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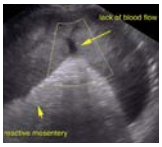
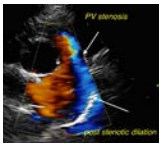
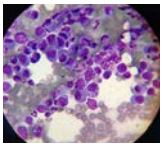
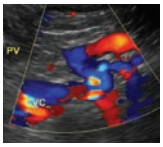

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1-800-838-4268 info@sonopath.com

PATIENT

Pearl Cowen

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

17 Years

WEIGHT

3.6 kg

INTERPRETED BY

Tam Mengine, DVM, DABVP (canine/feline practice)

IMAGING PERFORMED BY

Dr. Callihan/AEC

HOSPITAL NAME

Animal Emergency Care

REFERRING VET

Dr. Callihan/AEC

INVOICE

44973

DATE

8/27/23

PRESENTING CLINICAL SIGNS

Presented on ER for 4 days not eating, and vomiting. Recent history of benign subcutaneous mass removal from chest 3 weeks ago, and FNA's of 2 pulmonary nodules assessed as malignant but likely slow growing and recommendation made to recheck in a few months (no further information available) . Had normal bloodwork at that time and owners think a UA also. Hyperthyroid, has been on 7.5 mg methimazole p.o. b.i.d. Pt is highly reactive/fractious in this environment and unable to be assessed without sedation.

Abnormal PE/Chem/CBC/UA Results: PE is pretty unremarkable, some wasting along topline, parasternal murmur 2/6. Under sedation (butorph/midaz/alfaxalone) blood was drawn and showed BUN 50, Cr 2.0, Glucose 67, otherwise normal. CBC was normal other than mild neutrophilia and monocytosis. Unable to collect urine as bladder is empty. 1 mL of dextrose was given (diluted) IV and glucose 3 hours later was 70. We are treating as if septic though pt does not appear clinically as ill as would expect. Other r/o insulinoma (very rare in cats), paraneoplastic syndrome, other??

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is distended with anechoic urine, and no luminal sediment is present. The ureteral papillae, trigone and pelvic urethra (visible to 2.0 cm) are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted.

The kidneys are hyperechoic, and exhibit moderately decreased cortico-medullary differentiation. There is no evidence of nephrolithiasis, mineralization, pyelectasia or hydronephrosis. The proximal ureter is not visible (normal). The left kidney measures 3.2 cm. The right kidney measures 3.1 cm.

Adrenal Glands

The adrenal glands are both identified in their normal locations. They are normal in size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. The left adrenal gland measured 3.1 mm. The right adrenal gland measured 3.0 mm.

Spleen

There are multiple hyperechoic masses within the splenic parenchyma measuring <1.0 cm in size, with no visible deviation of the splenic capsule. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal. The spleen measures 7.6 mm wide at the hilus.

Liver

The liver is of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. The portal and hepatic vasculature are of normal size and appearance. However, there is a 3.0 cm long thrombus noted within the portal vein. Color doppler interrogation shows no evidence of venous occlusion secondary to the thrombus.

The gallbladder is moderately distended with anechoic contents and a small amount of freely-moveable echogenic sludge. The wall was thin and continuous with no focal lesions. The cystic duct is tortuous, which is an incidental finding in an older cat. The common bile duct is normal.

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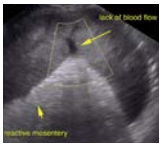
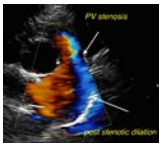
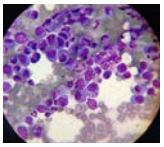
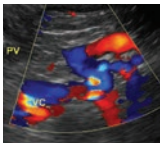

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Gastrointestinal

The stomach is empty. The gastric wall is normal in thickness (2.7 mm) with normal deviations due to rugal folds, and exhibits appropriate wall layering. The pylorus is of normal appearance.

The visualized portions of the duodenum, jejunum, and ileum are of normal thickness with intact wall layering that exhibits the appropriate 1:3 muscularis to mucosa ratio. Duodenum wall measures 2.5 mm. Jejunum wall measures 2.3 mm. Intestinal motility appears normal.

The visible portions of the colon are of normal thickness (1.6 mm) with intact wall layering. The ileocecal junction is visualized and normal.

Pancreas

The pancreas is hypoechoic, but of normal size and with no changes to the surrounding mesenteric fat. There is no evidence of peripancreatic inflammation. The pancreatic duct appears normal.

Free Abdomen

There is no evidence of free fluid within the peritoneal cavity. The omentum and intra-abdominal fat are of appropriate echogenicity. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

PRIMARY FINDINGS

- Large, non-occlusive portal vein thrombus

SECONDARY FINDINGS

- Chronic renal changes
- Chronic pancreatic changes
- Splenic myelolipomas, which are an incidental finding

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no definitive cause for the reported clinical signs and hypoglycemia noted for this patient. The presence of a portal thrombus could be associated with both sepsis or underlying hepatic disease. Because hypoglycemia can be seen in patients in liver failure, bile acid testing or an ammonia level would be recommended to further assess for this possibility. Because sepsis can also cause hypoglycemia, empiric treatment for sepsis and systemic inflammation is recommended. Treatment with low molecular weight Heparin or Rivaroxaban would be recommended in the hopes of preventing further thrombosis. The changes in the kidneys should be treated in accordance with laboratory parameters and the IRIS guidelines.

There is no evidence of an insulinoma on today's ultrasound. However, these cannot always be detected sonographically. If the blood glucose falls below 60, then paired insulin and glucose levels would be recommended. A continuous glucose monitor may be useful in detecting episodic hypoglycemia for this purpose.

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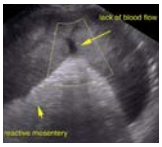
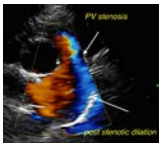
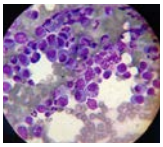
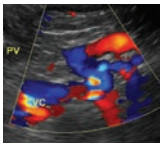

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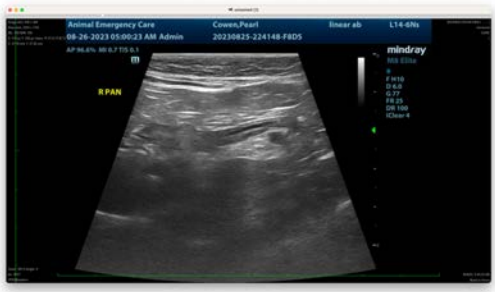
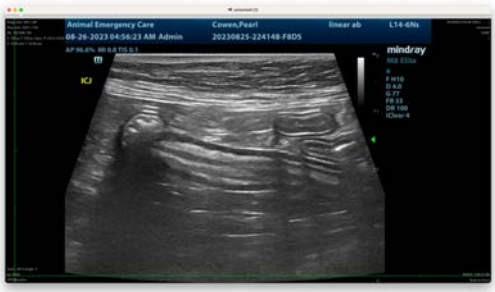
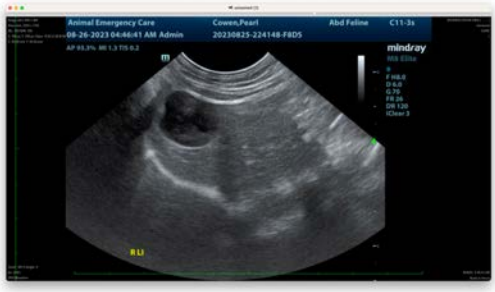
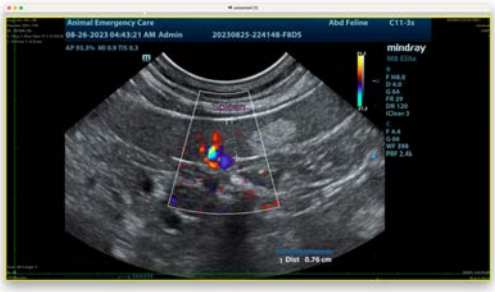
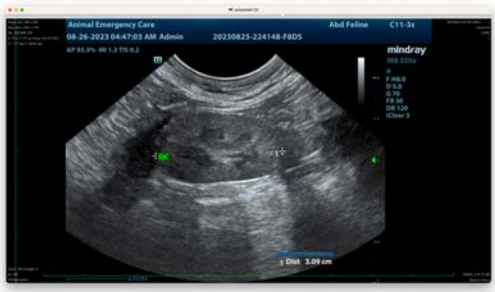
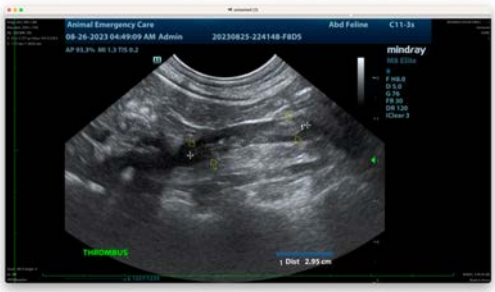
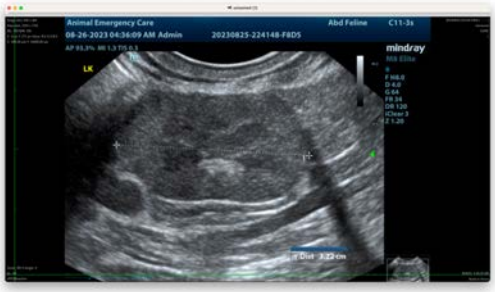

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Tam Mengine, DVM, DABVP (canine/feline practice)

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