



**PATIENT**

Kingston Samuels-  
Ellington

**SPECIES**

Rabbit

**BREED**

Holland Lop

**SEX**

Neutered male

**AGE**

4 years

**WEIGHT**

4.06 lbs

**INTERPRETED BY**

Dr. Alicia Angosto  
Guerrero

**IMAGING  
PERFORMED BY**

Yvonna Aranda

**HOSPITAL NAME**

Santa Clara AH

**REFERRING VET**

Dr. Giddens

**INVOICE**

68811

**DATE**

11/18/25

**PRESENTING CLINICAL SIGNS**

History: Clinical Exam Findings: Pet came in today for cryptorchid neuter (one external and one internal) - sx was uneventful. Under anesthesia the cranial abdomen felt extremely full and large doughy stomach. Pet took a really long time to recover and after speaking more with owner she did say that pet has been ingesting cardboard and may or may not have been eating less. (O swapped from timothy hay to timothy/orchard grass mix recently). Pet had buccal points on the upper teeth, and minor lingual points on the bottom teeth.

ABNORMAL Labwork Values n/a Current Medications no meds prior to today's sx Radiographic Findings Two view rads- lateral has huge GI (stomach?) of what looks like ingesta (r/o cardboard? Hairball?)

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The bladder lumen is moderately distended. The wall of the urinary bladder appears thin and smooth. The cloudy appearance of the urine is consistent with normal calcium excretion. The vesicourethral junction appears normal. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney has a normal shape and size, measuring 3.56 × 1.92 cm, with a cortical thickness of 0.27 cm in the sagittal plane. The cortex is isoechoic compared to normal liver parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary differentiation is preserved. The renal sinus appears hyperechoic, as expected in rabbits. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

The right kidney has a normal shape and size, measuring 3.41 × 1.57 cm, with a cortical thickness of 0.19 cm in the sagittal plane. The cortex is isoechoic compared to normal liver parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary differentiation is preserved. The renal sinus appears hyperechoic, as expected in rabbits. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

**Adrenal Glands**

The adrenal glands are not visualized.

**Spleen**

The spleen is not visualized.

**Liver**

The liver appears subjectively normal in size, structure, and contour. The parenchyma is uniform and hypoechoic compared to the spleen, with a mildly coarse echotexture. No hepatic lymphadenopathy is observed.



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The gallbladder lumen is moderately distended. The wall is thin, and the luminal content is primarily anechoic. The cystic duct and common bile duct are not dilated.

**Gastrointestinal**

The stomach is markedly distended with an impacted ingesta pattern (if a foreign body were present, it cannot be differentiated sonographically, though radiographs are more consistent with food material). The gastric wall is of normal thickness (body: 0.07 cm; pylorus: 0.20 cm) with preserved wall layering.

The small intestine has a normal mural thickness (0.05–0.06 cm) with intact wall layering. The small intestinal loops are markedly distended and fluid-filled. Peristalsis is present. One loop contains ingesta showing a mild back-and-forth (to-and-fro) motion, but this loop cannot be fully followed cranially, so it is not possible to determine whether a complete obstructive process exists. No definitive foreign body is identified sonographically. However, an heterogeneous soft-tissue-to-particulate mass (consistent with a partially obstructive ingesta-hair conglomerate) is observed between the small intestines and the cecum. It is not tightly impacted

The cecum shows a very thin, normal wall (0.01–0.02 cm) with normal contents. The sacculus rotundus and appendix were not visualized. The proximal colon (0.34 cm) contains ingesta. The distal colon has a normal mural thickness (0.14–0.22 cm) with formed feces and distal acoustic shadowing within the lumen.

**Pancreas**

The pancreas is not visualized.

**Peritoneal Cavity**

No abdominal effusion, peritonitis, or lymphadenomegaly is observed.

**ULTRASONOGRAPHIC FINDINGS**

- Significant gastric distension with a large volume of heterogeneous ingesta.
- Small intestine diffusely fluid-filled, but with preserved motility.
- Heterogeneous intraluminal material caudal to dilated small intestinal loops, composed of ingesta mixed with hair and probable cardboard; no discrete obstructive foreign body.



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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

There is marked gastric distension with a large volume of ingesta, and the small intestine is fluid-filled but exhibits preserved motility, arguing against a complete obstruction. However, immediately caudal to the dilated loops, there is a heterogeneous intraluminal material composed of ingesta possibly mixed with hair and small pieces of chewed cardboard.

This material does not produce a clean acoustic shadow, which helps differentiate it from a classic discrete obstructive foreign body (stone, metal, dense plastic). Instead, it forms a heterogeneous soft-tissue-to-particulate mass, consistent with a partially obstructive ingesta-hair conglomerate, or a transient obstruction that may resolve with hydration and motility support.

At this stage, it is not tightly impacted, and some peristalsis is visible, suggesting that passage is still possible. Whether it progresses or resolves depends on the patient's response in the next 12-24 hours.

Radiographs showed no definitive "break point," which supports a functional or partial obstruction rather than a complete mechanical obstruction.

Recommendations

- Aggressive fluid therapy (IV).
- Analgesia.
- Gastric decompression if severe discomfort—oro gastric tube can be lifesaving but only if the team is trained for that).
- Positive-contrast study (barium or iohexol) can be performed in rabbits (useful for partial obstruction vs. severe functional ileus).
- Repeat abdominal radiographs in 12-24 hours to evaluate movement of the intraluminal material, changes in gastric and intestinal dilation, or evidence of progression toward obstruction.
- Monitor fecal output closely; any fecal passage is encouraging.
- Recheck ultrasound if clinical signs worsen or if radiographs raise suspicion of progression.

Based on this single ultrasound assessment alone, I cannot not recommend sending the patient to surgery immediately. However, I do not have the patient in front of me and cannot assess their clinical status or duration of illness, so the decision should also be guided by physical examination findings, progression of clinical signs, and the veterinarian's overall assessment of the patient. In rabbits, surgery is indicated only in very specific situations because GI surgery carries significant morbidity and mortality. Most gastric impactions and ileus episodes are treated medically unless unmistakable evidence of mechanical obstruction is present. Surgery is indicated when:

- A true mechanical obstruction is confirmed.
- A discrete foreign body is identified that cannot be medically passed or dissolved.
- Clear radiographic break point (dilated bowel → collapsed bowel).
- No motility + progressive small intestinal dilation.
- The rabbit deteriorates despite 12-24 h of intensive medical therapy.



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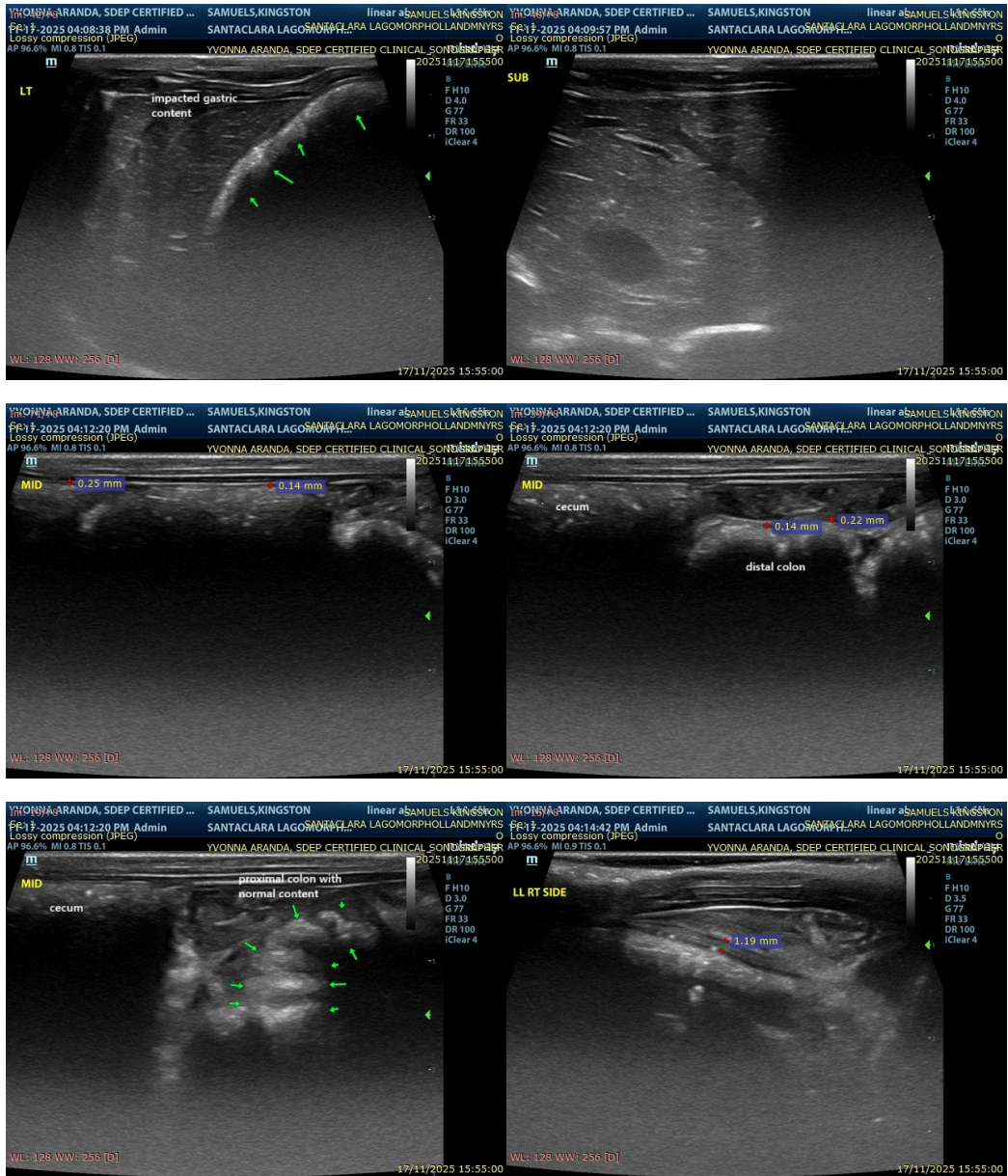
Dr. Giddens

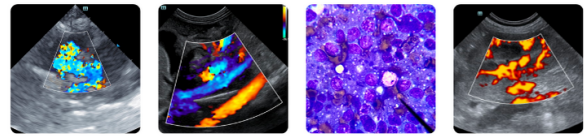
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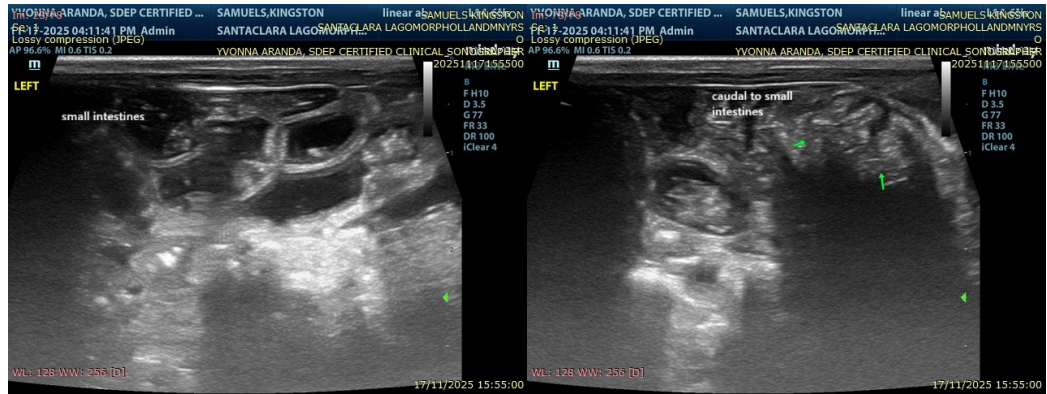
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

MV Esp Ultrasound in Domestic and Wild Animals

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