



PATIENT

Lola McConnell

SPECIES

Feline

BREED

Siamese

SEX

Spayed Female

AGE

5 Years

WEIGHT

9 Pounds

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Brandon

HOSPITAL NAME

Dillsburg VC

REFERRING VET

Dr. Amber

INVOICE

35565

DATE

1/23/26

PRESENTING CLINICAL SIGNS

- Vomited liquid 3-4 times 5 days ago. Was seen at another animal hospital on 1/19 and received Cerenia and Convenia (chronic URI). Vomited approx 24 hours later. Went back to animal hospital on 1/21 and received SQ fluids, Cerenia, combo inj of Dexamethasone/Amoxi/B12, and 1 dose of Mirataz gel. CBC/comp were WNL. Rads showed smaller sized kidneys and maybe suspicious area mid cranial abdomen. Barium was recommended but not performed. She has not vomited 1/20 but still not eating much at all and lethargic.
- Abnormal PE/Chem/CBC/UA Results: CBC/comp WNL on 1/21

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is very distended. The bladder wall appears thin and smooth. The urine is predominantly anechoic with scant suspended echoes. The bladder neck and proximal urethra have a normal ultrasonographic appearance. No uroliths are identified, and there is no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 3.22x1.64 cm, with a cortical thickness of 0.30 cm in the sagittal plane. The renal cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

The right kidney is normal in shape and size, measuring 3.20x2.03 cm, with a cortical thickness of 0.28 cm in the sagittal plane. The renal cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

The left adrenal gland measures 0.23 cm at the cranial pole and 0.23 cm at the caudal pole. The right adrenal gland is not visualized.

Spleen

Splenic thickness measures 0.63 cm. The splenic parenchyma demonstrates normal echogenicity with a fine, homogeneous echotexture and no focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

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

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

Gastrointestinal



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The stomach is distended and contains a mixture of fluid and partially digested ingesta. Gastric wall layering is preserved, with a mural thickness of 1.24 mm. No ultrasonographic evidence of gastric wall thickening, ulcerative lesions, or increased echogenicity of the perigastric fat is identified. The pylorus and duodenum are not clearly visualized.

The jejunum measures 2.06 mm in mural thickness, with preserved wall layering. The ileocecal junction measures 2.23 mm. No ultrasonographic evidence of intestinal inflammation, obstructive pattern, or foreign material is identified in the visualized intestinal segments.

The ascending colon wall measures 0.80 mm and contains formed fecal material with distal acoustic shadowing. The descending colon wall measures 0.90 mm and contains formed feces.

Pancreas

The evaluated pancreatic regions do not show ultrasonographic evidence of overt inflammation.

Free Abdomen

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

PRIMARY FINDINGS

- Mild to moderate gastric distension with mixed fluid and small amounts of residual ingesta.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach is moderately distended and contains a mixture of fluid and partially digested ingesta. While this finding is nonspecific, the persistence of gastric contents despite a history of vomiting raises consideration for delayed gastric emptying or proximal outflow dysfunction, rather than distal intestinal obstruction. No obstructive pattern is identified in the small or large intestines, and distal intestinal segments demonstrate normal wall thickness and preserved layering, arguing against a mid- to distal small intestinal obstruction.

The pyloroduodenal region and proximal duodenal flexure are not visualized on this examination. Therefore, a mechanical obstruction at the level of the pylorus or proximal duodenum cannot be completely excluded, as foreign material or functional obstruction at this location may not produce a classic distal obstructive pattern.

Alternatively, acute inflammatory gastrointestinal disease in cats may be associated with minimal or absent ultrasonographic changes, especially in the absence of significant intestinal wall thickening or lymphadenopathy.

Overall, the ultrasonographic findings do not support a distal gastrointestinal obstruction or infiltrative intestinal disease. The primary limitation of this examination is incomplete visualization of the pyloric region and proximal duodenum, which remains the most relevant area of concern given the clinical history and the appearance of the stomach.

Recommendations:



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- Correlate ultrasonographic findings with clinical timing, specifically the interval since last food intake, as this information is critical for interpretation of persistent gastric contents.
- Repeat focused ultrasonographic evaluation of the gastric outflow region may be considered if vomiting or anorexia persists, particularly to reassess for subtle or intermittently obstructive material; alternatively, contrast radiography may be pursued based on clinical judgment.
- In the absence of progressive clinical signs, laboratory abnormalities, or development of an obstructive pattern, supportive medical management for suspected acute gastritis or gastroenteritis is reasonable, recognizing that such conditions may not produce definitive ultrasonographic changes.
- Escalation endoscopic evaluation may be considered in cases of persistent clinical signs, failure to respond to supportive care, or increasing concern for proximal gastrointestinal obstruction.



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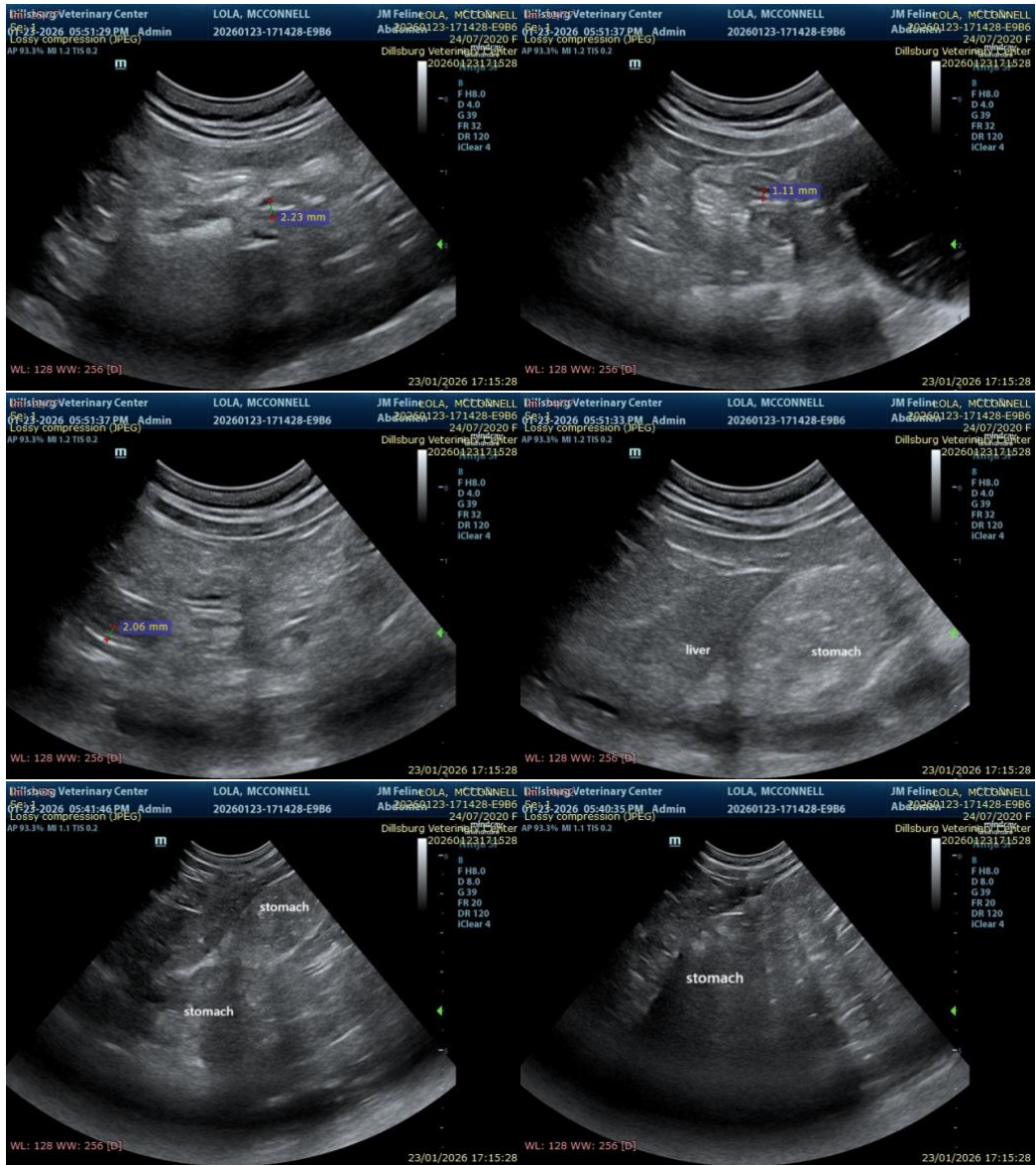
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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