



PATIENT

Majora Wilson

SPECIES

Feline

BREED

DMH

SEX

Spayed Female

AGE

6 Years 6 Months

WEIGHT

5.31 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Alejandro Vargas
Lumbreras, RVT

HOSPITAL NAME

Central Island Vet
Emergency Hospital

REFERRING VET

Dr. Valerie Drolet

INVOICE

38884

DATE

6/19/22

PRESENTING CLINICAL SIGNS

Seen 2 days ago, overnight (June 16) w/ hx of vomiting, lethargy, drooling, and discomfort. Indoor only w/ no known dietary indiscretion. Uncomfortable on abdominal palpation on PE. Had sedated rads performed: no obvious FB or obstruction, uniform gas distension in SI and colon. Treated w/ injection cerenia and sent home to monitor. Since discharge - not doing anything, very lethargic, moves a little if she wants to avoid owners. no interest in food or water, not using the litter box. drooling a lot this morning (as soon as the antinausea medication wore off) no vomiting. took a while to wake up from the sedative.

Abnormal PE/Chem/CBC/UA Results: BCS 7/9. Marked ptyalism, nothing obvious noted on oral exam, nothing under tongue. very uncomfortable on abdominal palpation, generalized - not able to localize to one area. no obvious FB or mass effect appreciated. mild skin tent. bradycardic and tachypneic. CBC: Hemoconcentration (HCT 58.6%), marked neutropenia w/ left shift, monocytosis. Biochemistry: stress hyperglycemia, hypokalemia, fPL: abnormal. Admit to hospital: - IVFT @ 2x maintenance - Cerenia 1mg/kg q24 - Pantoprazole 1mg/kg q12 - Vetergesic 0.02mg/kg q8 - Ampicillin 22mg/kg q8 Overnight:- Discontinued IVFT - administered 2mg/kg lasix IV, repeat q2 until breathing resp rate and effort improves - reduced pantoprazole to q24 Additional abdominal radiographs obtained at 4am - empty stomach, no obstructive pattern noted, feces in colon - unstructured interstitial lung pattern, most profound ventral quadrants and right caudal lung. - proBNP abnormal - restarted IVF at Maint IDEXX thx rad report summary: Generalized cardiomegaly, free pleural fluid, mixed pulmonary infiltrates left congestive heart failure and cardiogenic pulmonary edema is a top differential.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 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.

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 3.4 cm. The right kidney measured 3.7 cm.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.41 cm.

The right adrenal gland was not definitively visualized. No overt pathology in the area of the right adrenal gland.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The spleen measured 0.57 cm. 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.



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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. 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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Transdiaphragmatic view revealed comet tail lung pattern, which is echogenic sound wave interface with microconsolidations within the caudal lung field. The lung field should not be visualized by sonogram unless pathology is present. Chest radiographs are recommended to rule out alveolar/lung disease such as neoplasia, thromboembolic disease, chronic inflammatory disease with microconsolidation.

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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.

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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 obstruction or foreign material. Minor areas of non-obstructive jejunal ileus present.

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

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Pancreas

The visualized pancreas exhibited normal size and contour with potential subtle hypoechoic parenchyma compared to adjacent non-reactive, non-inflamed peripancreatic omentum.

Other

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Subjective mild volume caudal pleural free fluid was visualized.

ULTRASONOGRAPHIC FINDINGS

- Overall sonographically unremarkable abdomen, mild gastroenteritis or low grade pancreatitis possible
- Transdiaphragmatic comet tail artifact - can be seen with alveolar/lung disease such as neoplasia, thromboembolic disease, chronic inflammatory disease with microconsolidation, other in conjunction with radiographic findings
- Confirmed pleural free fluid

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Sonographically, no overt abdominal visceral pathology...no signs of GI obstruction, foreign material, significant pancreatitis or neoplastic criteria as a possible cause of pulmonary metastasis. GI support for possible mild gastroenteritis and/or low-grade pancreatitis, which can present sonographically normal, would be reasonable. Pleural effusion analysis, cytospin / cytology +/- C/S if inflammatory cells and ideally echocardiogram are recommended.

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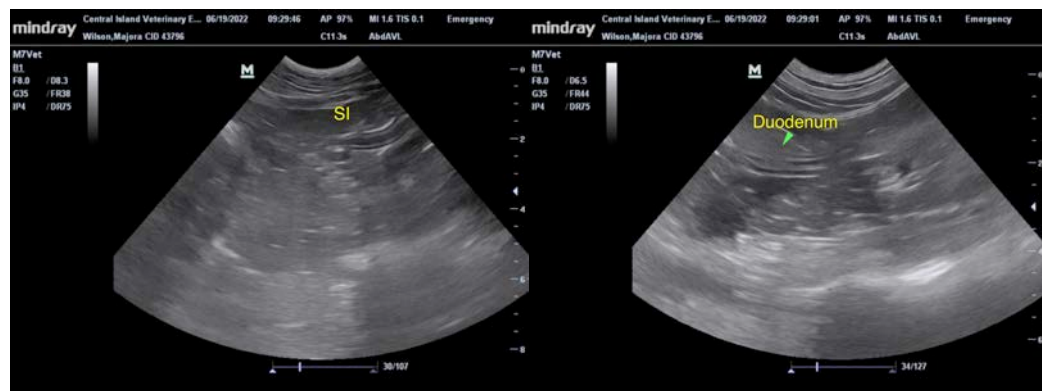
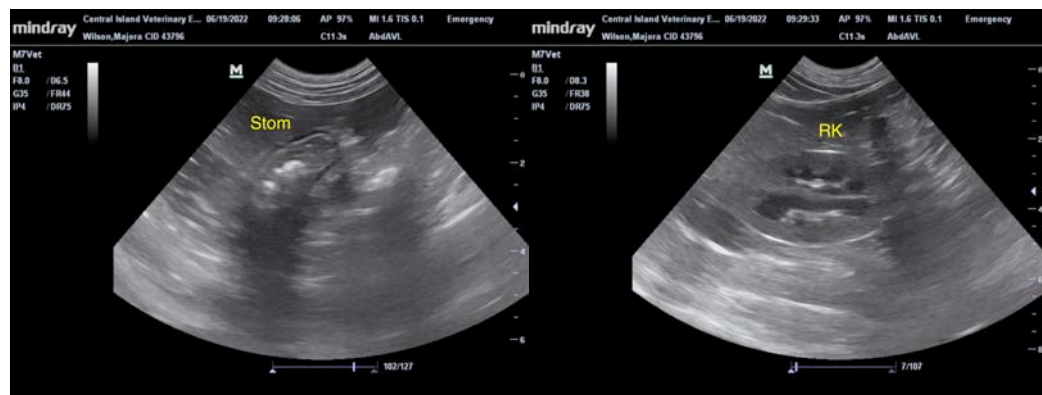
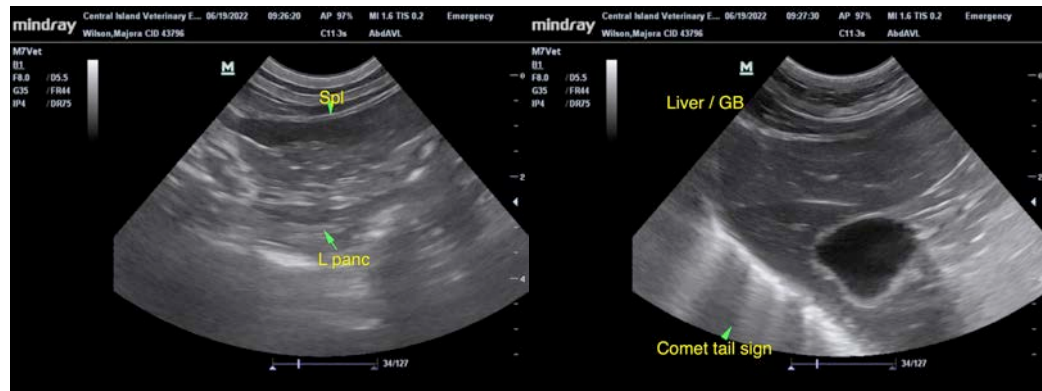
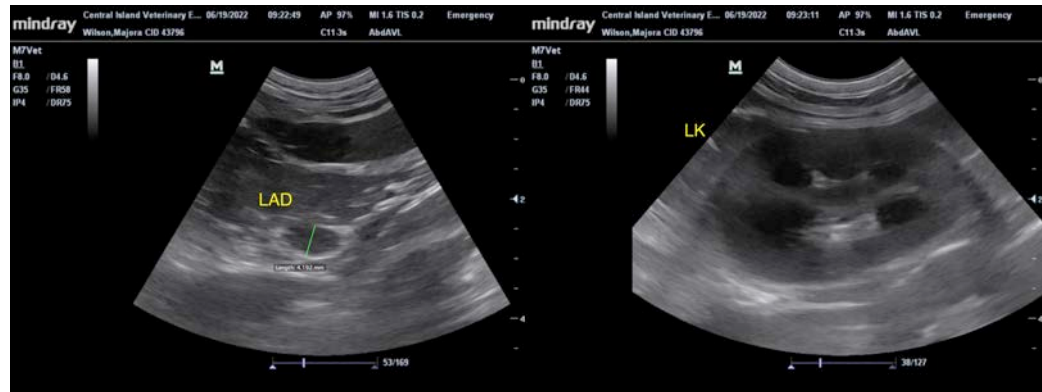
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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