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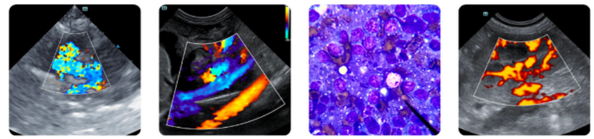


Clinical Sonography & Telecytology

Educational Teleconsultation Services™

PATIENT

George St. Onge

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

11 years

WEIGHT

7.7 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Anshu Gupta

HOSPITAL NAME

Liverpool Village Animal Hospital

REFERRING VET

Dr. Leia Lindley

INVOICE

11026

DATE

1/2/2026

PRESENTING CLINICAL SIGNS

Vomiting, diarrhea, weight loss. Suspected hiatal hernia at ER yesterday.

Abnormal PE/Chem/CBC/UA Results: Anisocoria, hypersalivation. CBC/Chem NSF.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The bladder wall appears thin and smooth. The urine is predominantly anechoic with scant suspended echoes. The bladder neck and proximal urethra appear normal. No uroliths are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic disease.

The left kidney is normal in shape and size, measuring 3.34×1.99 cm, with a cortical thickness of 0.35 cm in the sagittal plane.

The right kidney is normal in shape and size, measuring 3.60×1.98 cm, with a cortical thickness of 0.40 cm in the sagittal plane.

Both: The renal cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler evaluation demonstrates a normal vascular pattern.

Adrenal Glands

Both adrenal glands demonstrate normal shape and echogenicity. The left adrenal gland measures 0.31 cm at the cranial pole, with a small focal mineralization, and 0.35 cm at the caudal pole. The right adrenal gland measures 0.30 cm at both the cranial and caudal poles.

Spleen

Splenic thickness measures 0.51 cm. The splenic parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

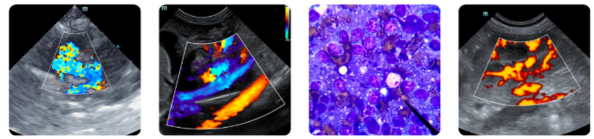
Liver

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

The gallbladder lumen is moderately distended. The gallbladder wall is thin, and the contents are primarily anechoic. The common bile duct measures approximately 4.59 mm proximally, tapering progressively to 1.70 mm distally.

Gastrointestinal

The stomach is empty and folded, with a mural thickness of 2.23 mm and preserved wall layering. The pylorus measures approximately 3.0 mm and contains a small amount of ingesta and fluid.



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The duodenum is not visualized. The jejunum measures 1.71 mm, and the ileum measures 1.16 mm, with preserved wall layering. The ileocecal junction measures 2.63 mm, with a muscularis thickness of 0.80 mm.

A few intestinal segments are mildly fluid-distended, while the remaining bowel loops are not dilated but contain a moderate amount of intraluminal gas. No discrete foreign material or clear obstructive pattern is identified on the provided video loops.

The colonic wall measures approximately 1.01 mm and appears empty.

Pancreas

The pancreas measures approximately 4.77 mm in thickness. Pancreatic parenchyma is isoechoic relative to the adjacent omental fat. The pancreatic duct is not dilated. No ultrasonographic evidence of pancreatitis or pancreatic neoplasia is identified.

Free Abdomen

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

PRIMARY FINDINGS

- Mild segmental fluid distension of small intestinal loops with increased intraluminal gas.
- Mild proximal prominence of the common bile duct with distal tapering, without obstruction.

SECONDARY FINDINGS

- Small focal mineralization within the left adrenal gland (incidental).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach and small intestine demonstrate preserved wall layering and normal wall thicknesses, with mild, segmental fluid distension of a few intestinal loops and increased intraluminal gas, findings that are nonspecific and most consistent with functional ileus, altered gastrointestinal motility, or acute inflammatory gastrointestinal disease.

Ultrasound has limited sensitivity for the diagnosis of hiatal hernia, and absence of sonographic abnormalities does not exclude this condition. Further evaluation with contrast esophagography or fluoroscopy would be required if clinical suspicion persists.

The common bile duct is mildly prominent proximally but tapers distally, with no evidence of biliary obstruction. Mild functional or transient biliary stasis may be present, without a clear association with the current clinical signs.

No abdominal ultrasonographic findings explain the reported anisocoria, which should prompt consideration of neurologic, ocular, or systemic causes independent of the abdominal findings.

Recommendations

- Continue medical management and monitoring for functional or inflammatory gastrointestinal disease, with close assessment of vomiting, diarrhea, appetite, and body weight.

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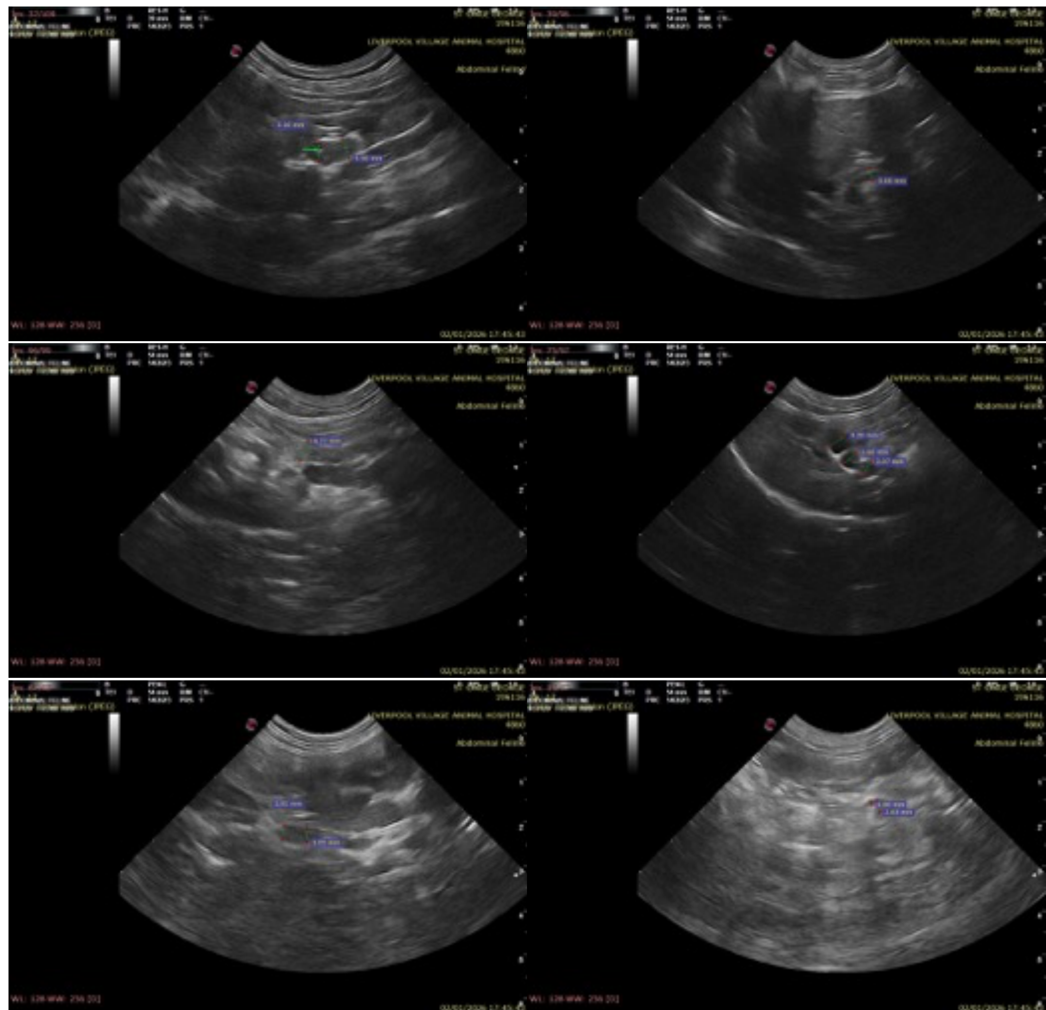
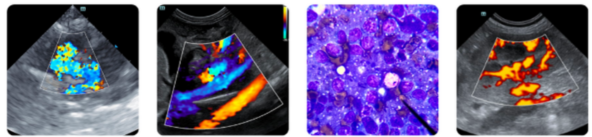
- Given the clinical signs, pancreatic lipase testing may be considered, recognizing the limited sensitivity of ultrasound for early or mild feline pancreatitis.
- If clinical concern for hiatal hernia or gastroesophageal reflux persists, further evaluation is best performed using contrast esophagography or fluoroscopy, as hiatal hernia is not reliably diagnosed by ultrasound and confirmation requires dynamic imaging studies.
- Investigate the anisocoria with ophthalmic and/or neurologic evaluation, as this finding is not explained by the abdominal ultrasound.
- Repeat abdominal ultrasound only if clinical signs worsen, new abnormalities develop, or there is concern for progression toward obstruction or infiltrative disease.





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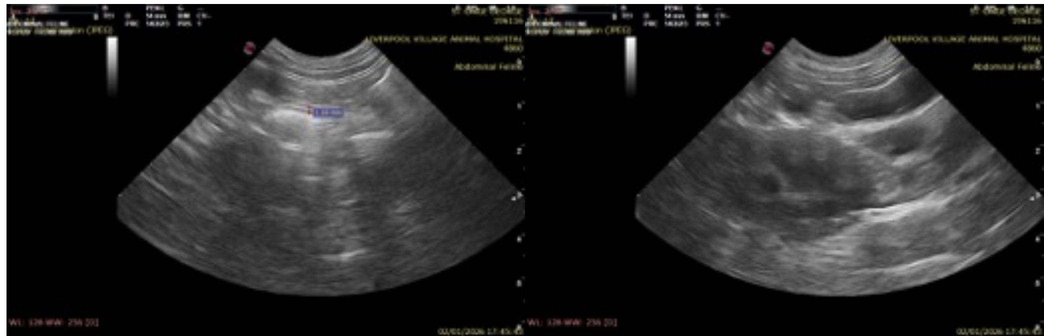

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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