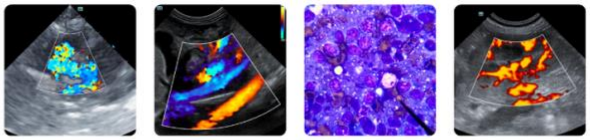


PATIENT

Shadow Sweeney

SPECIES

Feline

BREED

American Shorthair

SEX

Spayed Female

AGE

7 Years 7 Months

WEIGHT

10.8 pounds

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Kimberly Morgan

HOSPITAL NAME

Seven Fields Veterinary Hospital

REFERRING VET

Dr. Kimberly Morgan

INVOICE

12743

DATE

12/18/25

PRESENTING CLINICAL SIGNS

Presented on Tuesday for acute history of vomiting and not eating. Painful on abdominal palpation. Radiographs unremarkable.

Abnormal PE/Chem/CBC/UA Results: TP > 12, alb 5.1, ALT 370 ALP 290, Tbili 8.1 but patient is not icteric, low potassium

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

The left kidney is normal in shape and size, measuring 3.59×2.10 cm. Cortical thickness measures 0.37 cm in the sagittal plane.

The right kidney is normal in shape and size, measuring 3.81×2.26 cm. Cortical thickness measures 0.36 cm in the sagittal plane.

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

Adrenal Glands

The left adrenal gland measures 0.30 cm at the cranial pole and 0.33 cm at the caudal pole. The right adrenal gland is not clearly visualized.

Spleen

Splenic thickness measures 0.70 cm. The splenic parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

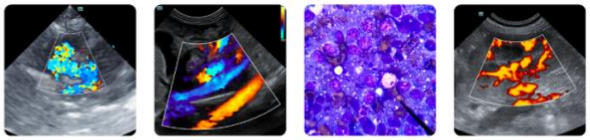
Liver

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

The gallbladder lumen is normally distended. The gallbladder wall is thin, and the contents are primarily anechoic. The common bile duct measures approximately 2.71–2.87 mm.

Gastrointestinal

The stomach is markedly distended and filled with fluid and gas. The pylorus and proximal duodenum are not clearly visualized, likely due to severe gastric and proximal intestinal distension. Within a segment of jejunum, an intraluminal structure compatible with a foreign body is identified, associated



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with a proximal obstructive pattern. The intestinal wall at the level of the suspected foreign body appears mildly thickened and altered.

Jejunum wall thickness measures approximately 2.15 mm, and the ileum measures 1.79 mm, with preserved wall layering. The ileocecal junction measures approximately 2.30 mm.

The colon measures 0.88 mm and contains formed fecal material in the descending segment.

Pancreas

The pancreas is not visualized.

Free Abdomen

No abdominal effusion or signs of peritonitis are observed. There is no evidence of intestinal perforation or pneumoperitoneum at the time of examination. Cranial mesenteric and ileocecal lymph nodes are not visualized, and the surrounding regions appear unremarkable. The iliac trifurcation appears normal.

PRIMARY FINDINGS

- Marked gastric distension with fluid and gas.
- Intraluminal jejunal structure consistent with a foreign body, associated with a proximal obstructive pattern.
- Mild focal jejunal wall thickening and alteration at the level of the obstruction.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Abdominal ultrasonography reveals findings consistent with an acute mechanical small intestinal obstruction, most likely due to a jejunal foreign body, resulting in marked gastric and proximal intestinal distension. The shape of the object lodged within the intestine is highly variable; therefore, it is unclear whether it represents a single foreign body with multiple edges or contours, or multiple foreign bodies clustered together.

The focal intestinal wall thickening at the site of obstruction is most consistent with secondary inflammatory and pressure-related changes caused by the foreign body. While pre-existing intestinal wall disease predisposing to obstruction is considered less likely, it cannot be entirely excluded based on imaging alone. Importantly, there is no ultrasonographic evidence of intestinal perforation, peritonitis, or free abdominal gas at this time, suggesting that the obstruction is acute and potentially surgically correctable if addressed promptly.

The markedly elevated total bilirubin (8.1 mg/dL) in the absence of overt clinical icterus is most plausibly explained by acute cholestasis secondary to severe gastrointestinal obstruction, dehydration, and systemic inflammation, rather than primary hepatobiliary disease. The liver and biliary tree appear structurally normal on ultrasound, supporting a functional or reactive hepatobiliary process. Similarly, the elevated ALT and ALP are likely secondary hepatocellular and cholestatic responses to the acute abdominal event.

The markedly elevated total protein and albumin, along with hypokalemia, are consistent with significant dehydration and electrolyte derangement, commonly seen in acute obstructive gastrointestinal disease in cats.

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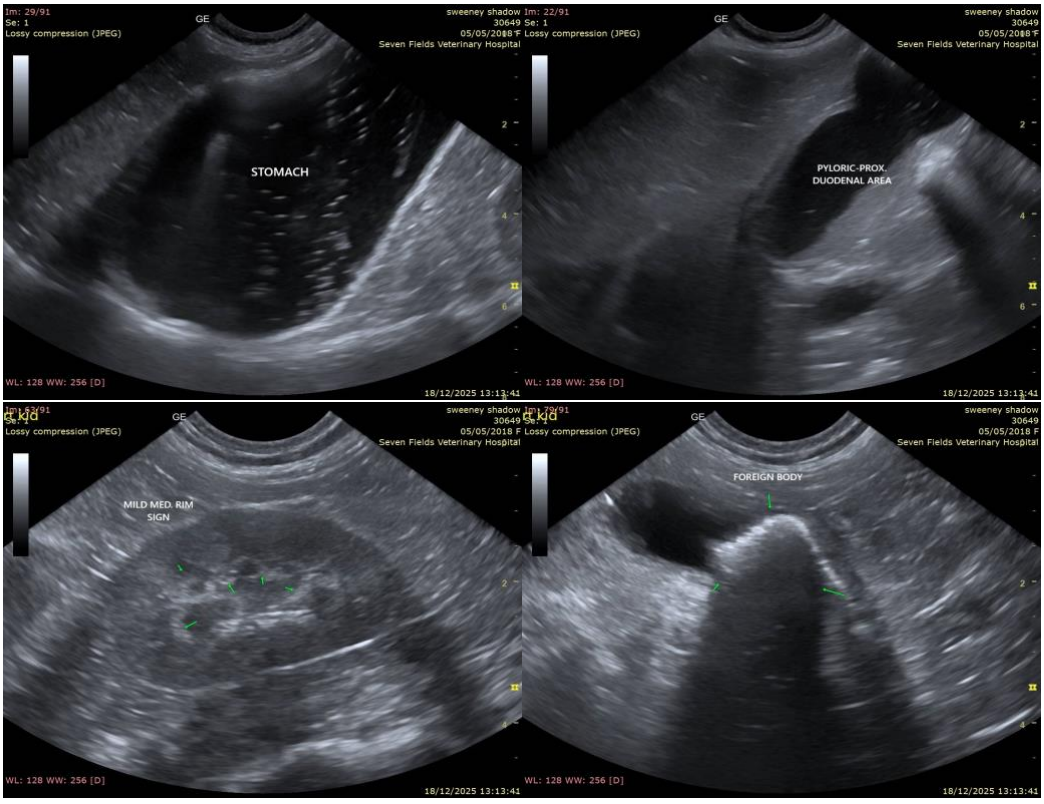
Overall, the findings are most consistent with an acute obstructive gastrointestinal emergency, with secondary metabolic and hepatobiliary abnormalities.

Recommendations

- Prompt surgical consultation is recommended, as the ultrasonographic findings are consistent with an acute mechanical small intestinal obstruction.
- Pre-operative stabilization, including correction of dehydration and electrolyte abnormalities (notably hypokalemia), is advised prior to anesthesia as clinically indicated.
- Continued monitoring for signs of intestinal compromise, including perforation or peritonitis, is recommended if surgical intervention is delayed.
- Post-resolution reassessment of hepatobiliary parameters is advised, as the elevated liver enzymes and bilirubin are most consistent with secondary, reactive changes related to the acute obstructive process.



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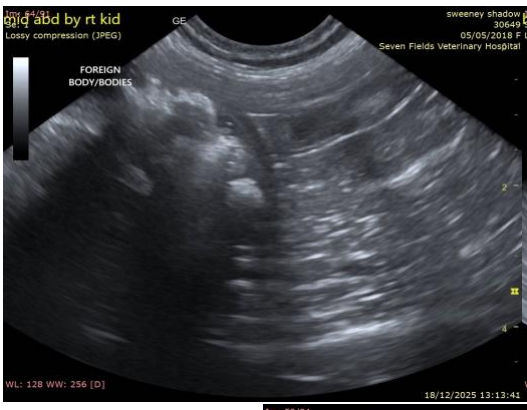

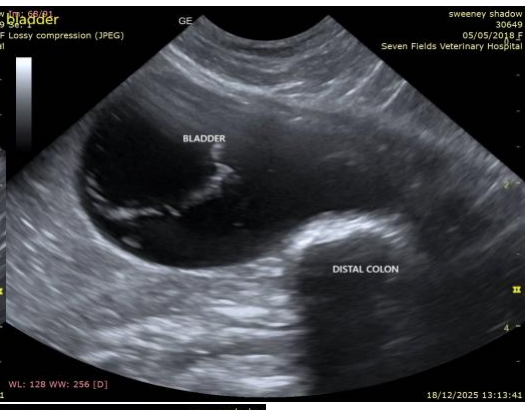

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com