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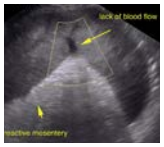
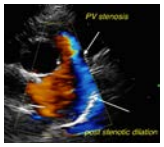
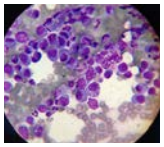
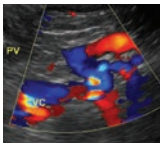

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1-800-838-4268 info@sonopath.com

PATIENT

Snickers Thomasen

SPECIES

Feline

BREED

American Long Hair

SEX

Neutered Male

AGE

13 Years

WEIGHT

4.66 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Patti Mayfield DVM

HOSPITAL NAME

Bend Animal Emergency Specialty Center

REFERRING VET

Dr. Gordon Bunting

INVOICE

38360

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6/3/22

PRESENTING CLINICAL SIGNS

Pt presenting at 2 am with acute hind end weakness and vocalization. -- Pt was normal last night; O found Pt at the bottom of the stairs with hind legs splayed out. -- O does not know of any trauma, no other pets in the house. -- Pt E/D/U/D normally before incident. -- Pt does get startled easily could of ran and fell down the stairs.
Abnormal PE/Chem/CBC/UA Results: Physical Exam: PAIN 3/4, BCS 5/9 General Appearance: Quiet, alert and responsive. Yowling in pain Oral Cavity: Grade II dental disease - Mild to moderate dental calculus and gingivitis with numerous absent incisor dentition. MM light pink and moist . Free of ulcers, lesions, and foreign material. Cardiovascular: Right parasternal murmur - Grade 2 of 6 systolic with no arrhythmias or gallop noted Musculoskeletal: Non-ambulatory paraparesis. Severe pain on palpation of the lumbosacral spine. No hip or stifle laxity appreciated. Neurologic: Appropriate mentation and gross exam. No CN deficits appreciated. TL and LS pain noted on palpation. Motor present in LHL. Weak motor noted in RHL with moderate CP deficits of the RHL Spine radiographs: -- Two view radiographs performed of the spine and pelvis. There are no significant skeletal abnormalities appreciated - no fractures or luxations. There is mild narrowing of the disk space at L3-4 [r/o positional vs subjective]. There is mild soft tissue swelling noted over the dorsal lumbar spine - r/o adipose. No pulmonary contusions noted on visible radiographs. -- NIBP: 104 mmHg in LHL. Close or matching in all limbs. -- CBC: Machine error, unable to read sample. *Repeated and confirmed.* PCV/TP: 12% and 3.6 g/dL. *Repeated and confirmed.* Slide Autoagglutination: None on the slide **Feline blood type: Type A** -- CHEM: Glu 217, BUN 55, Ca 7.4, TP 4.0, Alb 1.7, Glob 2.3, ALKP 11, Chol 59, K 3.2. *Suspect hemorrhage given broad hypoproteinemia.* -- Brief AFAST: No FF noted, score 0/4. No pleural or pericardial effusion appreciated. 0430: NIBP decreased to 75 mmHg. T 95.4F Norm R 45 ml Fluid bolus over 15 min. BP initially improved to 98 mmHg and then decreased to 70 mmHg. Hetastarch 20 ml bolus over 15 min. P starting to have some facial twitches. Repeated crystalloid bolus of 40 ml over 15 min Repeated colloid bolus of hetastarch 20 ml over 15 min. No improvement of blood pressure or ECG Hospital Feline Type B blood - Expired 5/30/22, 30 ml. Crossmatch shows very minimal/mild reaction but otherwise compatible blood. ** No other blood available locally. ** 0600: Patient defecated dark, black tarry stool. Suspect gastrointestinal bleed - open. -- Owner understands risk of transfusion and consents. Started feline blood transfusion with 30 ml Type B blood. 0640: ECG 160 bpm NIBP increased to 96/64 MAP 75 P began displaying signs of tachypnea at 60 brpm. No crackles or wheezes noted on auscultation. Given presumed transfusion reaction, ADD Diphenhydramine 5 mg IM in the R epaxials. Occasional VPC noted on ECG * No UA or coagulation times have been obtained at this time. -- 8:00 am WBC Differential: CBC WBC Count: Sample too dilute, unable to get accurate count on ProCyte Segmented: Relative: 94 % Absolute: utd Lymphocyte: Relative: 0 % Absolute: UTD Monocyte: Relative: 4 % Absolute: UTD Eosinophil: Relative: 1 % Absolute:utd Basophil: Relative: 0 % Absolute: utd Bands: Relative: 1 % Absolute: utd Reticulocytes: Relative: none nRBC: Relative: none WBC Morphology and Comments: Neutrophils very reactive, occasional inclusions noted in cytoplasm. Platelet Estimate: 60,000-72,000 /uL Average: 4/oil Platelet Morphology: Clumping noted throughout sample RBC Morphology and comments: Marked polychromasia and spherocytes noted. Occasional dark staining RBC noted, no nRBC or other signs of regeneration noted. Additional Observations and Comments Examined 1 smears obtained from EDTA whole blood. Scanned entire feathered edge and entire slide w/ 10x, counted WBC at 100x and observed cell morphology at 100x oil. Slides allowed to air-dry and stained via Diff-Quik. -- 12:30 pm Post Transfusion PCV/TP PCV: 15% TS: 3.8g/dL Serum slightly icteric

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. Primarily anechoic urine was present in the lumen. Moderate, primarily dependent sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

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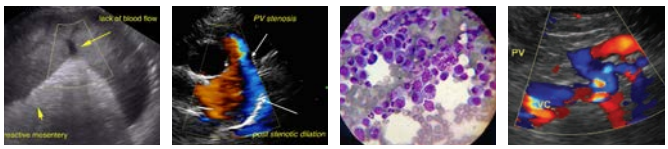

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Sonographic assessment, including doppler assessment, in the area of the iliac trifurcation revealed no obvious evidence of a saddle thrombus or regional peri iliac pathology, including no overt evidence of medial iliac or sublumbar lymphadenopathy

The right kidney was subnormal in size, measuring 2.2 cm diameter. Cortical hypertrophy with marked hyperechoic cortex, enhanced corticomedullary border demarcation, yet loss of corticomedullary border distinction. Reduced medullary volume with hypoechoic medullary parenchyma and mild pyelectasia.

The left kidney exhibited mild generalized enlargement. Reduced medullary volume and areas of pinpoint medullary mineral noted. Focal lateral cortical infarct noted. The left kidney measured 5.0 cm.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.49 cm. The right adrenal gland measured 0.39 cm.

Spleen

The spleen exhibited mild subnormal size (0.64 cm in width), likely owing to volume contraction, with 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.

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.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. A moderate amount of retained chyme was present in the stomach, extending into the area of the pyloric outflow tract.

The small intestine exhibited overall normal wall layering with maintained 1:3 muscularis to mucosa ratio. Potential for mild retained chyme ball present in the upper duodenum, which did not overtly pick up significant blood flow on doppler assessment. Possibility for a luminal mass lesion or luminal upper intestinal blood clot possible if evidence of hematemesis.

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

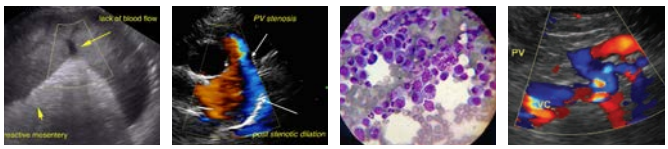
Pancreas

The pancreas exhibited overtly normal size with areas of capsule asymmetry. Subtle hypoechoic to potential nodular parenchyma noted in the left pancreatic limb. No obvious evidence of peripancreatic reactive mesentery or peripancreatic free fluid.

Free Abdomen

No evidence of peritoneal free fluid as with intraabdominal hemorrhage or peritonitis.

Intermittent, mildly prominent colic lymph nodes were present, not overtly consistent with inflammatory or neoplastic criteria. The lymph node was essentially isoechoic to adjacent omentum



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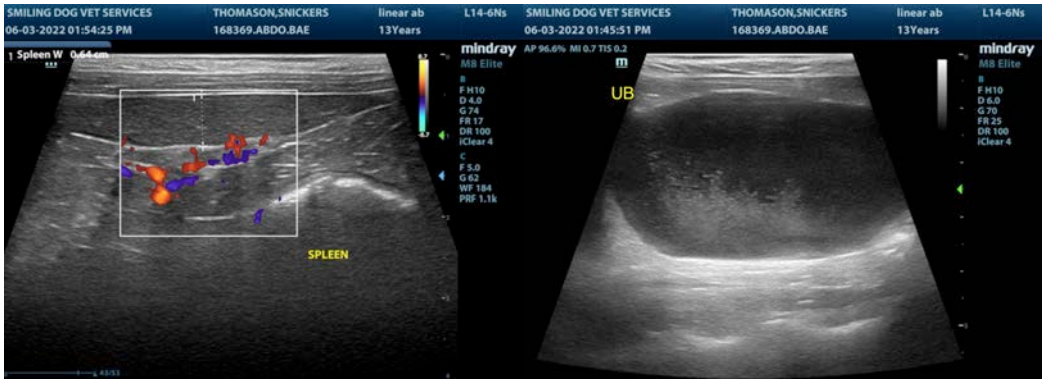
without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5).

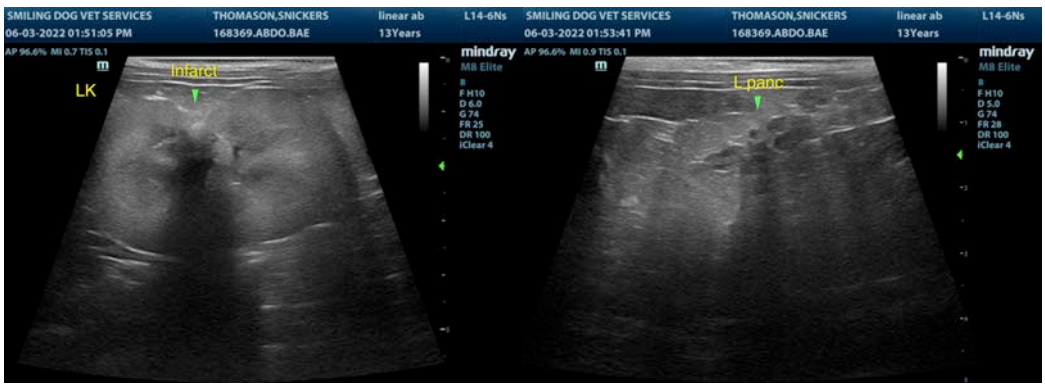
ULTRASONOGRAPHIC FINDINGS

- Urinary bladder sediment.
- Bilateral chronic interstitial nephrosis renal pattern with left kidney infarct, subnormal right kidney size with suspect left kidney compensatory hypertrophy.
- Suspect low-grade active to chronic active pancreatitis – no evidence of pancreatic neoplastic criteria.
- Intact gastrointestinal walls with suspect retained upper gastrointestinal chyme – possible upper duodenal luminal mass versus blood clot if evidence of hematemesis .

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. Assessment of systemic blood pressure as well as clotting status recommended. Obvious evidence of a current saddle thrombus was not definitively evident, yet the possibility of a transient saddle thrombus cannot be definitively excluded. Ideally, echocardiogram is suggested to assess for evidence of left atrial enlargement consistent with potential thrombus formation. Sonographic differentiation between retained upper gastrointestinal chyme, possible luminal mass or blood clot may be difficult. Sonographic reassessment and monitoring of the upper gastrointestinal tract recommended. Gastroprotectant protocol suggested if strong concern for upper gastrointestinal bleed.





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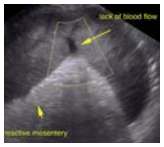
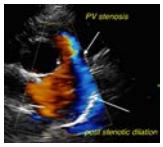
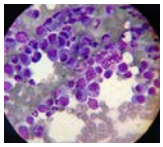
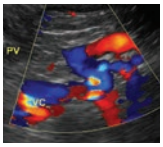

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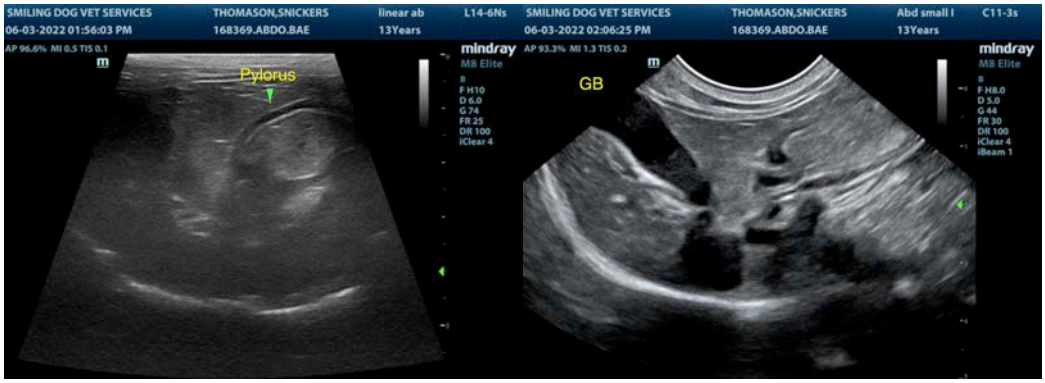

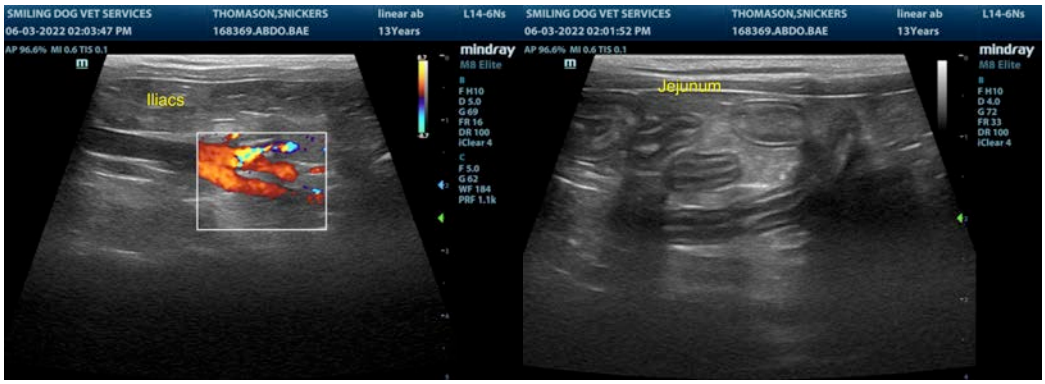

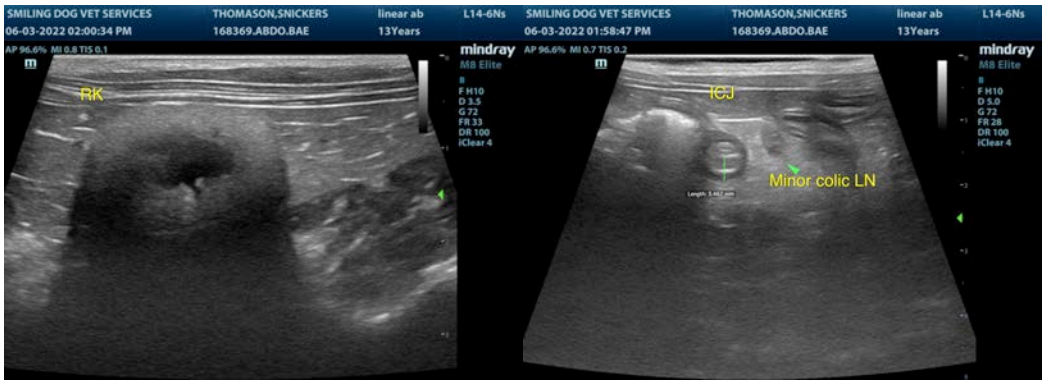

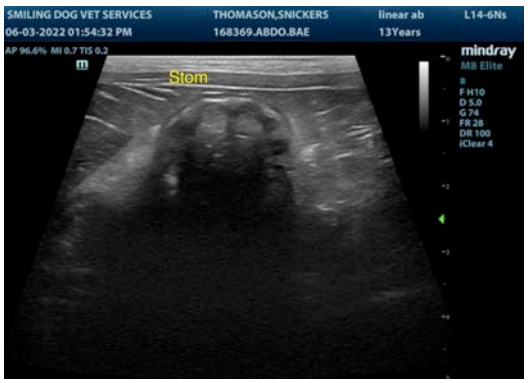

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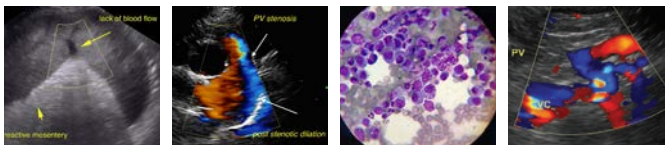

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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