

**PATIENT**

Pepper Spina

**SPECIES**

Feline

**BREED**

DSH

**SEX**

NM

**AGE**

7y 5m

**WEIGHT**

10 lbs.

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Michaleen

**HOSPITAL NAME**

DPC VH

**REFERRING VET**

Dr. Feldt

**INVOICE**

14733

**DATE**

8/26/22

**PRESENTING CLINICAL SIGNS**

8/13/22 notes Rechecking: ANorexia, Vomiting, diarrhea History: No vomiting since wednesday, today had 1st BM since in 2-3 days (was normal today), appetite is back to normal. Ab Rads VCA Hollywood 8/10/22 - NSF other than single loop of dilated bowel with mineral opacity that radiologist felt was proximal colon with liquid feces and mineral debris, less likely a proximal SI obstruction. Rec Ab US if not improving. Has approx 1 GI episode per year which tends to resolve with empirical care. Has eaten hair ties, rubber bands in past and thrown them up, never passed in stool One prior dvm started him on Prednisolone for suspect IBD but given only 1 episode per year and history of getting into things he shouldn't we d/c. Meds: Cerenia, Flagyl, Forti Flora  
Abnormal PE/Chem/CBC/UA Results: Exam Notes: BAR, mm pm, Ab Palp WNL, normal compressible but formed stool in colon. Diagnostics & Testing: A: Resolved Vomiting/Diarrhea/Anorexia Treatment Plan: D/C Flagyl Continue with Cerenia 3 more days then d/c Continue w/Forti Flora for another month then D/C Long term....consider change to GI friendly diet such as Purina EN but if gets GI upset from getting into something her shouldn't may not make much of a difference. Consider using Cerenia and Forti Flora prn If not improving I would do an Ab US rather than repeating Ab Rads

**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 was 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 4.0 cm in length. The right kidney measured 4.0 cm in length.

**Adrenal Glands**

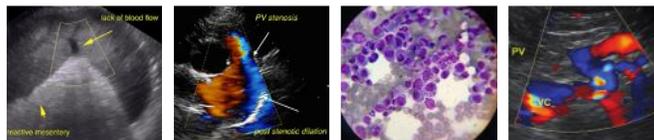
No overt pathology was noted in the area of the left or right adrenal glands.

**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.

**Liver/ Gallbladder**

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.

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**Gastrointestinal**

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty without evidence of gastric distention with retained ingesta, fluid, or foreign material. The gastric body wall width measured 0.24 cm.

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The small intestine was normal to the level of the ileocolic junction. The duodenum wall measured 0.22 cm width. The jejunum wall measured 0.21 cm width. The ileum and ileocolic wall measured 0.32 cm width.

**SEX**

NM

Subjective mild prominent proximal colon wall width measuring 0.23 cm width was present. The proximal colon appeared to be primarily empty with mild fecal content. By comparison, descending colon containing formed feces measured 0.17 cm wall width.

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**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 were evident.

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**Free Abdomen**

No evidence of overt or significant intraabdominal lymphadenopathy was noted. No evidence of peritoneal free fluid was present.

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**ULTRASONOGRAPHIC FINDINGS**

- Overtly normal gastrointestinal tract - potential resolving inflammatory bowel episode
- Mildly prominent proximal colon walls - nonspecific, potential for low-grade potentially resolving proximal colitis

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Given the Improved to resolved gastrointestinal signs, the potential for resolving inflammatory bowel episode is possible. However, given the potential recurrent GI signs in this patient, the possibility of a more chronic inflammatory gastroenterocolic process cannot be definitively excluded. Further assessment may include a GI panel to include PLI/TLI/Cobalamin/Folate to assess for occult or low-grade structurally insignificant intestinal disease, as well as rule out potential for low-grade pancreatic inflammation. A long-term novel protein or hydrolyzed diet trial may be beneficial in this patient.

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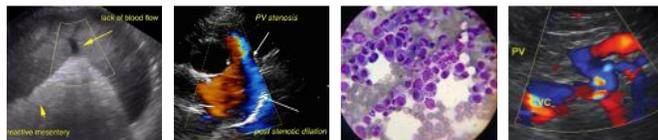
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Recheck sonogram is recommended ideally if another inflammatory bowel episode occurs for a reassessment of the gastrointestinal and colon wall, sooner if recurrent gastrointestinal signs are noted.

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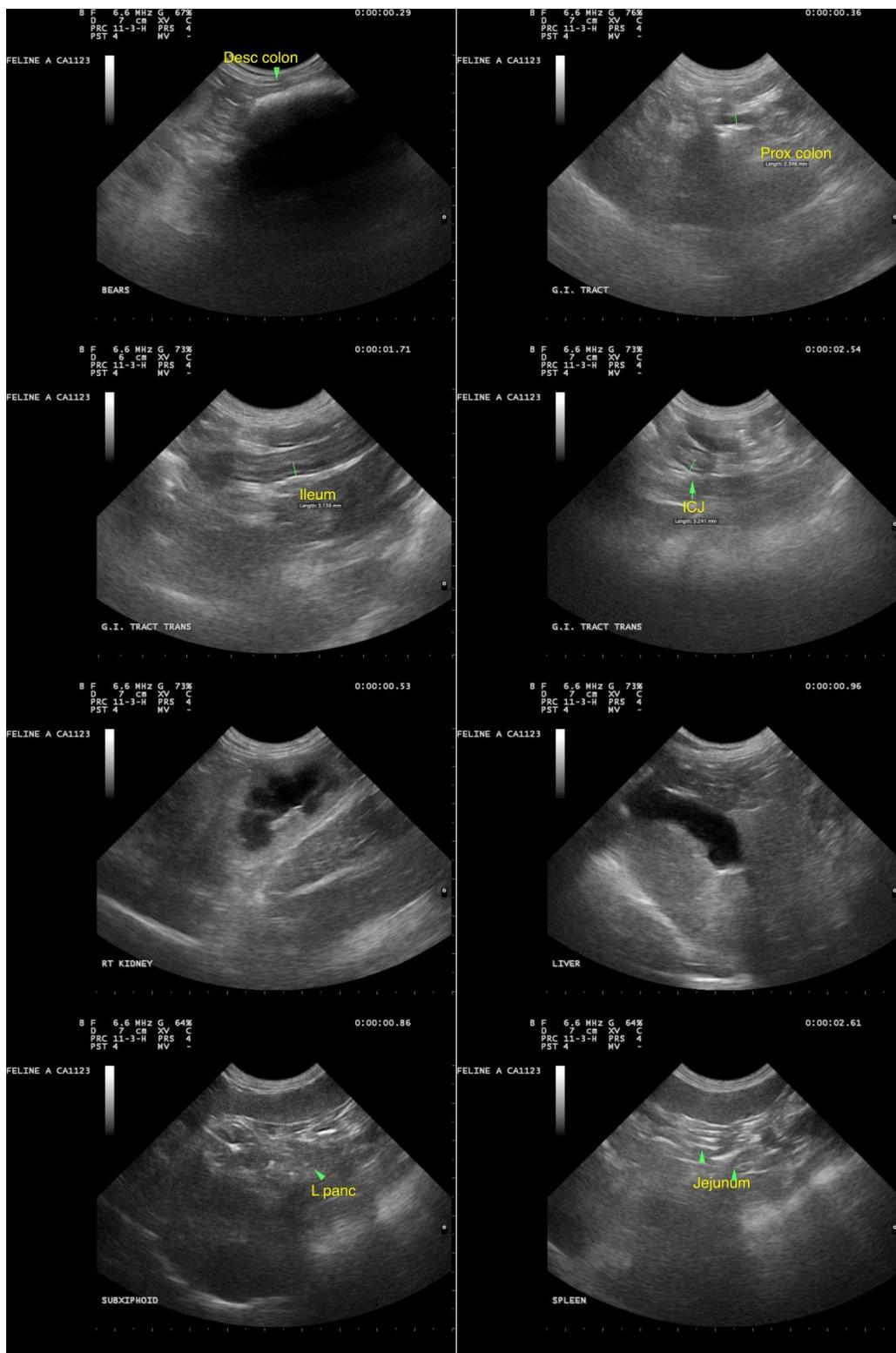
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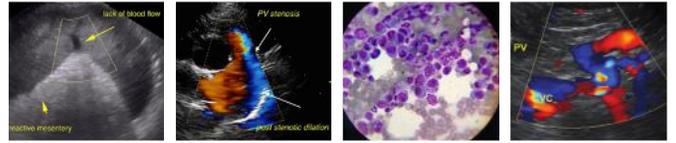
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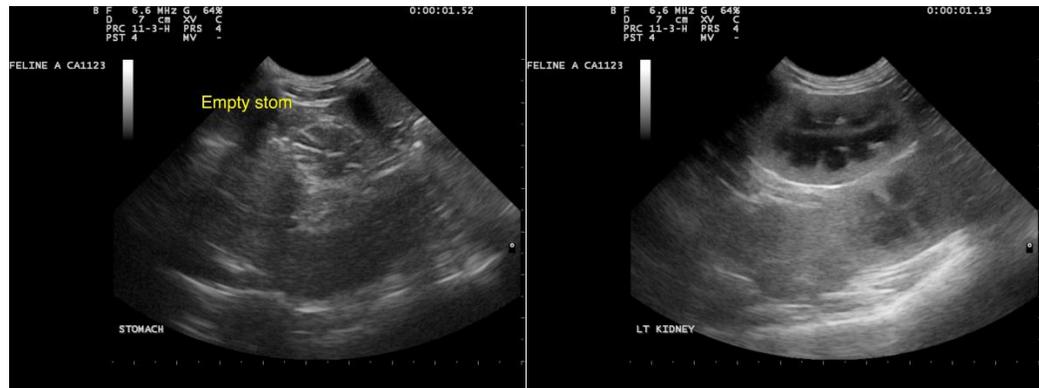
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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