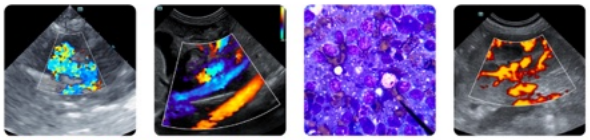


PATIENT

Blueberry Hahn

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

15 years

WEIGHT

10 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Claudia Hernandez

HOSPITAL NAME

All Creatures Great and Small Denville

REFERRING VET

Dr. Ashmore

INVOICE

70268

DATE

1/19/26

PRESENTING CLINICAL SIGNS

- Hematoemesis, Anorexia for 3 days.
- Xray: Calcified mass in mid abdomen.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The urinary bladder wall appears thin, smooth, and regular. The bladder lumen contains turbid urine with a large amount of suspended echogenic material. A small intraluminal calculus measuring approximately 4.52 mm is identified. The bladder neck and proximal urethra are unremarkable. There is no sonographic evidence of inflammatory or neoplastic changes of the bladder wall.

The left kidney is normal in shape and size, measuring 3.38×2.14 cm, with a cortical thickness of 0.40 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 3.70×2.06 cm, with a cortical thickness of 0.39 cm in the sagittal plane. In both kidneys, the renal cortex is very mildly hyperechoic relative to the liver parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

The left adrenal gland measures approximately 0.31 cm at the cranial pole and 0.30 cm at the caudal pole. The right adrenal gland is not clearly visualized therefore it could not be reliably measured on the provided images.

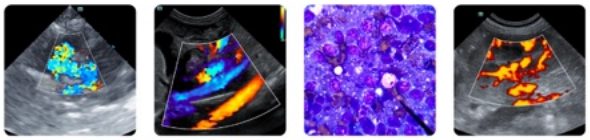
Spleen

The spleen measures approximately 0.43 cm in thickness. The splenic parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal lesions. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with sharp margins and a smooth contour. The hepatic parenchyma is uniform and isoechoic relative to the falciform fat, with normal echotexture. No hepatic lymphadenopathy is identified.

The gallbladder is normally distended. The gallbladder wall is thin, and the lumen contains predominantly anechoic bile with a small amount of biliary sludge. The common bile duct measures approximately 3.64 mm proximally, tapering to 2.71 mm and 1.42 mm distally, without evidence of biliary obstruction.



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Gastrointestinal

The stomach is empty and folded, with a mural thickness of approximately 2.49 mm and preserved wall layering. The pylorus measures approximately 2.73 mm.

Only the most proximal portion of the duodenum is visualized and appears normal, measuring approximately 1.16 mm.

The jejunum measures approximately 1.61–1.96 mm, with preserved wall layering:

- Mucosa: 1.16 mm, Submucosa: 0.55 mm, Muscularis propria: 0.26 mm

The ileum measures approximately 1.55 mm, with preserved wall layering:

- Mucosa: 0.56 mm, Submucosa: 0.70 mm, Muscularis propria: 0.29 mm

The ileocecal junction measures approximately 2.33 mm, with a muscularis thickness of 0.50 mm. No sonographic evidence of obstruction, ileus, or intraluminal foreign material is identified.

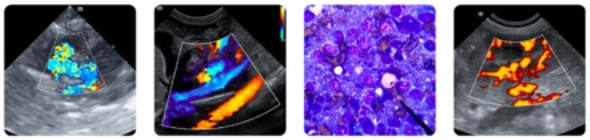
A focal region of marked acoustic shadowing is identified within the mid-abdominal region, measuring approximately 1.47×1.10 cm. This finding lacks identifiable soft tissue architecture, does not demonstrate a definable parenchymal origin, and is not associated with adjacent mural thickening, mass effect, or regional inflammatory changes. Based on its location and sonographic appearance, there is an impression that this finding may be intraluminal and associated with the colon, possibly within the transverse or proximal descending colon. However, due to the very thin colonic wall and the absence of high-frequency transducers on the provided examination, its exact relationship to the colonic wall and precise colonic segment cannot be confidently determined. The remaining portions of the colon appear largely empty, with normal wall thickness and preserved mural layering, and without evidence of diffuse colonic disease or obstruction.

Pancreas

The right pancreatic limb, body (4.67 mm), and left limb (4.76 mm) appear normal. The pancreatic parenchyma is isoechoic relative to the adjacent omental fat. The pancreatic duct measures approximately 0.60 mm. There is no sonographic evidence of pancreatitis or pancreatic neoplasia.

Peritoneal Cavity

No abdominal effusion or sonographic evidence of peritonitis is observed. Cranial mesenteric and ileocecal lymph nodes are not visualized; the surrounding mesenteric regions appear unremarkable. The iliac trifurcation is normal.



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ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- No sonographic evidence of a discrete abdominal mass
- Marked acoustic shadowing possibly associated with intraluminal colonic content, but no evidence of gastrointestinal obstruction or mural mineralization.
- Small urinary bladder calculus (≈4.5 mm) with urinary sediment.

SECONDARY FINDINGS

- Mild biliary sludge.
- Very mild bilateral renal cortical hyperechogenicity.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Review of the provided ultrasound videos does not identify a parenchymal or mural abdominal mass to correspond with the radiographically reported calcified structure. The gastrointestinal tract demonstrates preserved wall thickness and layering throughout, without evidence of focal mural mineralization, mass effect, or mechanical obstruction.

The only structure consistently producing marked acoustic shadowing during the examination lacks identifiable mural or parenchymal architecture and does not demonstrate a definable mass effect. Its exact anatomic origin cannot be confidently determined based on the provided images; however, its sonographic behavior is most compatible with dense colonic content rather than a true soft tissue mass. In light of the history of acute hematemesis, it is plausible that ingested foreign body material may have previously been present within the stomach or esophagus, potentially contributing to mucosal irritation or erosive injury and subsequent bleeding, and has since progressed distally into the colon. This hypothesis is further supported by the absence of current gastric or proximal intestinal structural abnormalities on ultrasound.

Overall, the ultrasonographic findings do not demonstrate a primary abdominal mass lesion; however, the referenced radiographs were not available for review.

Recommendations

- Serial abdominal radiographs are recommended to document progression or resolution of the radiopaque structure and to confirm its localization within the colon.
- Conservative monitoring is reasonable if the patient remains clinically stable, including observation for defecation and passage of the suspected ingested material, as spontaneous resolution is possible.
- If radiographic uncertainty persists, contrast radiography may be considered to further clarify the relationship of the mineral opacity to the gastrointestinal lumen.
- Advanced imaging (CT) should be reserved for cases in which the mineralized structure persists, fails to progress, or if clinical signs recur or worsen.

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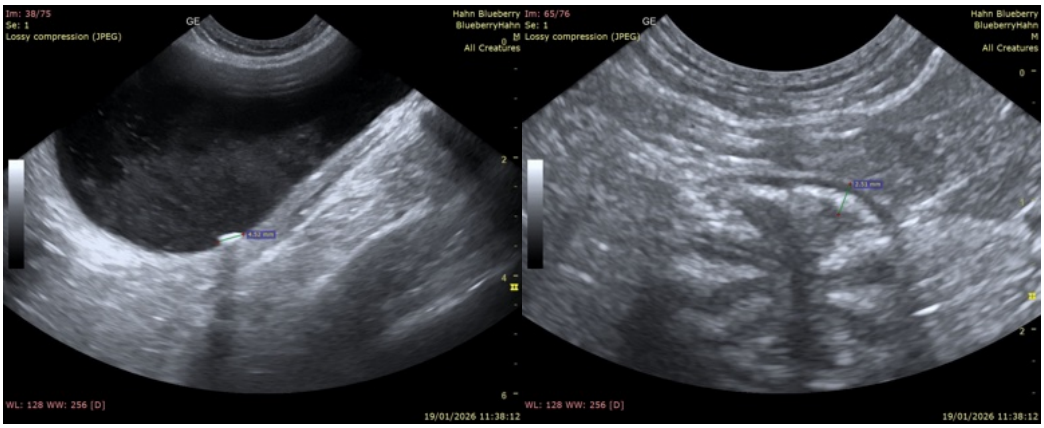
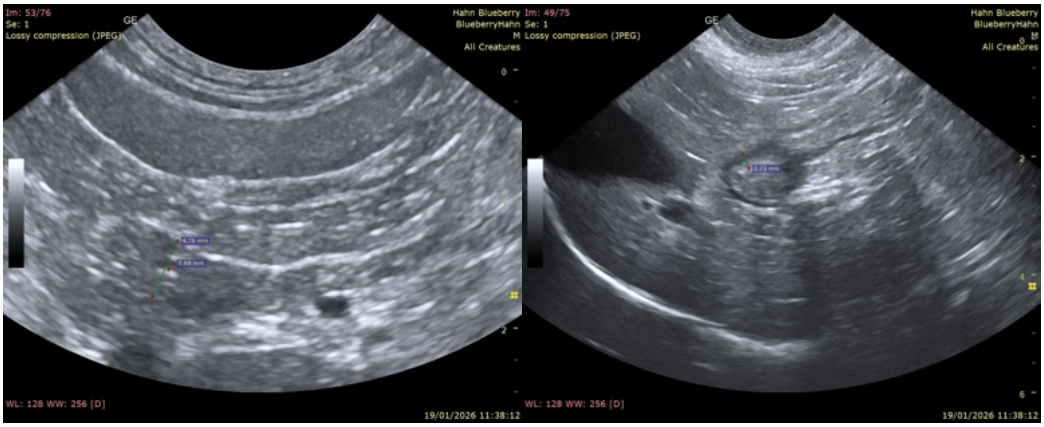
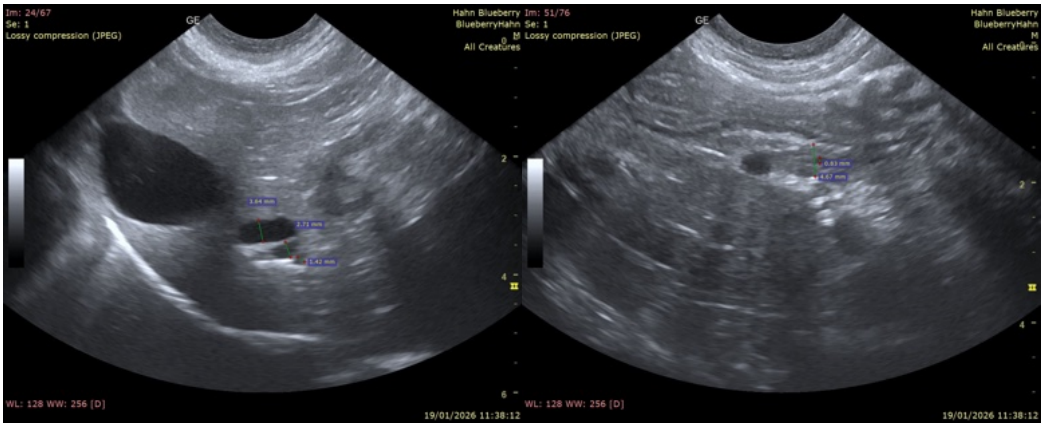
- Exploratory surgery should be considered only if new imaging demonstrates a fixed, non-progressive lesion or if the patient develops signs of obstruction or clinical deterioration.







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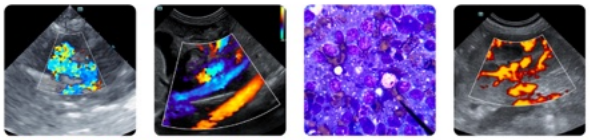

Clinical Sonography & Telecytology
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SonoPath.com info@sonopath.com 1.800.838.4268

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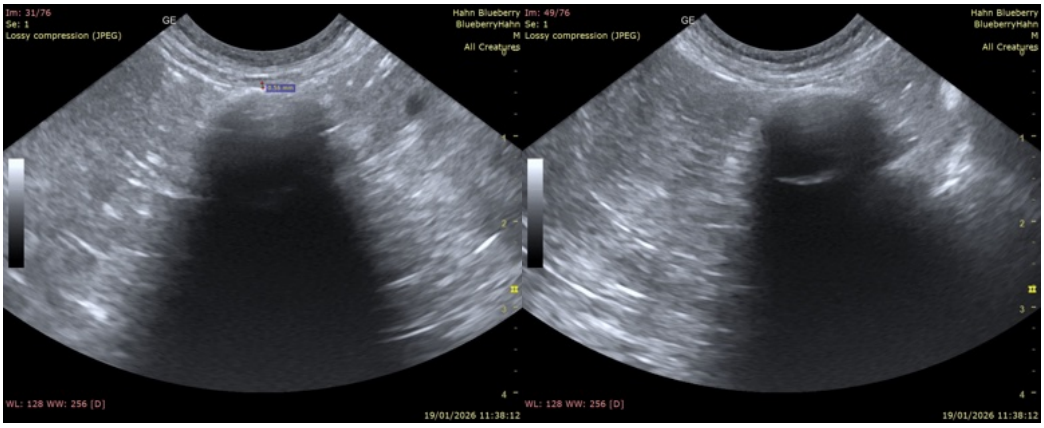

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

MV Esp Ultrasound in Domestic and Wild Animals

info@SonoPath.com