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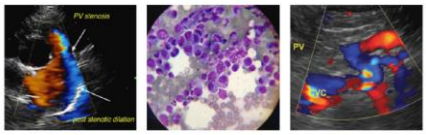
SVS Mobile Imaging CT 262 - 366 - 5970
fredgromalak@gmail.com



SonoPath
Clinical Sonography & Telecytology
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PATIENT

Toby Behnken 51898A

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

6 yr

WEIGHT

7.15 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Madison Veterinary Specialists-Dr. Calhoun

INVOICE

11033ag

DATE

07/05/2022

PRESENTING CLINICAL SIGNS

History: On Monday owner noted that Toby was lethargic and was refusing food, pcdvm ran a urinalysis which showed red and white blood cells but no crystals. Toby was given a Convenia injection and sent home with some pain medications. 24 hours after that visit Toby had still not urinated or eaten anything, owners took him back to pcdvm and they were able to express a large amount of bloody urine from him, bloodwork that day was normal per owners. Toby seemed to improve slightly and was less lethargic and more interactive according to owners, but was still not interested in food. On Saturday they brought him back to pcdvm because he was still anorexic, x-rays were normal and owner was told to stop the pain medications. Tonight (7/4) Toby has vomited many times, including while in the litterbox and immediately afterward, owners did not see any urine in the box tonight. Toby has been previously urinary obstructed twice in the past.

Abnormal PE/Chem/CBC/UA Results: Abdomen: mildly tense and repeatably uncomfortable on mid abdominal palpation, no palpable masses, urinary bladder small and soft NEU- 12.88 (2.30-10.29) SDMA- 16 (0-14)

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 mild nondependent particulate to mildly hyperechoic 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 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. A hyperechoic corticomedullary band, consistent with a medullary rim sign, was present. This is a nonspecific finding seen in both normal and abnormal kidneys. It may be associated interstitial renal disease, hypercalcemia, tubular necrosis, lymphoma, and FIP. However, it is a nonspecific finding.

The left kidney measured 4.0 cm in length. The right kidney measured 4.3 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.42 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.50 cm width.

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 1.0 cm in width at the level of the hilus.

Liver

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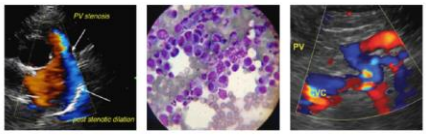

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The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was moderately distended with retained primarily anechoic fluid and potential mild chyme. No signs of ileus, obstruction or foreign material were noted to the level of the pyloric outflow. The gastric body wall measured 0.22 cm in width.

The duodenum extending into the jejunum exhibited concurrent distention with retained anechoic fluid extending caudally to a subjectively uniform echo likely in the jejunum exhibiting distal acoustic shadowing measuring approximately 2.5 cm in diameter. Empty small intestine which appeared to be distal jejunum and ileum to the level of the colon exhibited intact wall layering and a 1:3 muscularis/mucosa ratio without evidence of fluid distention or ileus. Normal appearing intestinal wall measured 0.26 - 0.27 cm.

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

Pancreas

The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia.

Free Abdomen

Regional peri intestinal mildly hyperechoic mesentery along with small pockets of scant primarily peri intestinal free fluid were present. Intermittent mildly prominent to enlarged mesenteric nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). A lymph node measured 1.4 cm x 0.43 cm. Concurrent similarly appearing gastric lymph nodes were also present and not consistent with neoplastic criteria.

ULTRASONOGRAPHIC FINDINGS

- Nondistended urinary bladder with mild sediment-indicitive of cellular debris
- Non specific bilateral medullary rim sign
- Small intestinal foreign body vs potential luminal lesion with distended gastrointestinal tract proximal, empty small intestine distal-consistent with obstructive pattern
- Potential mild concurrent pancreatitis
- Mild peri intestinal hyperechoic mesentery and small pockets of scant free fluid-suspect secondary inflammatory omental changes, potential for emerging peritonitis possible

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Exploratory laparotomy with gross inspection of the GI tract potential enterotomy if FB is present vs resection and anastomosis if luminal lesion is found. Concurrent full thickness intestinal biopsies may be considered to assess for underlying intestinal disease if clinically indicated. Post op GI supportive care and conservative therapy for low grade pancreatitis would be reasonable.

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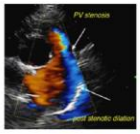
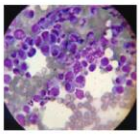
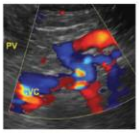

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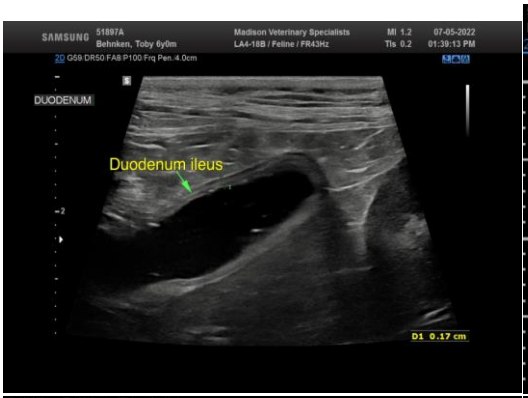

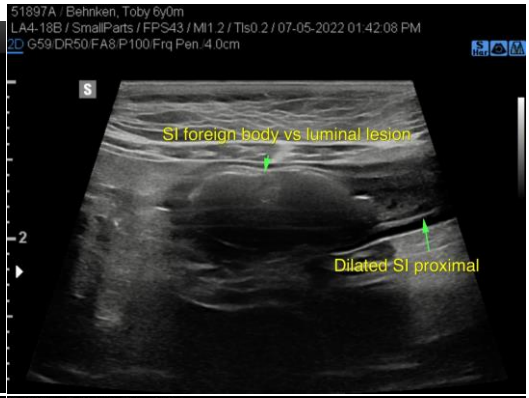

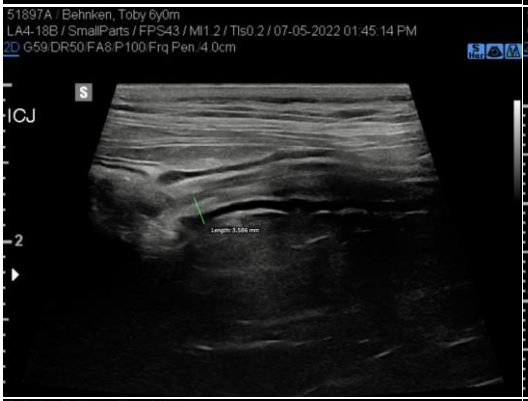

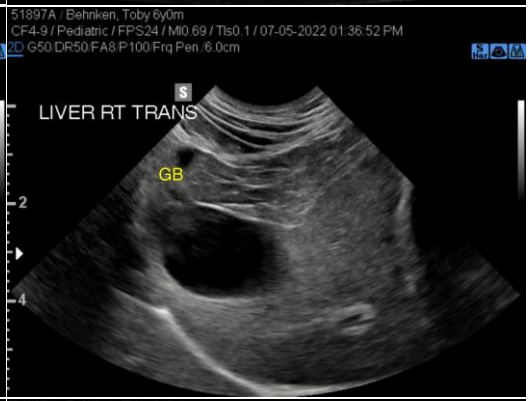

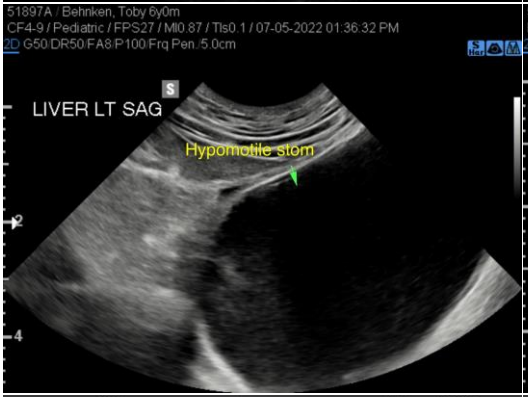

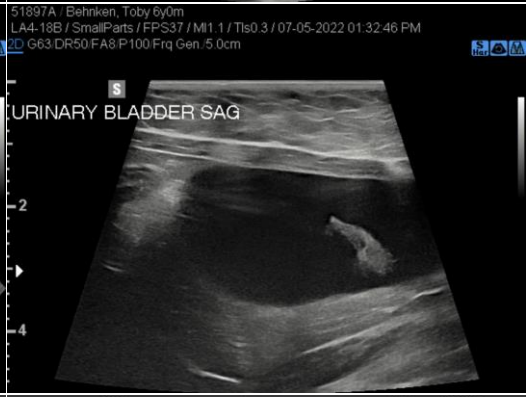

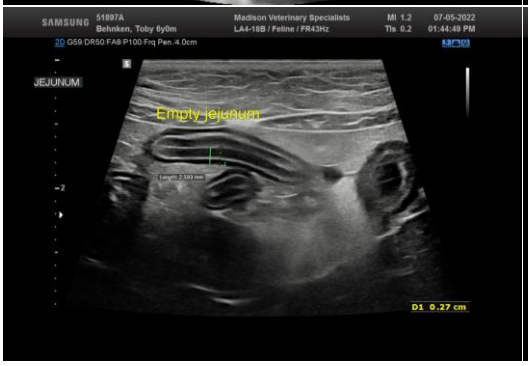

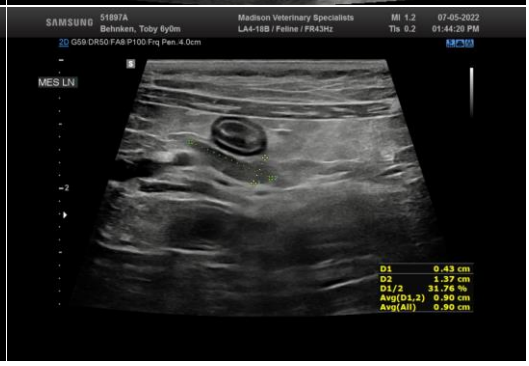

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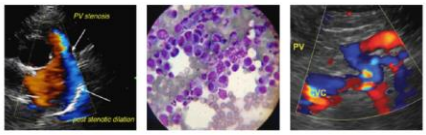

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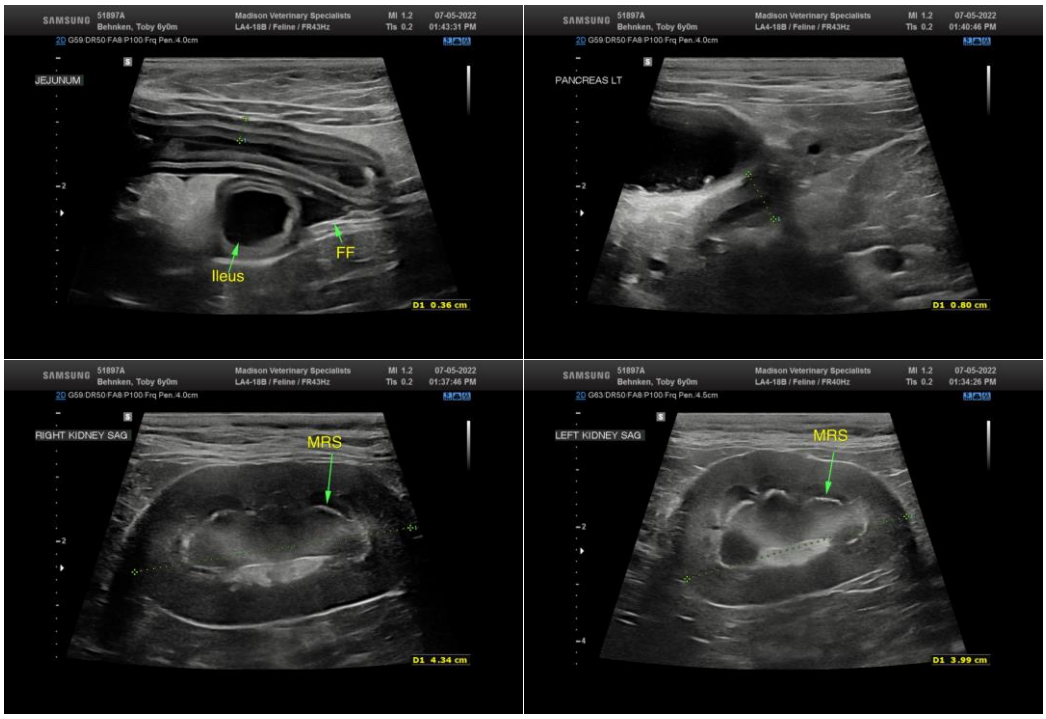

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@SonoPath.com