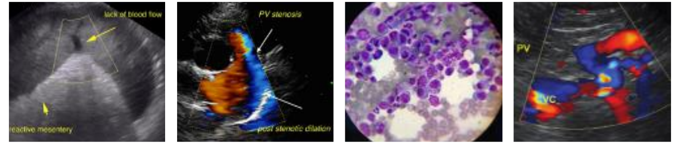

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1-800-838-4268 info@sonopath.com

PATIENT

Shadow Kapocias

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

13 Years

WEIGHT

4.88 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Patti Mayfield, DVM

HOSPITAL NAME

Emergency VH

REFERRING VET

Patti Mayfield, DVM

INVOICE

23860

DATE

8/10/23

PRESENTING CLINICAL SIGNS

Patient presented to EVH on 8/8/23 for Vomiting and anorexia x 3 days + profound lethargy. Routine blood work diagnosed hyperthyroidism and Methimazole, SQF, Mirtazapine and cerenia treatment was initiated. He was discharged later that day and re-presented to EVH on 8/9/23 for lack of clinical improvement. Methimazole 2.5 mg PO BID Cerenia 24 mg: 1/2 tab PO q 24 hours Additional treatments include IVF. Patient developed significant diarrhea whilst in hospital overnight and remains hyporexic, although did eat a small amount ~ 12 hours ago. Patient required alfaxalone/butorphanol to facilitate AUS

Abnormal PE/Chem/CBC/UA Results: PE: -- dehydrated ~ 8%, LS OU, tachycardia appreciated, NMA, evidence of cachexia/sarcopenia 8/8/23: CBC: -- PMN: 10.8 K/uL (2.3-10.2) -- LYMPH: 0.33 K/uL (0.92-6.88) CHEM: -- BG: 176 mg/dL (71-156) UA (cysto: -- Unremarkable; USG: 1.038 TT4: 8.2 ug/dL (0.8-4.7) Thoracic rads: Normal cardiac silhouette, mild bronchiolar pulmonary parenchymal pattern, otherwise unremarkable. Abdominal rads: Significant gas retention within the stomach and the colon, however no indication of GI obstruction or FB. Ileus is suggested by mild "bunching" effect of the SI. No other significant findings.

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. Mild dependent to nondependent particulate 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.

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 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. Pinpoint medullary mineral was noted. The left kidney measured 4.2 cm in length. The right kidney measured 4.1 cm in length.

Adrenal Glands

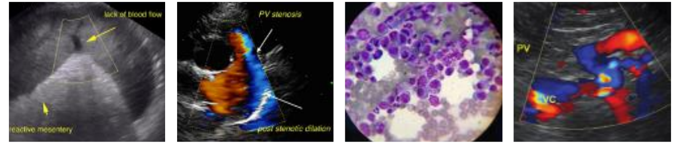
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.48 cm.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.43 cm.

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.

Liver



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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 normal in size with anechoic content and minor echogenic gallbladder sediment. The cystic and common bile ducts were normal. No evidence of inflammatory gallbladder or common bile duct criteria.

Gastrointestinal

The stomach presented overtly normal visualized wall layering. The stomach appeared to exhibit mild to moderate gas distention.

The small intestine presented generalized intact wall layering with subjective propensity for decreased small intestinal mucosa echogenicity. Subjective mild prominent segmental to generalized intestinal wall layering was noted. Minor segmental nonobstructive duodenojejunal ileus pattern was noted. Prominent wall layering was present in the area of the distal ileum and ileocolic junction. The duodenum wall measured 0.30 cm. The jejunum wall measured 0.27 cm. The ileocolic wall measured 0.49 cm.

The colon revealed overtly normal wall layering. The colon exhibited moderate distention with generalized non-formed fecal matter, consistent with patient history, extending into the area of the colorectum.

Pancreas

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. No evidence of peritoneal effusion or omental masses.

Free Abdomen

Intermittent, enlarged mesenteric lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident.

ULTRASONOGRAPHIC FINDINGS

- Subjective mild to moderate gas distended stomach
- Acute/subacute enteropathy
- Ileitis pattern
- Moderate generalized colon distention with non-formed fecal matter
- Intermittent generally mild hypoechoic mesenteric lymphadenopathy- suspect mesenteric lymphadenitis
- Mild chronic renal changes
- Mild urinary bladder sediment

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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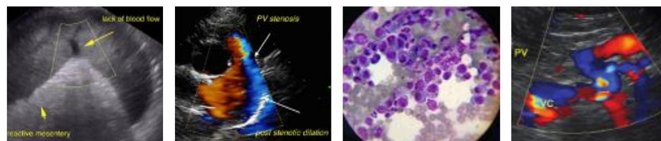
Clinical Sonography & Telecytology



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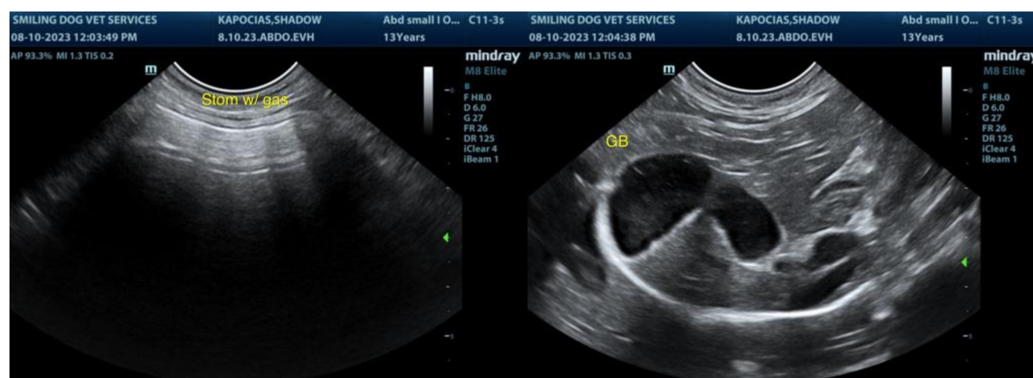
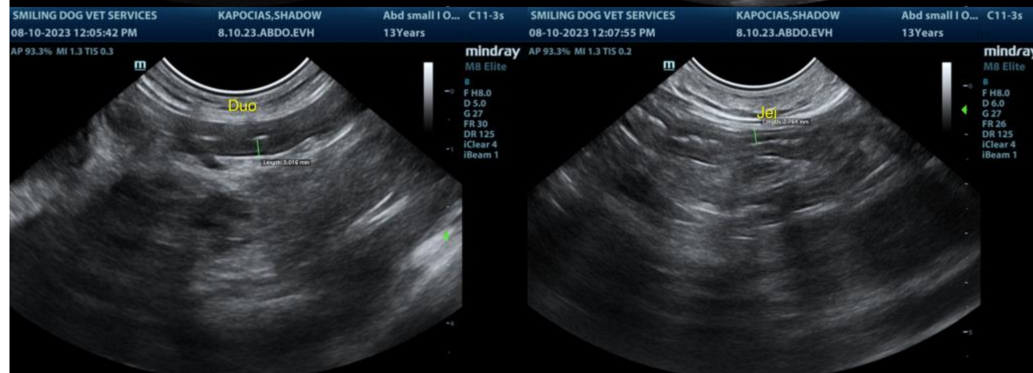
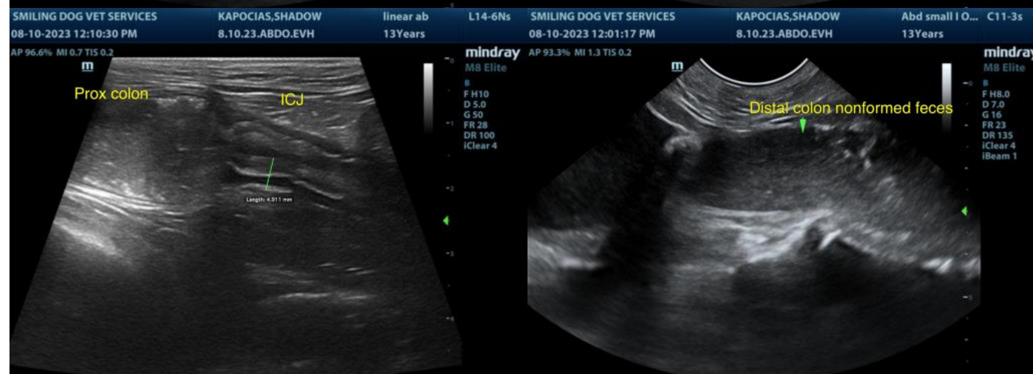
Dietary indiscretion/food intolerance, dysbiosis, nonspecific acute to subacute inflammatory bowel episode, infectious disease, enterotoxic insult, occult parasitism, low-grade pancreatitis, which may present sonographically normal and occult infiltrative intestinal neoplasia are all potentials.

Further assessment may include a GI panel to include PLI/TLI/Cobalamin/Folate. Hospitalization with as needed supportive care, including, once the patient is eating, novel protein or hydrolyzed diet, high colony count probiotic, empirical deworming, antibiotic therapy (if clinically indicated) and assessment of clinical response would be reasonable. Sonographic reassessment is recommended if persistent/progressive gastrointestinal signs, despite recommended diagnostics and supportive care.

Ultimately, intestinal biopsies may be required for a definitive diagnosis.







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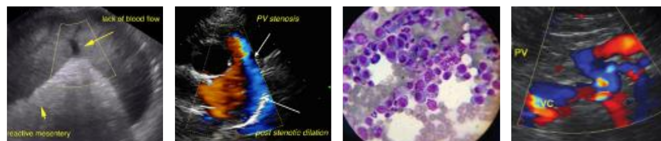

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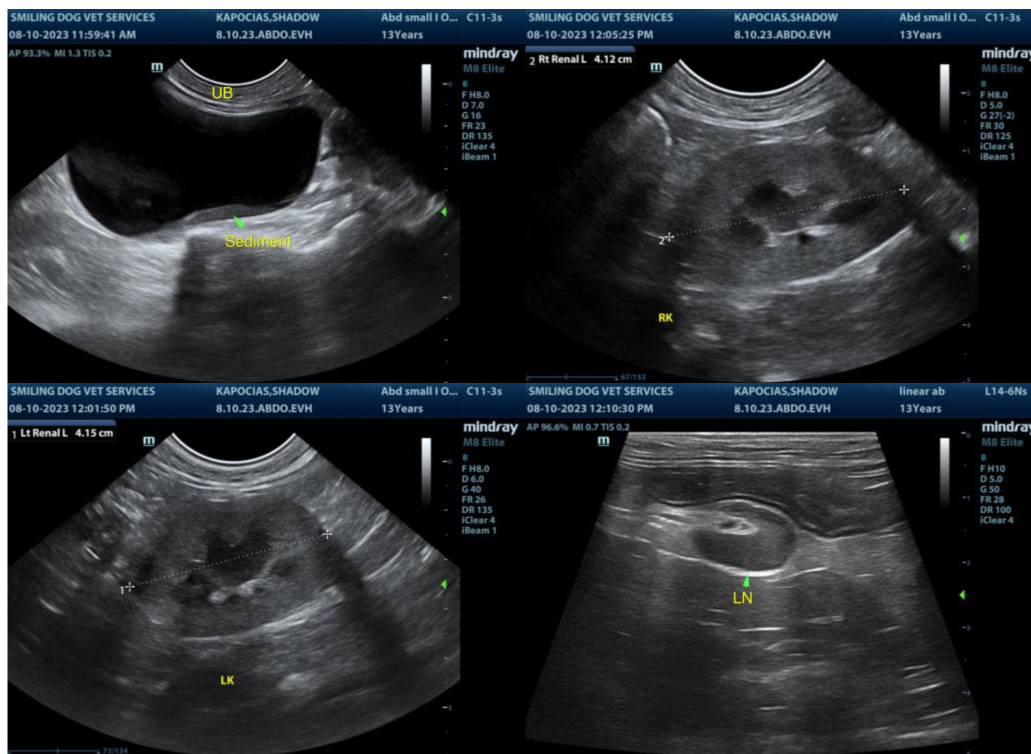

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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