



PATIENT

Simba Lawson

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

4 years

WEIGHT

10 lbs

INTERPRETED BY

Dr. Alicia Angosto
Guerrero

IMAGING PERFORMED BY

Dr. Ugorji

HOSPITAL NAME

Craig Road AH

REFERRING VET

Dr. Womack

INVOICE

70837

DATE

1/21/26

PRESENTING CLINICAL SIGNS

- Presenting for acute-on-chronic vomiting and crying out in pain. O states P has a history of vomiting, but when P does vomit, usually it is only occasional. O noted an increase in frequency with vomiting starting early this week, and early yesterday morning, P was vomiting continuously and then crying out in pain so O brought P in on an emergency basis.
- X-ray report from 1/20 images: In the absence of evidence of small intestinal dilatation, a diagnosis of gastritis/gastroenteritis seems most likely. Pancreatitis and esophagitis remain reasonable differential diagnoses.
- Repeat images from this AM show improvement in small intestinal dilation
- No interest in eating today
- Neutrophilia ($14.18 \times 10^3/uL$)-Acute inflammation (w/bands), Chronic inflammation, Corticosteroid (Stress, Cushing's, Iatrogenic), Chronic Myeloid Leukemia (rare) Lymphopenia ($0.53 \times 10^3/uL$)- Glucocorticoid-induced (stress), Acute Inflammation, Depletion (Chylous effusion, Loss of lymph w/ GI dz) Hyperalbuminemia (3.7g/dL)-dehydration Hyperglycemia (149mg/dL)-Chronic stress, Acute stress, postprandial, DM type 1 (dogs), DM type 2 (cats), hyperadrenocorticism (Cushing's), Acromegaly, endotoxemia, drugs (glucocorticoids, xylazine, ketamine)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is poorly distended; therefore, mural evaluation is limited. The urine is anechoic. No uroliths are identified.

Left kidney: Normal shape and size (3.68×2.43 cm). Cortical thickness is 0.39 cm in the sagittal plane. Right kidney: Normal shape and size (3.84×2.31 cm). Cortical thickness is 0.40 cm in the sagittal plane. In both kidneys, the renal cortex is mildly increased in echogenicity, resulting in increased corticomedullary distinction. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is observed. Doppler evaluation shows normal perfusion.

Adrenal Glands

Both adrenal glands appear normal in shape and echogenicity. Measurements could not be obtained from the provided images.

Spleen

Splenic thickness is 0.78 cm. The parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture without focal abnormalities. The splenic capsule is smooth and regular.

Liver

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



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The gallbladder is moderately distended. The wall is thin, and the contents are anechoic. No dilation of the cystic duct or common bile duct is identified.

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Gastrointestinal

The stomach is empty but markedly distended with fluid. Gastric wall thickness is 1.48 mm, with preserved layering. The pylorus measures 2.98 mm.

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The duodenum measures 1.37 mm. The jejunum measures approximately 2.61 mm, and the ileum measures 1.40 mm, with preserved mural layering. The ileocecal junction is not visualized.

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Multiple small intestinal loops are moderately to markedly distended, reaching up to approximately 1.21 cm in diameter, and contain fluid. Peristalsis is markedly reduced; the limited motion observed is pendular rather than propulsive. Segmental variation in intestinal diameter is noted, with some distal segments (ileum) appearing less distended or not distended at all.

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One elongated structure with mild distal acoustic shadowing is identified within a region labeled as colon; however, its precise luminal origin cannot be confirmed with certainty. No visible stool or fecal material is observed in the remaining segments of the colon.

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Pancreas

INTERPRETED BY

Dr. Alicia Angosto
Guerrero

Sonographic changes consistent with pancreatitis are identified in the pancreatic regions evaluated.

Peritoneal Cavity

IMAGING PERFORMED BY

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A mild volume of free abdominal fluid is present, noted within the rectovesical recess, the splenorenal recess, and between hepatic lobes. The mesenteric fat appears mildly hyperechoic and reactive. Cranial mesenteric lymph nodes measure approximately 5–7 mm in thickness, are elongated, and mildly hypoechoic. Ileocecal lymph nodes are not visualized. The iliac trifurcation is normal.

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ULTRASONOGRAPHIC FINDINGS

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- Stomach very distended with fluid pattern. Marked fluid distension of multiple small intestinal loops with reduced motility. Segmental variability in intestinal loop diameter.
- Mild abdominal effusion.
- Reactive mesenteric fat.
- Mild enlargement and hypoechoic of cranial mesenteric lymph nodes.
- No sonographic changes consistent with pancreatitis.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The intestinal pattern is not specific and may represent:

- Functional (paralytic) ileus secondary to severe gastroenteritis.
- Or mechanical obstruction, particularly given the segmental nature of the intestinal dilation (some loops markedly distended while others, including the ileum, are relatively less affected).

An intraluminal structure with mild acoustic shadowing is identified in a region presumed to be colon; however, due to image limitations and overlap of bowel segments, its precise location and clinical significance cannot be definitively determined. As such, an obstructive foreign body cannot be confidently confirmed nor excluded on the basis of this examination.

The presence of mild free abdominal fluid and reactive mesenteric fat further indicates active abdominal pathology.

Overall, although an intestinal foreign body could not be definitively confirmed on this abdominal ultrasound examination, persistent concern remains based on the intestinal distension pattern, reduced motility, and segmental variability in bowel caliber.

Recommendations

- Hospitalization and close clinical monitoring are strongly recommended, given the severity of clinical signs, marked small intestinal distension, reduced motility, and ongoing concern for a possible mechanical obstruction. Supportive care should include appropriate analgesia, antiemetic therapy, intravenous fluid therapy, and strict gastrointestinal rest.
- Short-interval repeat abdominal ultrasonography (within 12–24 hours) is advised, ideally with a meticulous, segment-by-segment reassessment of the entire gastrointestinal tract, to evaluate for progression or resolution of intestinal distension, changes in motility, or emergence of a more clearly defined obstructive lesion.
- Advanced imaging (abdominal CT) may be considered if available, as it offers superior sensitivity for detection of gastrointestinal foreign material and obstructive processes, particularly when ultrasonographic findings are equivocal.
- Exploratory laparotomy should be strongly considered if the patient fails to show clear clinical improvement, develops worsening pain, persistent vomiting, or progressive abdominal distension, or if repeat imaging continues to support an obstructive pattern. In this context, surgical exploration may be both diagnostic and therapeutic.



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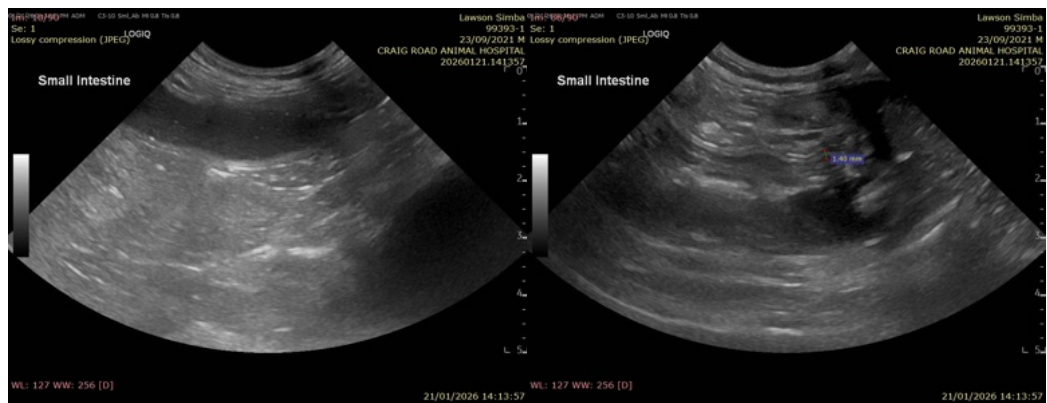
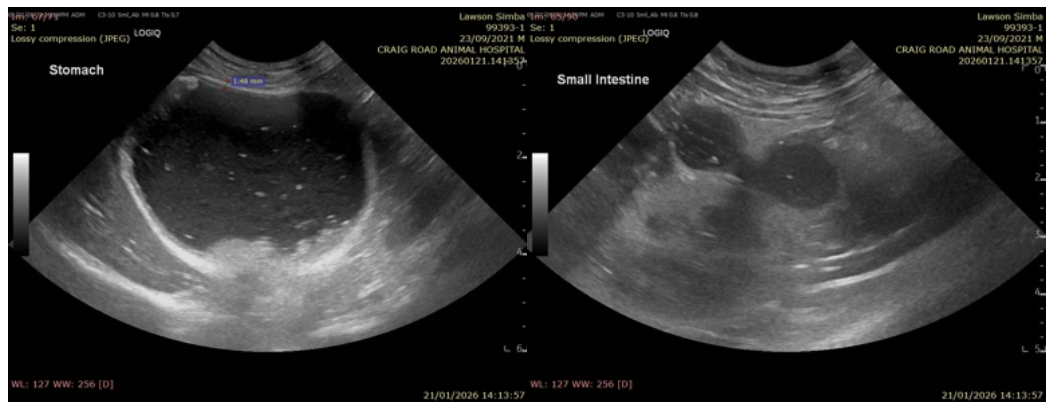
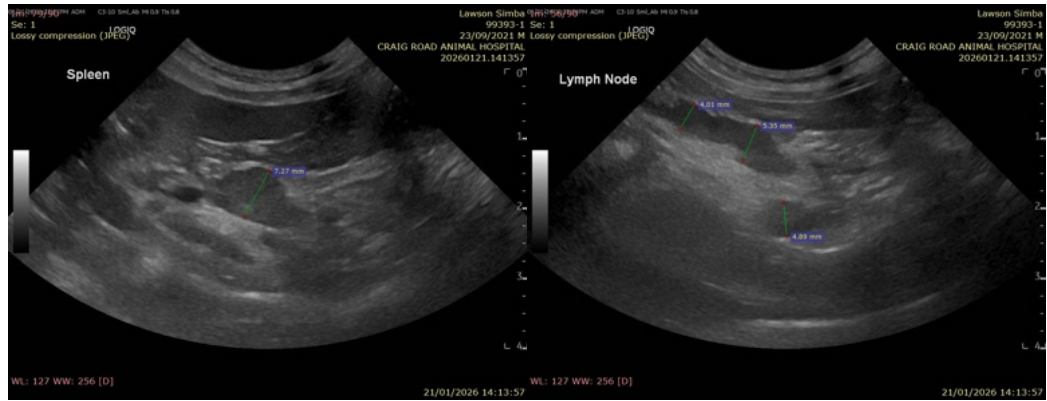
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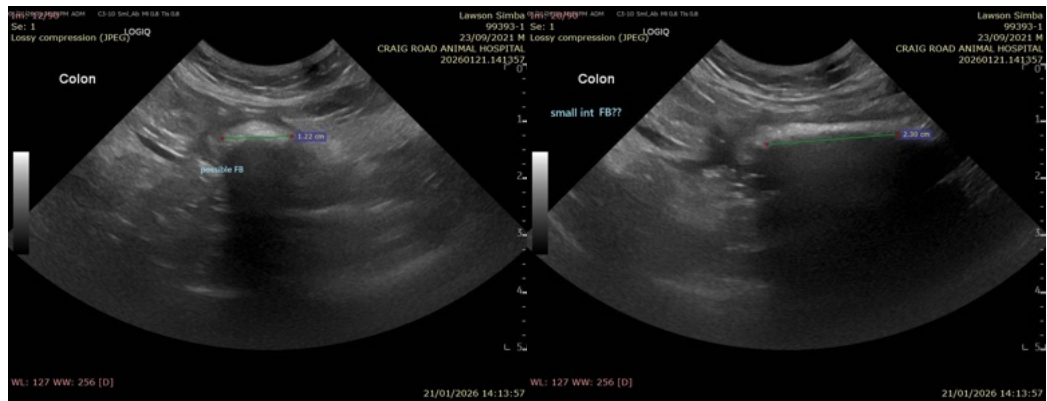
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

MV Esp Ultrasound in Domestic and Wild Animals

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