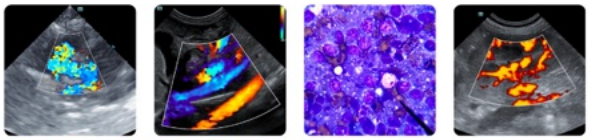




**PATIENT**

Benson Walters

**SPECIES**

Feline

**BREED**

Domestic Shorthair

**SEX**

Neutered male

**AGE**

10 years

**WEIGHT**

11.5 lbs

**INTERPRETED BY**

Alicia Angosto Guerrero, DMV, PgDip, MSc.

**IMAGING PERFORMED BY**

Dr. Saum Hadi

**HOSPITAL NAME**

Nimbus PH

**REFERRING VET**

Dr. Hadi

**INVOICE**

75560

**DATE**

5/14/26

## PRESENTING CLINICAL SIGNS

History: Benson presented for AUS for further investigation of hematemesis and elevated ALT. he has a history of URI - calicivisus and intermittently vomiting hairballs
5/10/26 - Benson had a large bout of hematemesis with a possible trichobezoar and a copious amount of melena in the vomitus. He remained BAR with a good appetite throughout the remainder of the weekend. He had no further vomiting episodes. Stool was normal per O.
He present on Tuesday for a check up. he was BAR on examination. BW performed showed: HCT: 51.7, MCT: 19.8 (H), MCHC: 41..3 (H), remaining wnl CHEM: ALT: 175 U/L (H), Glob: 5.3 (H), creatinine: 1.7 (H), BUN: wnl UA on 4/10/26: USG: 1.047 4/10/26 Creatinine 1.6

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is predominantly anechoic with abundant suspended echoes. The bladder neck and proximal urethra appear normal. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.71×2.73 cm, and the thickness of the cortex is 0.36 cm in the sagittal plane. The right kidney is normal in shape and size: 3.91×2.50 cm, and the thickness of the cortex is 0.40 cm in the sagittal plane. Both kidneys demonstrate mildly increased cortical echogenicity compared to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. Mild medullary rim sign is present bilaterally. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

### *Adrenal Glands*

The left adrenal gland is not confidently visualized. The right adrenal gland measures 0.26 cm.

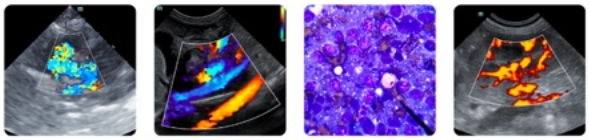
### *Spleen*

Splenic thickness is 1 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

### *Liver*

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

The gallbladder lumen is normally distended. The wall is thin and the contents are predominantly anechoic. The common bile duct measures approximately 1.98–2.89 mm in diameter, which is mildly prominent but remains within acceptable limits for some adult cats, particularly in the absence of visible obstruction or additional hepatobiliary abnormalities.





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## *Gastrointestinal*

The stomach contains ingesta and demonstrates preserved wall layering with mural thickness measuring approximately 2.61 mm. Relative prominence/thickening of the submucosal layer is noted, measuring approximately 1.74 mm. This appearance may reflect a non-fasted state, mild gastritis, edema, or delayed gastric emptying.

Near the pyloric region, a focal approximately 1 cm intraluminal hyperechoic structure generating distal acoustic shadowing is identified and may represent a small trichobezoar/hairball aggregate. No convincing ultrasonographic evidence of complete gastric outflow obstruction is identified.

The pylorus measures 3.57 mm. The duodenum measures 1.77 mm. The jejunum measures 2.28 mm (mucosa 1.26 mm, submucosa 0.32 mm, muscularis propria 0.35 mm). The ileum measures 1.76 mm (mucosa 0.65 mm, submucosa 0.53 mm, muscularis propria 0.57 mm). Wall layering is preserved throughout the evaluated intestinal tract. The ileocecocolic junction was not confidently visualized.

No ultrasonographic evidence of mechanical ileus, intestinal foreign body, focal intestinal mass lesion, or diffuse inflammatory enteropathy is identified.

The colon measures approximately 1.10 mm in thickness and contains formed fecal material within the descending colon.

## *Pancreas*

The evaluated pancreatic regions do not show evidence of overt inflammation or neoplastic disease.

## *Free Abdomen*

No sonographic evidence of abdominal effusion or peritonitis is identified. Cranial mesenteric lymph nodes measure approximately 2.77–3.41 mm in thickness and demonstrate normal shape and echogenicity. The ileocecocolic lymph nodes were not confidently visualized; however, the surrounding regions appear unremarkable. The iliac trifurcation appears normal.

## PRIMARY FINDINGS

- Mild bilateral renal cortical hyperechogenicity with mild bilateral medullary rim sign
- Mild gastric submucosal prominence/thickening

## SECONDARY FINDINGS

- Small suspected pyloric trichobezoar/hairball aggregate

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach contains ingesta with mild diffuse submucosal prominence/thickening and a small suspected trichobezoar near the pyloric region. Mild prominence of the gastric submucosal layer is nonspecific and may reflect mild gastritis, edema, recent vomiting, or a non-fasted state. The remainder

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of the gastrointestinal tract appears overall within normal ultrasonographic limits.
No convincing ultrasonographic evidence of gastric outflow obstruction is identified; however, mild delayed gastric emptying and/or mild reactive gastritis is considered possible.
The reported acute episode of hematemesis may have been associated with transient gastric mucosal irritation, gastritis, or minor erosive mucosal injury related to trichobezoar passage or hairball-associated gastric irritation. Importantly, ultrasonography has limited sensitivity for superficial gastric erosions or mild ulcerative disease, and these conditions may be present despite relatively subtle imaging abnormalities.

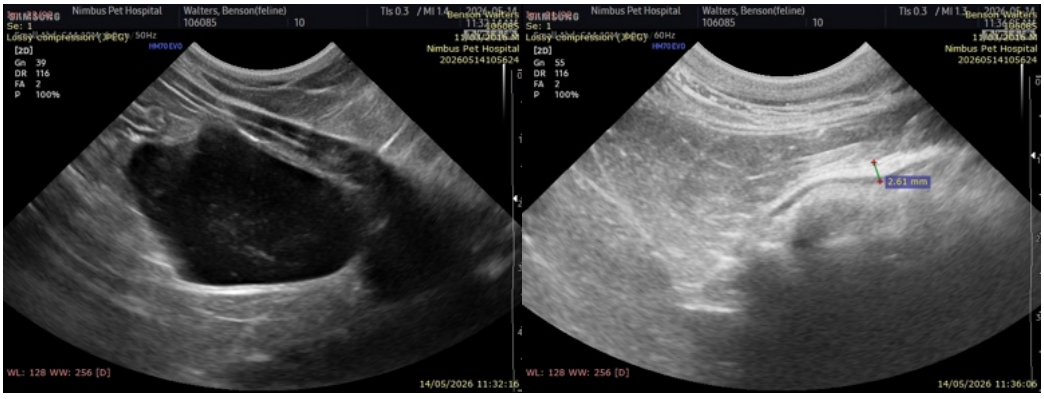
No ultrasonographic evidence of diffuse inflammatory bowel disease, focal gastrointestinal neoplasia, intestinal obstruction, pancreatitis, or diffuse peritonitis is identified on the current examination.

Mild bilateral renal cortical hyperechogenicity and medullary rim sign are present. These findings are nonspecific and may be seen with mild chronic renal change, tubular mineralization, concentrated urine states, or incidental age-related change. At this time, there is no ultrasonographic evidence of advanced chronic kidney disease or obstructive nephropathy.

Recommendations

- Conservative medical management for gastritis/gastrointestinal irritation may be considered as clinically indicated.
- Hairball management strategies (dietary modification, grooming optimization, lubricants/laxative hairball products if appropriate) may be beneficial given the suspected trichobezoar.
- If vomiting or hematemesis recurs, further investigation for gastritis, ulcerative disease, or intermittent trichobezoar-associated obstruction should be considered. Endoscopy may ultimately be warranted if clinical signs persist or worsen.
- Correlation with renal values, SDMA, urinalysis, urine specific gravity, and blood pressure is recommended given the mild renal ultrasonographic changes and borderline creatinine elevation.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status.



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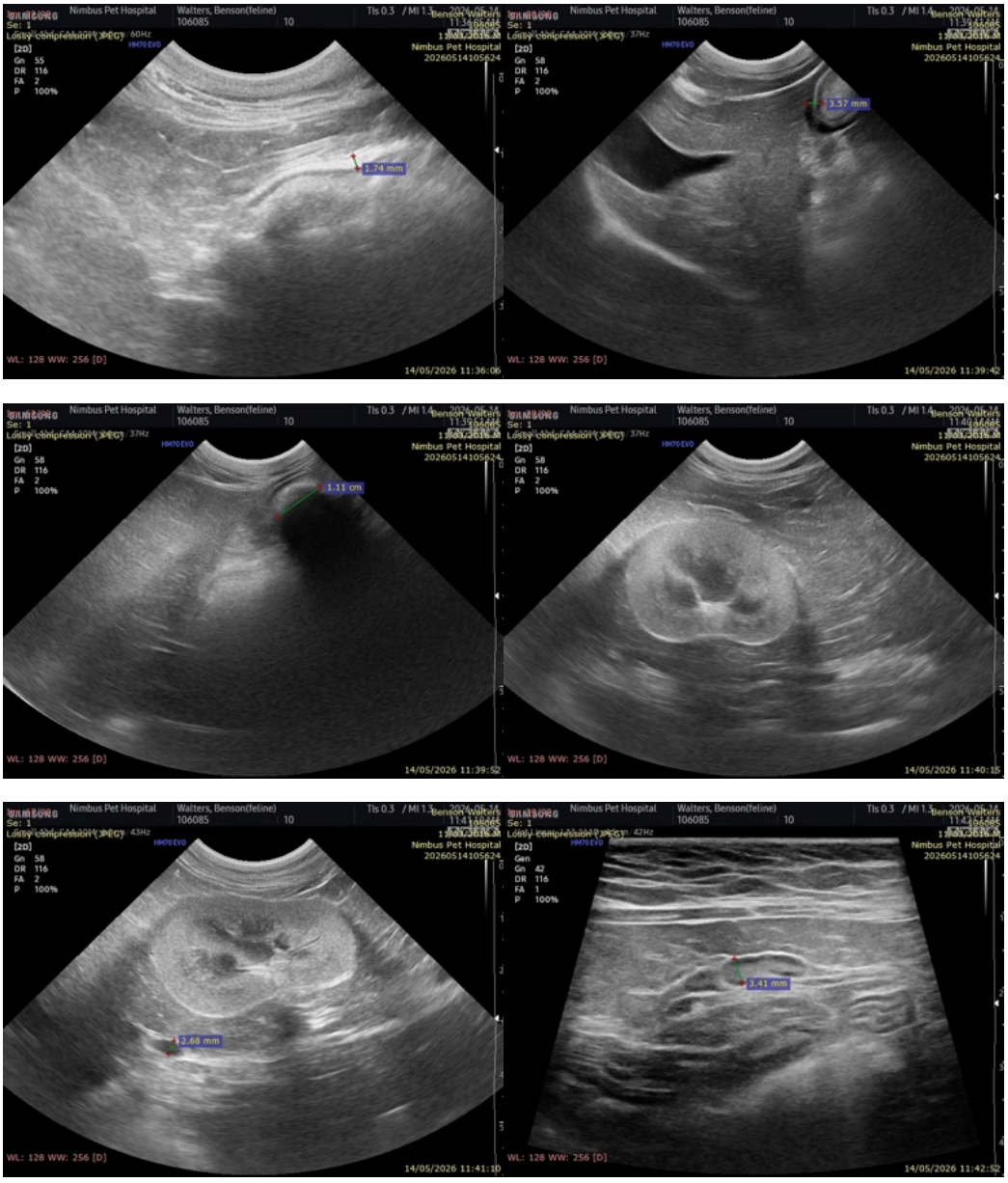

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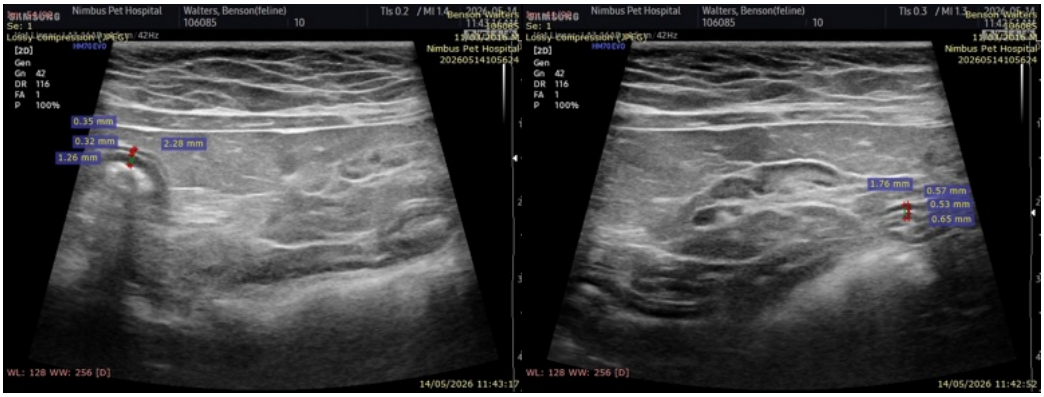


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

info@SonoPath.com