



PATIENT

Millie Swank

SPECIES

Feline

BREED

Domestic Medium Hair

SEX

Spayed female

AGE

3 years

WEIGHT

3.66 kg

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Leah Richter

HOSPITAL NAME

Allied Veterinary
Emergency & Referral

REFERRING VET

Dr. Richter

INVOICE

78180

DATE

6/1/26

PRESENTING CLINICAL SIGNS

History: Presented 5/30 for vomiting/anorexia. AXR was read out as nonobstructive GE. Treated with SQF/cerenia. Returned 5/31 for persistent vomiting/anorexia. Repeat AXR similar to first round. Hospitalized with IVF, metoclopramide, ondansetron, and cerenia. No further vomiting. No interest in food in hospital but potentially related to stress/anxiety. AUS performed 6/1 to determine if underlying enteropathy/other.

History of sensitive stomach, stomatitis, and frequent herpesvirus flare-ups.

Abnormal PE/Chem/CBC/UA Results: 5/30 AEVS @11AM CBC: Hct 59.9%. (RBC 13.19, Hg 17.7, RDW 28.2, Retic 116.1) WBC 7.11k (Neu 4.4, Lym 2.3, Mono 0.3, Baso 0.04). PLT 181k. Chem17/Lytes: BG 164, Phos 2.6, K 3.2 PanLipa: 1.5 UA (Cysto): USG > 1.050, pH 6.5, Pro 30, Glu/Ket neg, Blood 10, Bili 1, Urobili 4. WBC <1/HPF, RBC 23/HPF. No bacteria. nsEpi 1-2/HPF. 5/31 noon PCV/TP: 50% / 6g/dL Lytes: Na 155 (154), K 3.3 (3.2), Cl 111 (112) Phos: 2.8 (2.6)

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 anechoic. Normal appearance of the bladder neck and proximal urethra. There are no calculi and no sonographic evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 3.25×2.33 cm, and the cortical thickness measures 0.29 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 3.51×2.00 cm, and the cortical thickness measures 0.29 cm in the sagittal plane. The renal cortices are isoechoic compared to the hepatic parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. Mild bilateral medullary rim sign is present. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler evaluation demonstrates a normal vascular pattern.

Adrenal Glands

Both adrenal glands demonstrate normal shape, size, and echogenicity. Dorsoventral diameters measured in the sagittal plane are within normal limits. The left adrenal gland measures 0.29 cm. The right adrenal gland measures 0.22 cm.

Spleen

Splenic thickness is 0.41 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.



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The gallbladder lumen is moderately distended. The wall is thin and smooth, and the contents are primarily anechoic. The common bile duct measures 0.24 cm.

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Gastrointestinal tract

The stomach is empty and folded, with a mural thickness of 1.41 mm and preserved wall layering.

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The pylorus measures 3.10 mm. The duodenum measures 1.41 mm, the jejunum 1.75 mm, and the ileum 1.39 mm. Intestinal wall layering is preserved throughout the examined segments. Within the ileum, the mucosa measures 0.61 mm, the submucosa 0.72 mm, and the muscularis 0.27 mm.

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Mild fluid and gas distension is present within a few small intestinal segments. Subjectively decreased intestinal motility is noted during the examination. No foreign material, mechanical obstruction, or obstructive intestinal pattern is identified.

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The ileocecolic junction could not be visualized.

The colon measures 0.98 mm and contains minimal luminal contents.

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Pancreas

The pancreas measures 4.23-4.24 mm in thickness. Pancreatic parenchyma is isoechoic relative to the adjacent omental fat. The pancreatic duct measures 0.27 mm in diameter. No peripancreatic fat hyperechogenicity, free fluid, or other sonographic evidence of active pancreatic inflammation is identified.

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Free Abdomen

No sonographic evidence of abdominal effusion or peritonitis is identified. Cranial mesenteric lymph nodes measure 2.99-4.37 mm and are normal in size, shape, and echogenicity. The iliac trifurcation appears normal.

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PRIMARY FINDINGS

- Mild fluid and gas distension affecting a few small intestinal segments.
- Subjectively decreased small intestinal motility.

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SECONDARY FINDINGS

- Mild bilateral medullary rim sign.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Mild fluid and gas distension of a few small intestinal segments, together with subjectively decreased intestinal motility and reduced colonic contents, is most consistent with mild generalized gastrointestinal hypomotility, likely reflecting the combined effects of recent anorexia, dehydration, and mild hypokalemia. No sonographic evidence of mechanical gastrointestinal obstruction, foreign



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body, infiltrative intestinal disease, or other significant gastrointestinal pathology is identified. Intestinal wall thicknesses are within normal limits, wall layering is preserved, and the jejunal muscularis-to-mucosa ratio is approximately 0.44, which remains within normal limits and does not support inflammatory bowel disease or small-cell lymphoma.

The pancreas is within normal ultrasonographic limits, and there is no sonographic evidence of pancreatitis.

Mild bilateral medullary rim sign is present. Given the patient's recent dehydration and the absence of additional renal abnormalities, this finding is considered of uncertain clinical significance.

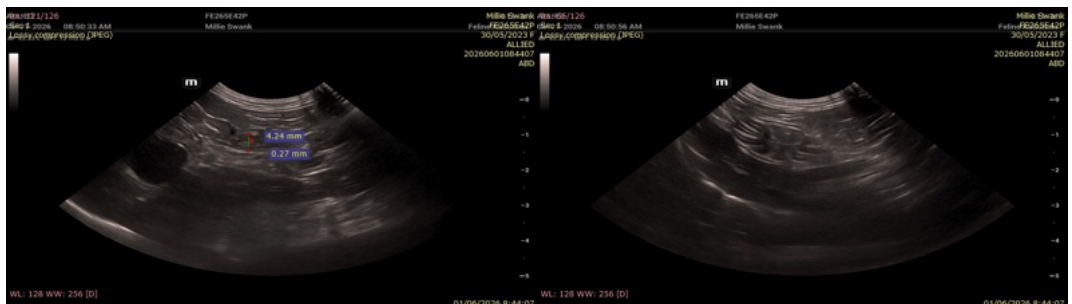
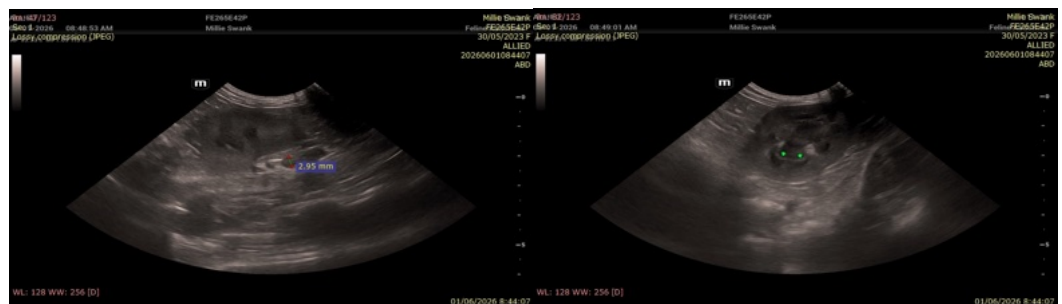
Moderate gallbladder distension is considered most likely secondary to the patient's recent anorexia. No sonographic evidence of biliary obstruction, cholecystitis, or extrahepatic biliary disease is identified.

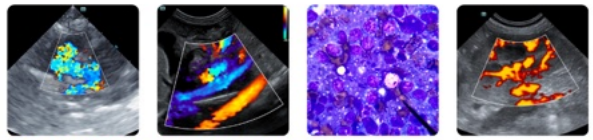
Overall, the examination supports a functional gastrointestinal process rather than a mechanical obstructive, infiltrative, pancreatic, or hepatobiliary disorder.

Recommendations

- Continue supportive care and monitor clinical status.
- Correlate with clinical response following rehydration and correction of electrolyte abnormalities.
- Given the history of chronic stomatitis, assessment of oral discomfort as a potential contributor to anorexia is recommended if not recently performed.

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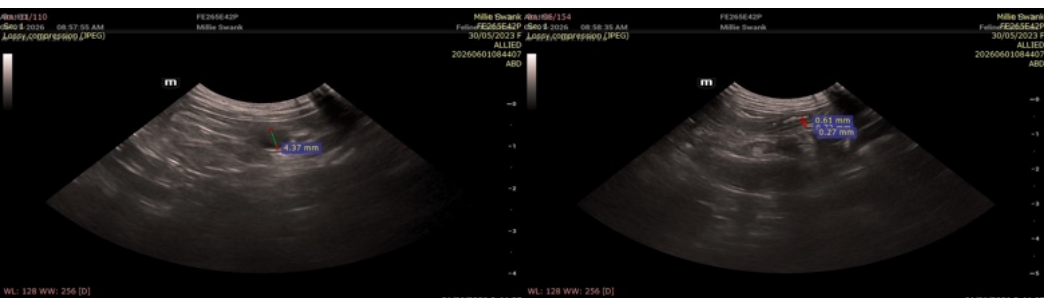
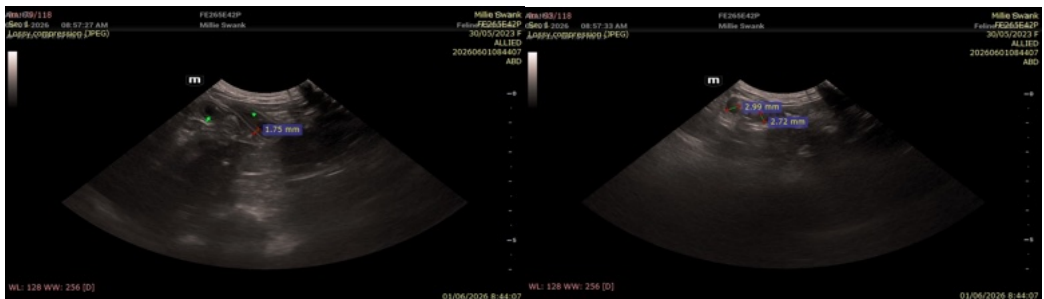
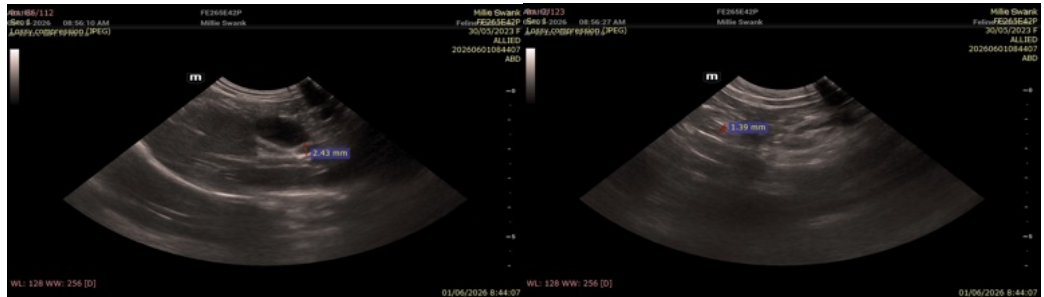
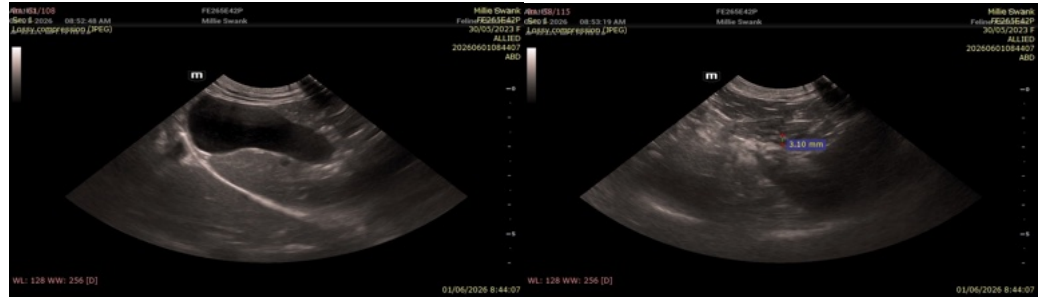
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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