



**PATIENT**

Simba Engleman

**SPECIES**

Feline

**BREED**

DSH

**SEX**

MN

**AGE**

14y

**WEIGHT**

10.06lb

**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**

11151ag

**DATE**

07/18/2022

**PRESENTING CLINICAL SIGNS**

History: History: STARTED 2 DAYS AGO P WAS LAYING ON TILE LATERAL FOUND MULTIPLE EPISODES OF VOMIT MOSTLY BILE AND HAIRBALL AND CARCUS OF ROACH. O STATES P JUST LAYING AROUND VERY UNUSUAL FOR P. VOMITING CONTINUED THROUGHOUT THE NIGHT O FOUND MULTIPLE PILES IN MORNING; DID NOT VOMIT YESTERDAY OR TODAY. O NOTICED WHEN P WAS LAYING LATERAL TAIL WAS TWITCHING ALSO ABNORMAL FOR P. NORMAL STOOLS. DISCUSS LAB RESULTS FROM DECEMBER.

Abnormal PE/Chem/CBC/UA Results: 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. No cough on tracheal palpation. Oral cavity: Moderate dental tartar Musculoskeletal: BCS = 5.5/9. Ambulatory x 4. Mild generalized muscle atrophy 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: Dull, sl unkempt hair coat. No ectoparasites seen Mentation: QAR Hydration: < 5% dehydration Fecal: Not performed today Diagnostic Testing Needed: CBC/CHEM/UA, fPL, AUS Declined Diagnostics/Treatments: None Findings: 1) CBC: MONO 0.89 (0.05-0.67), EOS 0.16 (0.17-1.57) 2) CHEM: WNL 3) UA (cysto): SG > 1.050, PRO 30mg/dL, BLD 50ERY/uL, WBC <1/hpf, RBC 4/hpf, cocci present, rods suspect presence, no crystals 4) fPL: ABNORMAL 5) AUS: Consult pending

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra 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 was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some mild increased echogenicity and loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present.

The left kidney measured 4.1 cm in length. The right kidney measured 4.2 cm in length.

**Adrenal Glands**

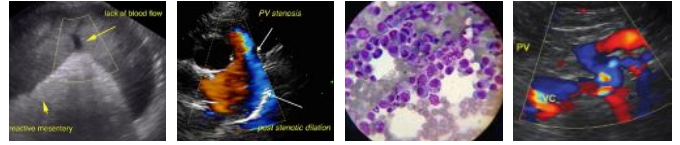
No overt pathology in the area of the left or right adrenal glands.

**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 0.65 cm in width at the level of the hilus.

**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



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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**

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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild to moderate variably echogenic yet nonshadowing ingesta/chyme with no signs of ileus, obstruction or foreign material. The gastric body wall measures 0.24 cm in width.

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The intestinal walls demonstrated intact wall layering and maintained 1:3 muscularis / mucosa ratio. The mucosa exhibited mild decreased echogenicity with occasional mucosal speckling. A segmental to diffuse jejunal ileus pattern consisting of mild fluid accumulation in the intestinal lumen was present without obstruction or foreign material. The duodenum wall measured 0.22 cm in width. The jejunum wall measured 0.21 cm in width.

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

**Pancreas**

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The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

**Free Abdomen**

**WEIGHT**

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

**INTERPRETED BY**

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(Canine and Feline)

**ULTRASONOGRAPHIC FINDINGS**

- Gastroenteritis pattern-subjectively mild
- Sonographically unremarkable pancreas
- Mild age related kidney changes

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

No overt evidence of significant visceral pathology was observed on this scan. Inflammatory bowel episode vs more chronic structurally insignificant gastrointestinal disease if persistent to recurrent GI signs or low grade to chronic pancreatitis could be present. No evidence of mechanical obstructive pattern with foreign or hairball density was observed. GI support which may include hydrolyzed diet trial +/- hairball therapy if clinically indicated would be appropriate.

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Given the presence of reported muscle atrophy which at times may be seen in cats with underlying more chronic GI disease, a GI panel to include PLI/TLI/Cobalamin/Folate is recommended.

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Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.

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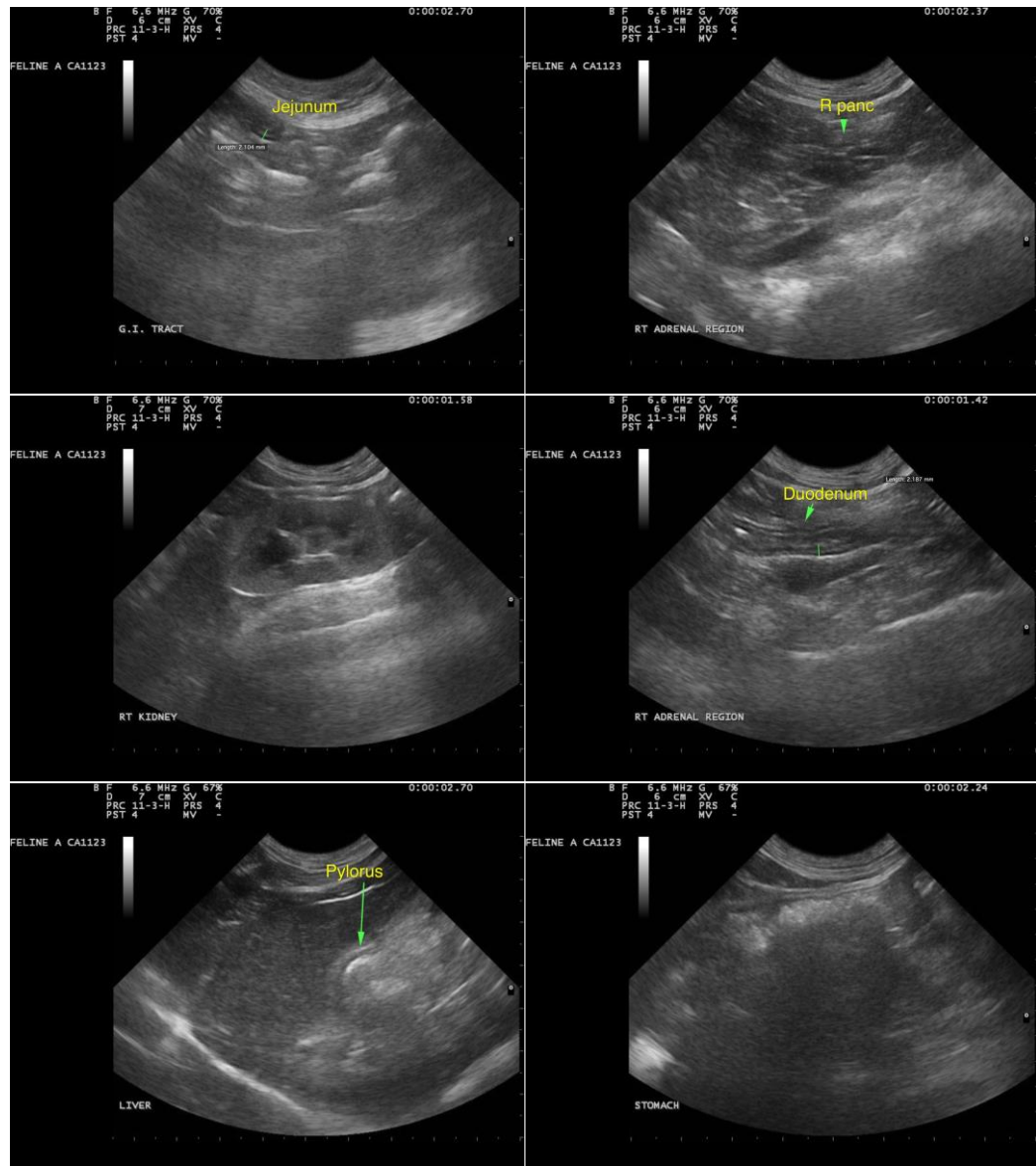
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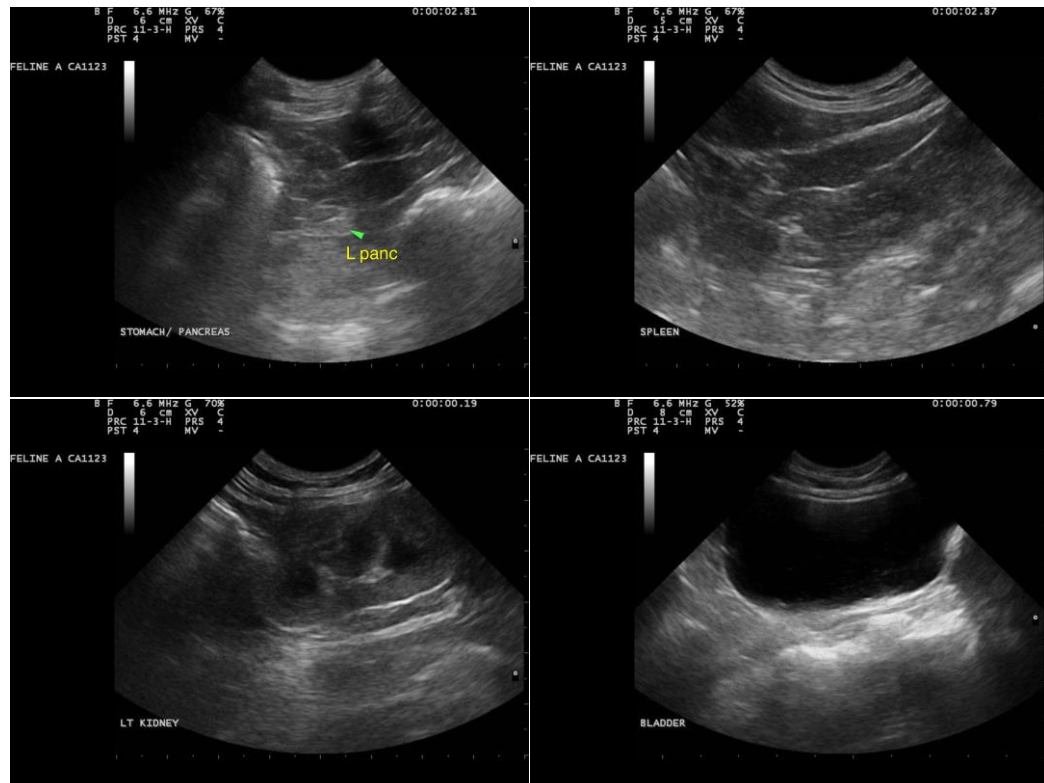
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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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