VOMITING History: 10YR 11MO SF DSH PRESENTED FOR STILL VOMITING. PET WAS HERE ON 4/11/23 WITH HISTORY OF VOMITING AND LETHARGY, BLOODWORK WAS DONE AND fPL CAME BACK ABNORMAL. PET WAS TREATED WITH CERENIA AND HYPOALLERGENIC FOOD. OWNER WAS ABLE TO GET CERENIA FOR THREE DAYS AND FOR A WEEK DURING THAT TIME THE PET DID NOT VOMIT. PET IS BACK TO VOMITING AGAIN. THE VOMITING CONSIST MAINLY OF HAIRBALLS. C/S/V/D: VOMITING E/D/U/D: WNL Diet: HYPO FAS Score: 5 Current Medications (dose and frequency): NONE TODAY Known Allergies and Medical Conditions: NONE

Abnormal PE/Chem/CBC/UA Results: 4/11/23 Vital Signs Weight: ~ 7.5lbs Temp: HR: RR: MM/CRT: pk, moist Physical Examination Key -- (N= Normal, A= Abnormal) CV/Respiratory: Normal heart rate and rhythm, no murmur, pulses strong and synchronous, normal bronchovesicular sounds. EENT: Clear OU and AU. No nasal discharge. Oral cavity: Mild dental tartar Musculoskeletal: BCS = 5/9. Ambulatory x 4 Uro/Perineum: No significant lesions Abd/GI: Soft, non-painful. No masses or fluid wave palpated Lymph Nodes: No peripheral lymphadenopathy Neurological: Alert and appropriate. No significant abnormalities Skin: Barbering at medial aspect of hindlimbs - no dermal lesions. Good hair coat. No ectoparasites seen Mentation: BAR Hydration: N Fecal: NPS Diagnostic Testing Needed: CBC/CHEM/UA, fPL, SDMA/TT4, Fecal Declined Diagnostics/Treatments: None Findings: 1) CBC: WNL 2) CHEM: WNL 3) UA(cysto): NSF 4) fPL: ABNORMAL 5) SDMA: WNL 6) TT4: 3.0 (0.8-4.7) Assessment: Acute vomiting: r/o pancreatitis vs. IBD vs. endocrine (hyperthyroid vs. DM vs. other) vs. gastritis vs. other Aggressive Periodontal disease (stage 1/4) Treatment Plan: Sedation - Gas (Iso + O2), Cerenia 10mg/ml (1mg/kg): 0.34ml SQ Treatment Declined: None Prescriptions to Dispense: 1) Cerenia 16mg: Give 1/4 tab PO SID x 3-5 days Dietary (food) Recommendations: HP for 3-5 days Recheck Needed: PRN if no improvement Follow-up Care: Abdominal US, +/- hospitalization with IV fluids and supportive care. 5/8/23 Exam Notes: PE no changes from last visit April 2023 Diagnostics & Testing: AUS- consult pending Treatment Plan: 1) Continue Cerenia SID PRN for vomiting 2) Trial with CatLax 3) Continue HP diet for now - pending AUS report 4) O requested Microchip Declined

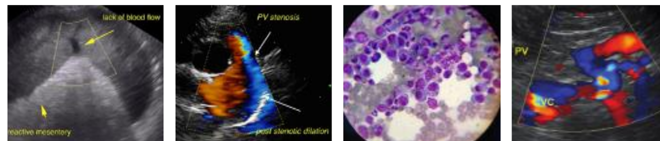
ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

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 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. Bilateral pinpoint to focal areas of medullary mineral were present. The left kidney measured 3.3 cm in length. The right kidney measured 3.4 cm in length.

The area of the aortic trifurcation was free of pathology.



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Adrenal Glands

The left and right adrenal glands were not definitively visualized. No obvious pathology was present in the area of the bilateral adrenal glands.

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 mild echogenic sludge. The cystic and common bile ducts were normal.

Gastrointestinal

Mildly thickened pylorus wall exhibiting decreased mural echogenicity and loss of discernable wall layer detail was present. The pylorus wall measured up to 0.42 cm in width. The degree of pyloric wall thickening was not overtly consistent with mechanical pyloric outflow obstruction or obstructive pyloric mural pathology. The lumen of the stomach was empty with mild luminal gas and no signs of ileus, obstruction or foreign material. The ventral gastric body wall measured 0.24 cm in width.

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 0.24 cm width. The jejunum wall measured 0.20 cm width.

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

Pancreas

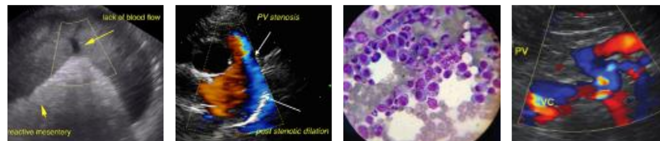
The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. Subjective minor pancreatic duct dilation was present in the area of the pancreas base and right limb.

Free Abdomen

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

ULTRASONOGRAPHIC FINDINGS

- Mildly thickened pylorus exhibiting decreased mural echogenicity and loss of wall layer detail.
- Sonographically unremarkable small bowel.
- Suspect mild chronic pancreatitis.
- Gallbladder debris (non-mucocele).
- Mild age related renal changes with minor medullary mineral.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

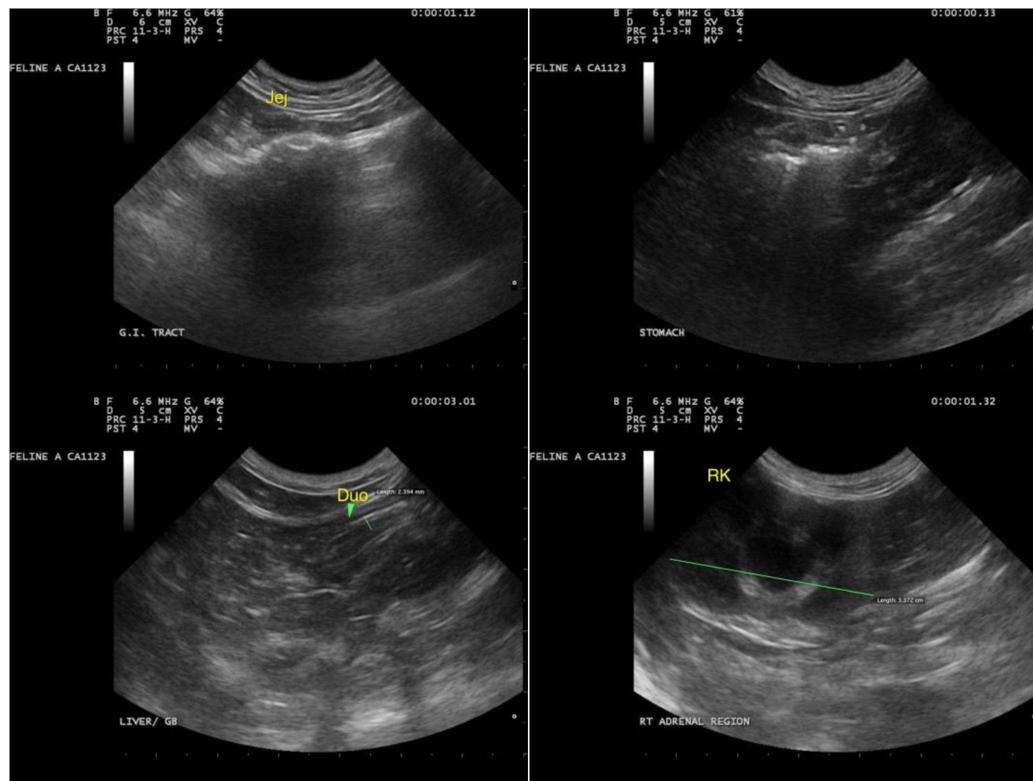
The primary finding in this case and likely contributing factor to the progressive vomiting is the mildly thickened pylorus. Considerations may include inflammatory/infectious disease with potential for emerging infiltrative neoplastic criteria. Biopsy of the pylorus would be required for a definitive diagnosis.

The appearance of the pancreas is not sonographically consistent with active pancreatitis as a primary clinical concern although low grade to chronic pancreatitis is suspected given concurrent elevated fPL.

The gallbladder debris is of unclear clinical significance given the lack of hepatic enzyme elevations yet at times has been associated with hepatobiliary inflammation if previous history of hepatic enzyme elevations. Correlation with monitoring of hepatic enzymes could be considered.

Empirically, gastroprotectant protocol i.e., omeprazole 1mg/kg PO BID over the next 3 weeks, canned hydrolyzed diet trial with avoidance of dry food and potential multiple smaller feedings or slurry feeding +/- empirical coverage for helicobacter and assessment of clinical response is recommended.

Sonographic monitoring of the pyloric wall for progressive changes may be considered if biopsies are not elected.



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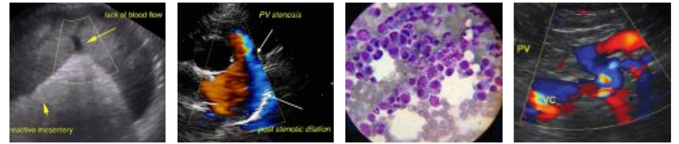

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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