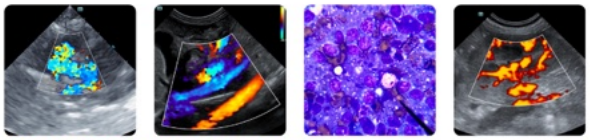


PATIENT

Vanish Reece

SPECIES

Feline

BREED

Domestic Medium Hair

SEX

Spayed female

AGE

2 years

WEIGHT

8 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Beth Coe

HOSPITAL NAME

Riverside AC

REFERRING VET

Dr. Brenner

INVOICE

77871

DATE

5/21/26

PRESENTING CLINICAL SIGNS

History: Lethargy and vomiting for the past 2 weeks. Tries to eat, then vomits within 5 min. Vomiting foam even when not eating. Unknown defecation habits. Owner not seeing urination. Indoor only cat. No medications. Does eat hair ties, beads from jewelry, foam pieces.
Past two days, acting less lethargic but still vomiting.
Abnormal PE/Chem/CBC/UA Results: PE: No foreign body under tongue. Temp normal. Soft abdomen, GI sounds present. Unremarkable exam overall CBC: PLT 147K, Rest WRI Chem: TP 9.1/Glob 5.2. Mild hypochloremia (suspect GI loss/vomit) fPL: Normal FeLV/FIV = Negative Abdominal rads: Stomach empty/small gas. SI empty/mixed gas, no obstructive gas pattern, dilation, or plication noted. Stool descending colon. Bladder mod full. *On VD view, ?gas? in duodenum with soft tissue density? vs ascending colonic gas/material? Not seen on lat image.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is anechoic. Normal appearance of the bladder neck and proximal urethra. There are no calculi, and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.39×2.33 cm, and the cortical thickness measures 0.30 cm in the sagittal plane. The renal cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

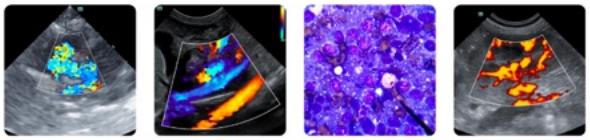
The right kidney is normal in shape and size: 3.42×2.01 cm, and the cortical thickness measures 0.30 cm in the sagittal plane. The renal cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.30 cm at the cranial pole and 0.30 cm at the caudal pole. The right adrenal gland measures 0.28 cm

Spleen

Splenic thickness is 0.96 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.



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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 primarily anechoic. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty and mildly folded, containing only a very small amount of fluid. Gastric wall thickness measures 1.82 mm with preserved wall layering. No convincing gastric foreign material is identified ultrasonographically.

The pylorus measures 3.28 mm and maintains normal wall layering. The duodenum measures 1.23 mm and is mildly corrugated. The jejunum measures 1.71 mm in total thickness, with mucosa measuring 0.92 mm, submucosa 0.44 mm, and muscularis propria 0.20 mm. The ileum measures 1.30 mm, with mucosa measuring 0.41 mm, submucosa 0.58 mm, and muscularis propria 0.17 mm. Intestinal wall layering is preserved throughout the evaluated small intestinal segments. The muscularis-to-mucosa ratios are within normal limits and do not support muscularis-predominant infiltrative enteropathy or low-grade alimentary lymphoma. The ileocecal junction was not confidently visualized.

Within the left dorsal cranial abdomen, dorsal to the spleen and medial to the colon, a segment of presumed jejunum contains focal intraluminal hyperechoic material associated with moderate distal acoustic shadowing. Two focal shadowing regions are identified, measuring approximately 0.7 cm and 1 cm in length. The affected intestinal segment is not dilated, and no obstructive intestinal pattern is identified. Importantly, the intestinal segment immediately oral/cranioproximal to this region also remains nondilated. No sentinel loop formation, focal intestinal wall thickening, mural compromise, or reactive hyperechoic mesenteric fat change is identified adjacent to this segment. Mild luminal particulate or foreign material is therefore present within the small intestine, although complete mechanical obstruction is not evident sonographically at this time. Differential considerations include ingested compact foreign material, intraluminal debris, or less likely focal trichobezoar-type material. Some intestinal transit appears preserved, as small amounts of material are present within the colon.

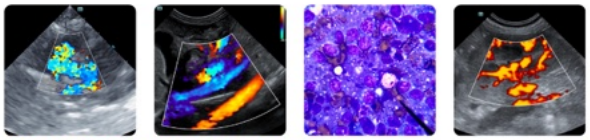
The colon measures 0.84 mm. Mild-to-moderate fecal material is present within the proximal and transverse colon, while the descending colon is largely empty.

Pancreas

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

Free Abdomen

No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation is normal.



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PRIMARY FINDINGS

- Focal shadowing intraluminal material within a presumed jejunal segment without current evidence of complete mechanical obstruction.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Focal intraluminal shadowing material is identified within a small intestinal segment, most likely jejunum, compatible with ingested luminal material/foreign material. At this time, there is no convincing ultrasonographic evidence of complete mechanical gastrointestinal obstruction, as no intestinal dilation, sentinel loop formation, mural compromise, or reactive mesenteric change is identified, and some distal intestinal transit appears preserved.

Given the patient's history of vomiting and known ingestion of nonfood items, a partial, or intermittently obstructive gastrointestinal foreign body process remains clinically important despite the absence of a classic obstructive sonographic pattern at the time of examination. The mild focal duodenal corrugation may represent mild reactive enteritis or localized gastrointestinal irritation.

No convincing ultrasonographic evidence of infiltrative gastrointestinal disease, pancreatitis, peritonitis, or other major abdominal abnormality is identified on the current examination.

Recommendations

- Close clinical monitoring is recommended, as the identified intraluminal material may represent ingested foreign material currently transiting through the gastrointestinal tract without evidence of complete mechanical obstruction at this time.
- Monitoring of appetite, vomiting frequency, water tolerance, abdominal discomfort, fecal production, and overall clinical progression is recommended.
- Repeat abdominal ultrasound or serial abdominal radiographs may be considered if clinical signs persist or worsen over the next 12–24 hours.
- Development of progressive abdominal pain, persistent projectile vomiting, inability to retain water, worsening lethargy, or absent fecal production would increase concern for progression toward clinically significant gastrointestinal obstruction and may warrant exploratory laparotomy depending on clinical evolution.

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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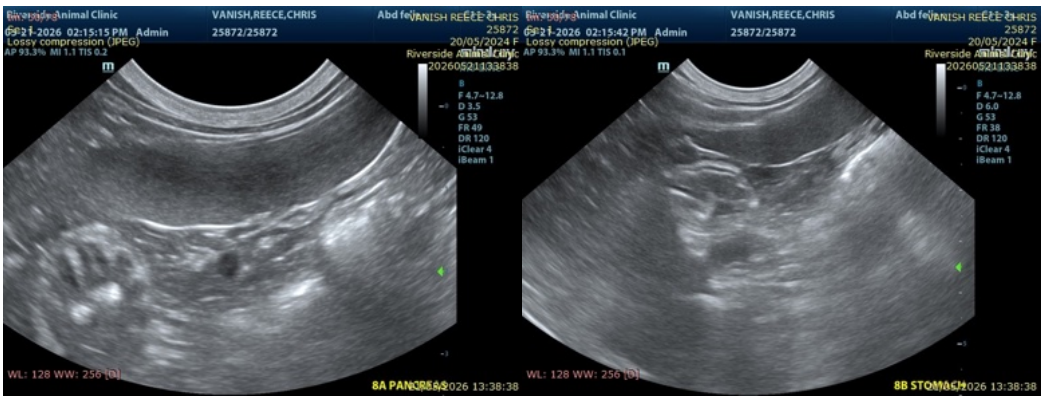

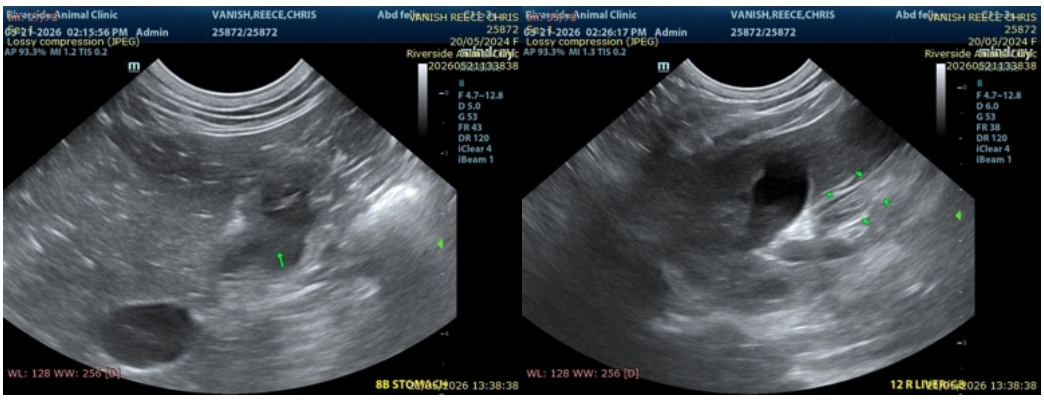

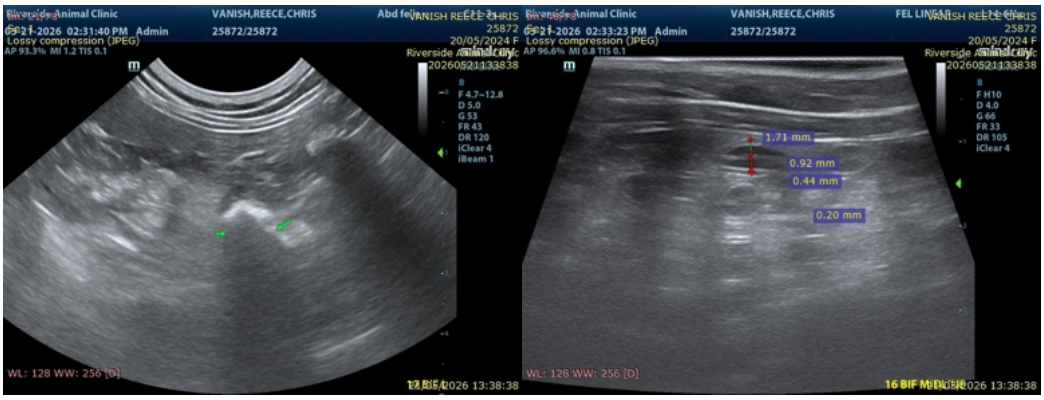

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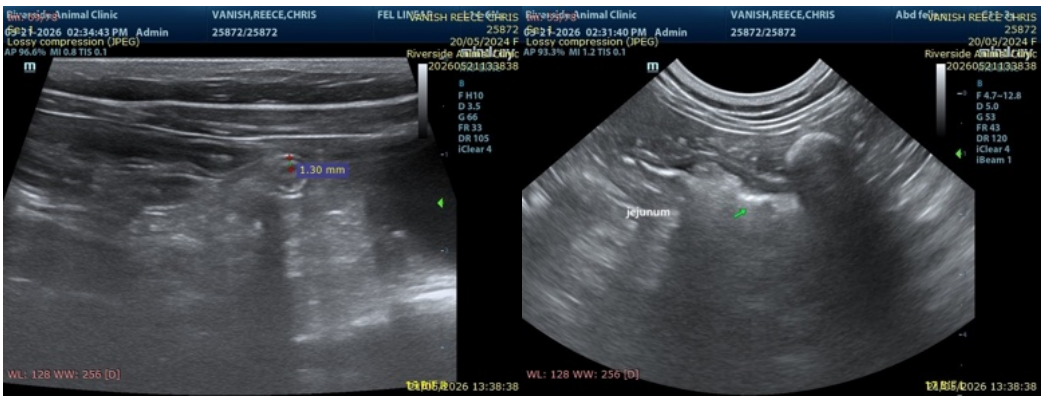

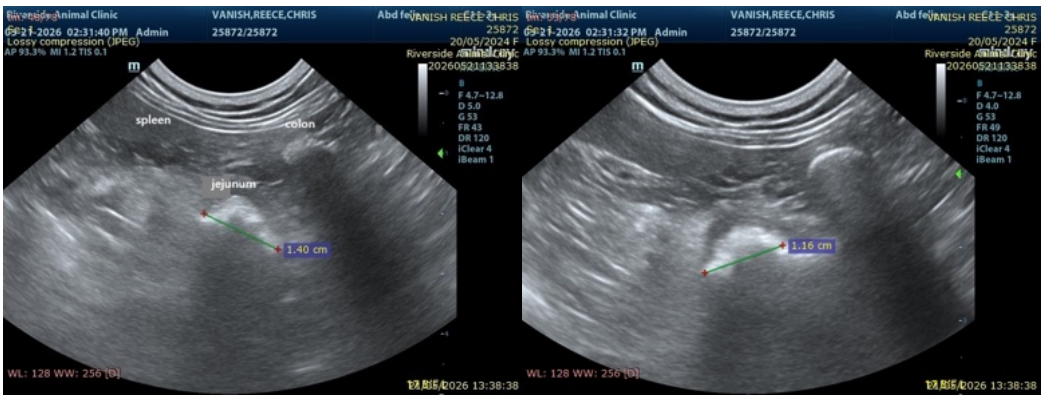

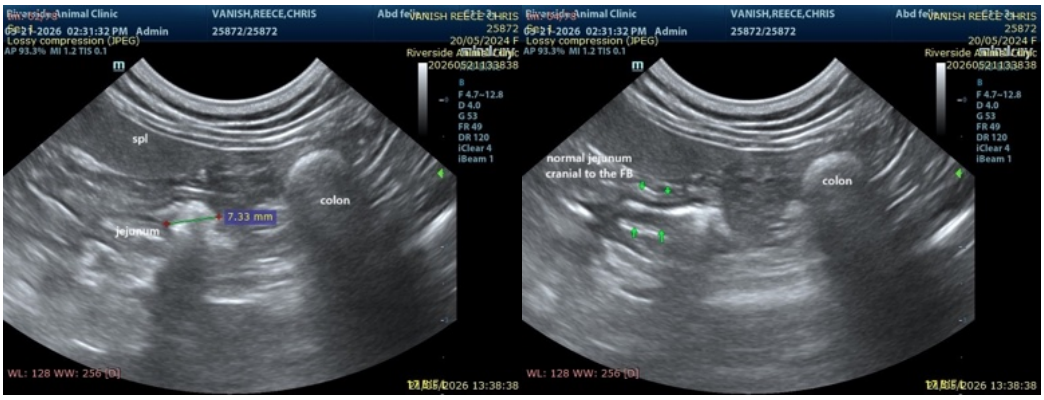

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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