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Clinical Sonography & Telecytology
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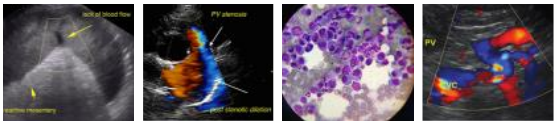


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

Flapjack Dewolfe

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

14 Years

WEIGHT

4.4 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

Q Street AH

REFERRING VET

Dr. Bret Schneider

INVOICE

17401

DATE

9/22/22

PRESENTING CLINICAL SIGNS

History: profound weight loss over couple months. recent collapse, possible seizure episode and hypoglycemia.

Abnormal PE/Chem/CBC/UA Results: HCT = 29%, glucose low during crisis, but eating since then and back to normal Current Medications Dexamethasone and Convenia Radiographic Findings none

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 were noted.

No overt pathology in the area of the aortic trifurcation or sublumbar space, including no evidence of medial iliac or sublumbar lymphadenopathy .

Normal size and margination was present in the kidneys. Both kidneys exhibited mild cortex hypertrophy with mild to moderate loss of corticomedullary border demarcation, minor reduced medullary volume and minor left kidney pyelectasia. The left kidney measured 3.9 cm in length. The right kidney measured 4.5 cm in length. No evidence of renal neoplastic criteria.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.45 cm.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.55 cm.

Spleen

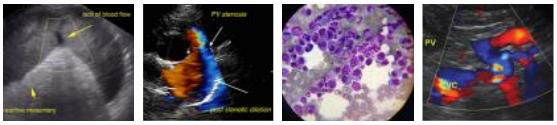
The spleen was not definitively visualized, potentially owing to splenic displacement or possible volume contraction.

Liver

The liver was subjectively normal in size and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was subnormal in size, secondary to the presence of gastrointestinal ingesta, with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal



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The stomach exhibited moderate nonshadowing variably echogenic ingesta/chyme with intact and sonographically unremarkable gastric wall layering. No overt evidence of mechanical pyloric outflow obstruction.

The small intestine exhibited subjective intact wall layering with maintained 1:3 muscularis/mucosa ratio with generalized small intestinal nonshadowing ingesta/chyme with secondary mild to moderate yet variable intestinal distention.

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

Pancreas

The pancreas was indistinctly visualized owing to the presence of gastric ingesta.

Free Abdomen

No overt evidence of significant lymphadenopathy, although potential for mild isoechoic mesenteric lymphadenopathy cannot be excluded. Mild volume anechoic free fluid was noted.

ULTRASONOGRAPHIC FINDINGS

- Intact generalized gastrointestinal wall layering with generalized moderate gastrointestinal distention with ingesta/chyme
- Mild volume peritoneal free fluid
- Bilateral chronic renal changes with minor left kidney pyelectasia

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The primary finding of generalized moderate gastrointestinal ingesta/chyme with secondary gastric and intestinal distention is nonspecific. Considerations may include post prandial presentation, malassimilation/maldigestion disorder, inefficient peristalsis, IBD, or infiltrate neoplasia, such as lymphoma, which may exhibit sonographically unremarkable intestinal walls, are all potentials. Concurrent low grade to chronic pancreatitis cannot be definitively excluded.

Further assessment may include a GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Full thickness gastrointestinal biopsies are likely required for a definitive diagnosis. Potentially, current steroid use may be masking intestinal mural change. If possible, peritoneal effusion analysis, cytology +/- culture and sensitivity (if clinically indicated) is suggested. Sonographic reassessment of the gastrointestinal tract following documented fast could also be considered.

If not done, three view chest radiographs are suggested to rule out occult thoracic pathology and assessment of cardiopulmonary status to rule out occult pathology as a contributing factor.

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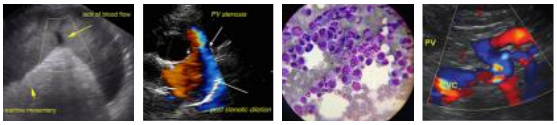

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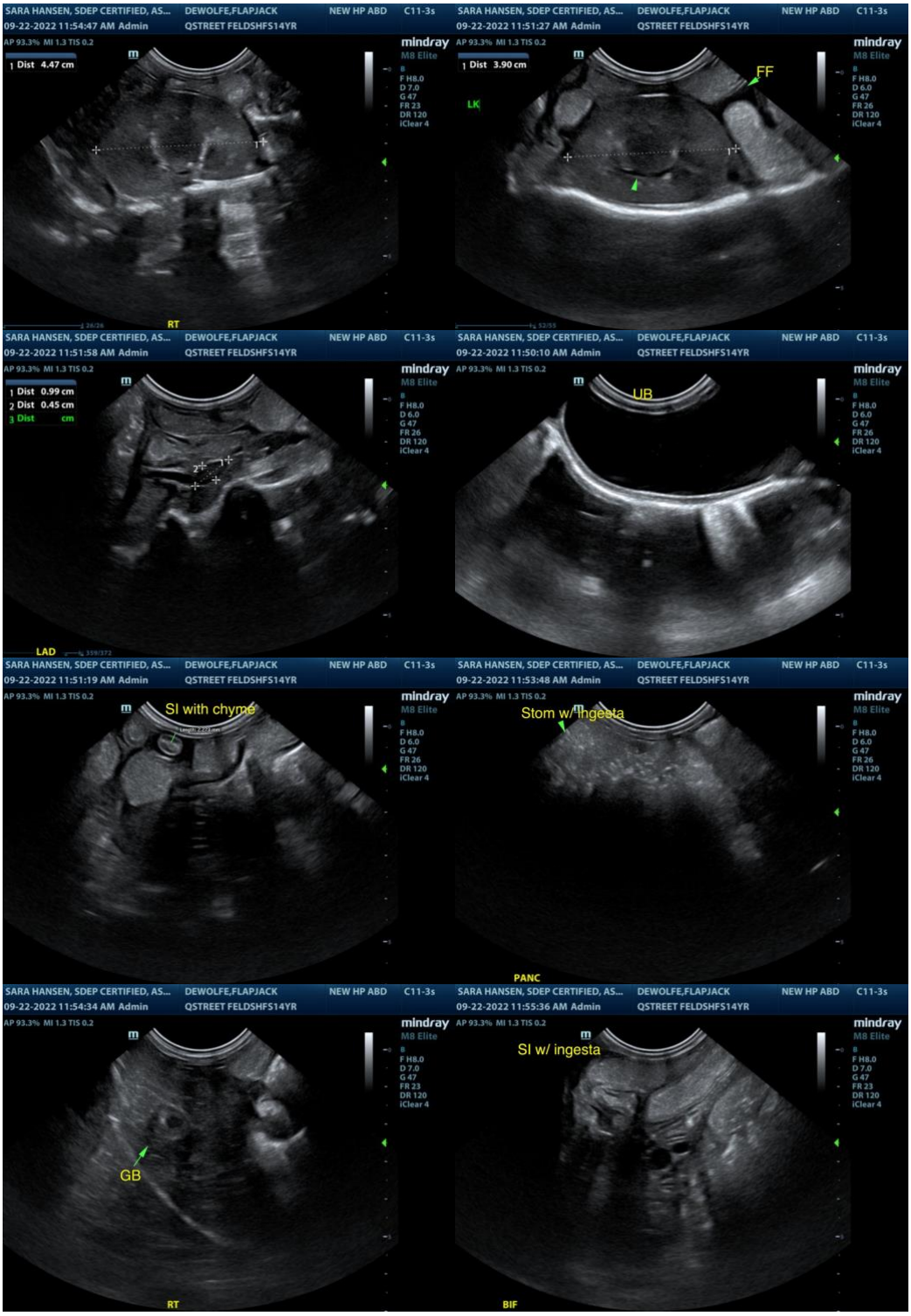

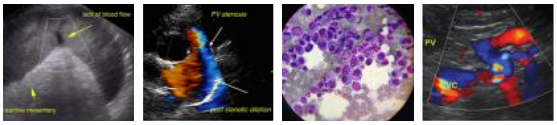

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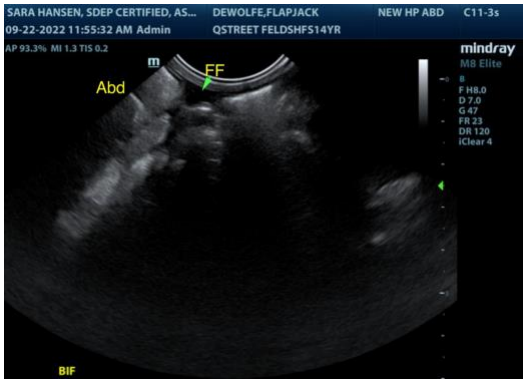

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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