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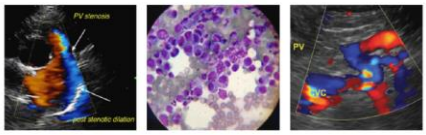
fredgromalak@gmail.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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PATIENT

Nonna Karnes 275310

SPECIES

Feline

BREED

DLH

SEX

FS

AGE

9yr

WEIGHT

4.1kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

WVRC-Dr. Jochman

INVOICE

11506ag

DATE

09/02/2022

PRESENTING CLINICAL SIGNS

Nonna presented to the WVRC-Emergency Service on 9/2/2022 for evaluation of vomiting, lethargy, and anorexia. Below is a summary of her medical history: 7/21/22- Pt was vomiting and had dilated loops of bowel on radiographs performed at her rDVM. Was transferred to WVRC and an AUS performed showing pancreatitis, intestinal hypomotility, and nonobstructive foreign material. Pt improved with tx and was discharged. 2 weeks ago- Pt vomited up a huge hairball 8/28/22- Anorexic and vomited 10-12x in small amounts 8/29/22- Went to rDVM and got SQ fluids and cerenia 8/30/22- Still anorexic and vomiting, prescribed mirtazapine 8/31/22- rDVM performed an endoscopy, finding hair and some kibble. Biopsies of stomach and duodenum taken, then Pt was discharged in PM. Bloodwork was performed and was normal except an ALT of 140. 9/1/22- Initially doing better, ate some canned food, but then this evening more lethargic and projectile vomited brown fluid with a coffee grounds appearance to it, twice. Endoscopy was performed on 8/31 where stomach and intestinal biopsies were taken. Results pending.

ULTRASONOGRAPHIC RECHECK 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 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 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 scant to mild pyelectasia slightly more prominent in the left kidney. The left kidney measured 4.0 cm in length. The right kidney measured 4.1 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 0.44 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.44 cm width.

Spleen

The spleen exhibited mildly subnormal size with subtle heterogeneous 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. The spleen measured 0.45 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 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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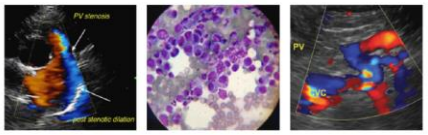

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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate variably echogenic non-shadowing ingesta with no signs of ileus, obstruction or foreign material. The pylorus wall measured 0.30 cm in width.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with minor segmental non-shadowing chyme and no signs of ileus, obstruction or foreign material. The duodenum wall measured 0.23 cm in width. The jejunum wall measured 0.20 cm in width.

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. Minor pancreatic duct dilation was present. No overt evidence of neoplasia.

Free Abdomen

No overt peritoneal effusion was present.

Intermittent, mildly prominent to enlarged mesenteric node was present. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). The lymph node measured 0.5 cm width.

Mild peri-intestinal hyperechoic mesentery was present.

ULTRASONOGRAPHIC FINDINGS

- Scant to mild bilateral pyelectasia more prominent in the left kidney, mild non-obstructive proximal left ureter dilation
- Moderate likely retained variable echogenic gastric ingesta-suspect metabolic gastric hypomotility
- Overt normal small bowel walls-no evidence of ileus or foreign material
- Persistent subjective mild pancreatitis
- Sonographically unremarkable liver-potential for low grade inflammatory or reactive hepatopathy if persistent mild ALT elevation

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The pyelectasia may be owing to chronic renal changes, potential pelvic scarring possibly owing to previous calculi passage, IV fluid therapy (if applicable). Left kidney pyelonephritis considered a less likely differential diagnosis. Urine C/S and protein: creatinine ratio on sterile urine sample is recommended. Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.

Continued as needed GI support and empirical therapy for persistent low grade pancreatitis pending GI histopathology would be reasonable. Gastric protectant medications are recommended given the recent coffee ground vomitus. Continued monitoring for gastric emptying vs retained gastric ingesta over the next 12-24 hours is recommended.

Hairball therapy may prove beneficial if clinically indicated.

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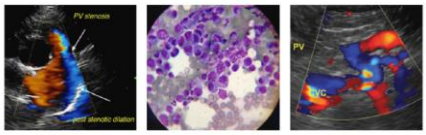

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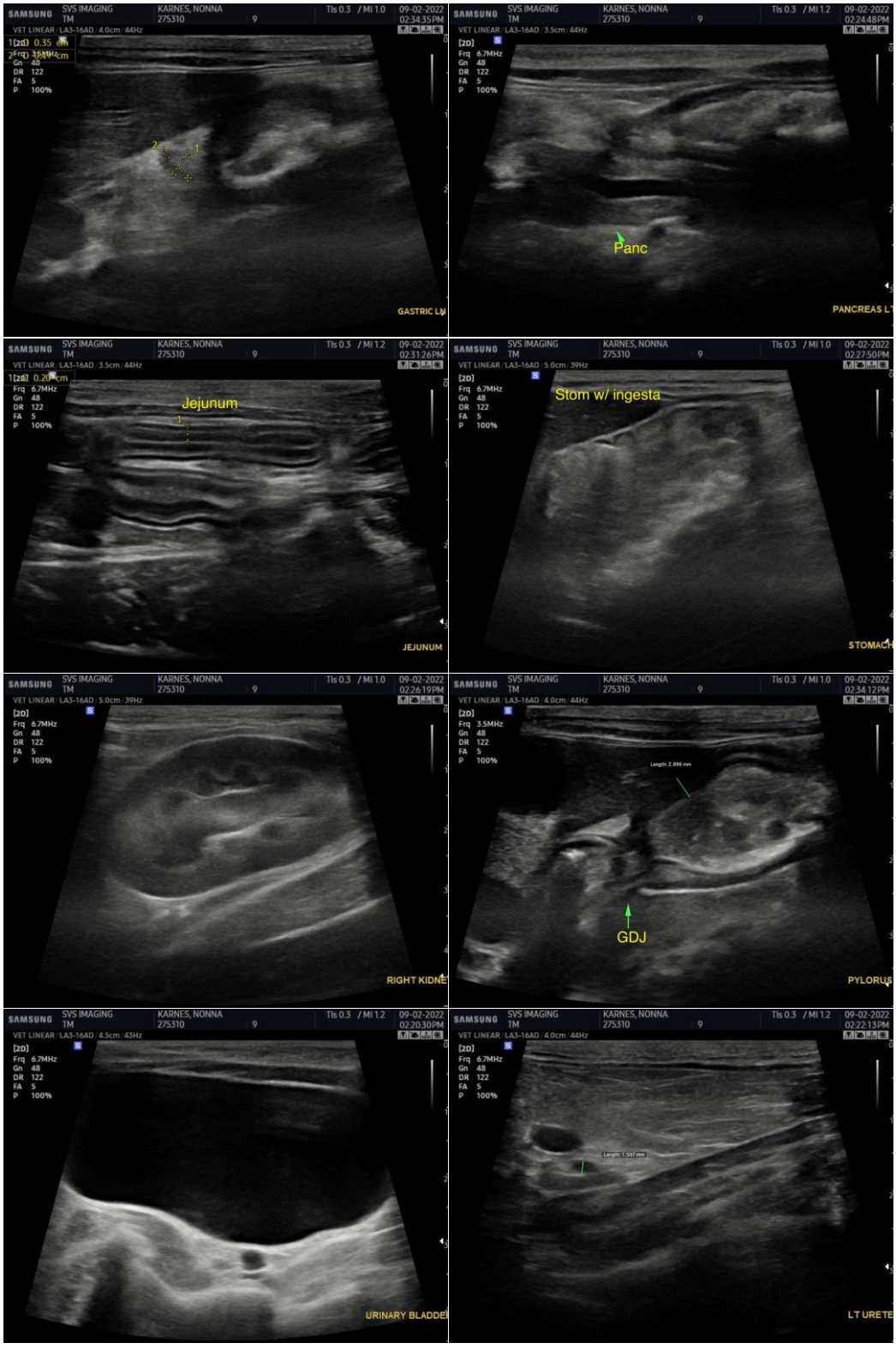

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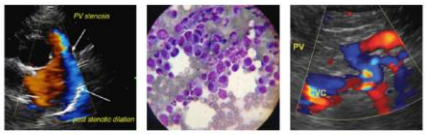

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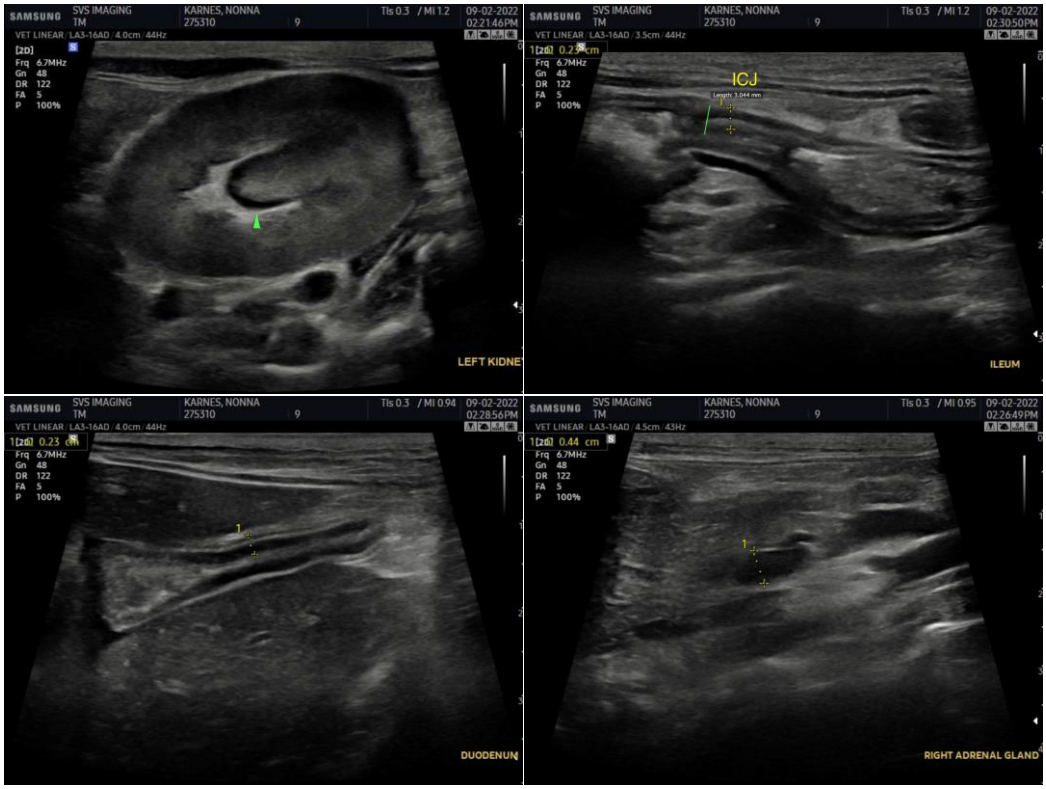

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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