



## PATIENT

Gypsy Eden

## SPECIES

Feline

## BREED

DMH

## SEX

Spayed Female

## AGE

10 Years

## WEIGHT

4.1 kg

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Dr. Meghan Myers

## HOSPITAL NAME

Hershey Animal  
Emergency Center

## REFERRING VET

Dr. Cara Sinopoli

## INVOICE

71932

## DATE

11/19/25

## PRESENTING CLINICAL SIGNS

Presented 11/18 evening for owner finding laterally recumbent in a puddle of orange urine. EENT/oral: pale pink moist/hypersalivating mm, crt 2-3s; bilaterally sunken eyes with mild bilateral ocular discharge. H/L: Grade II/VI heart murmur, snappy, weak but synchronous pulses Abd: Markedly painful on cranial abdominal palpation. Musc: Generalized cachexia Integ: Mod. prolonged skin tent; significant flea dirt present with generalized crusting/papules present with significant concentration at tail head/caudal dorsum.

Abnormal PE/Chem/CBC/UA Results: Intake 11/18 PM: - CBC: inflammatory leukogram (neutrophilia 12.36, immature neutropillia 0.21, monocytosis (0.69)), stress leukogram (lymphopenia (0.81) - Chem: stress hyperglycemia (226), low creatinine (0.6), elevated TP (9.3), hyperglobulinemia (6.5), ALP <10), elevated - EPOC: hyperlactatemia (3.34) - FIV/FELV/FIV: negative - fPL: WNL - BP: 100 (doppler) - Radiographs: Mild diffuse bronchial pattern, Mild colonic dilatation GB stones present. - U/A: USG 1.050, pH 6.5, UP 500, Bili 3, Urobili 8, WBC 2/hpf, RBC 12/hpf (H) - Recheck xray: severe gastric distention, with mineralization/gravel sign in stomach, gallbladder stones, possible area of free gas between stomach and liver, improved gas in intestines - PCV/TS: 28%/7.4 - EPOC: Na 142 L, K 3 L, Cl 109 L - USG: >1.050

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a large amount of echogenic non-shadowing debris, most consistent with exfoliated cells, crystals, mucous and/or small blood clots likely combined with incidental suspended lipid. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of mineral or infarcts observed. Left kidney measures 3.9 cm. Right kidney measures 4.1 cm. Trace pyelectasia is present bilaterally.

### Adrenal Glands

The area of the right adrenal gland is examined without evident adrenal gland pathology but is difficult to fully visualize/isolate for measurement.

The left adrenal gland is normal in size (0.41 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

### Spleen

Spleen is subjectively large in size (1.2 cm thick) with normal smooth margins. Parenchyma is normal in echogenicity with a diffusely coarse/heterogenous echotexture. No discrete sizable focal nodules or masses are observed. Splenic vasculature appears normal.



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## Liver

Liver is subjectively enlarged (swollen contour) with a diffusely mildly coarse architecture and subtly increased portal markings. Mildly mixed echogenic changes are noted diffusely. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. Several non-shadowing, non-visibly obstructive mineral densities are noted within the lumen. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

## Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is moderately to markedly overdistended with fluid and some very echogenic reverberation artifact from intraluminal gas. There is no definitively visible foreign material or infiltrative disease. However, complete visualization of the far wall is partially inhibited by gas, and foreign material can't be definitively ruled out. Having said that, the pyloric outflow tract is well visualized and appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

## Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

## Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

## PRIMARY FINDINGS

- As described above, gastric distention secondary to non-visible gastric foreign material can't be definitively ruled out, but there is no visible evidence of foreign material in these images at this time. Therefore, other causes of gastric distention/ileus should be considered.
- Coarse splenomegaly – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- The liver changes are non-specific but could represent a concurrent microscopic hepatopathy such as bacterial or lymphoplasmacytic cholangiohepatitis, hepatic lipidosis, and/or even infiltrative neoplasia can't be ruled out without tissue sampling.



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- The biliary mineral should be interpreted in combination with clinical signs, laboratory changes, etc., as an incidental finding is possible.

**SECONDARY FINDINGS**

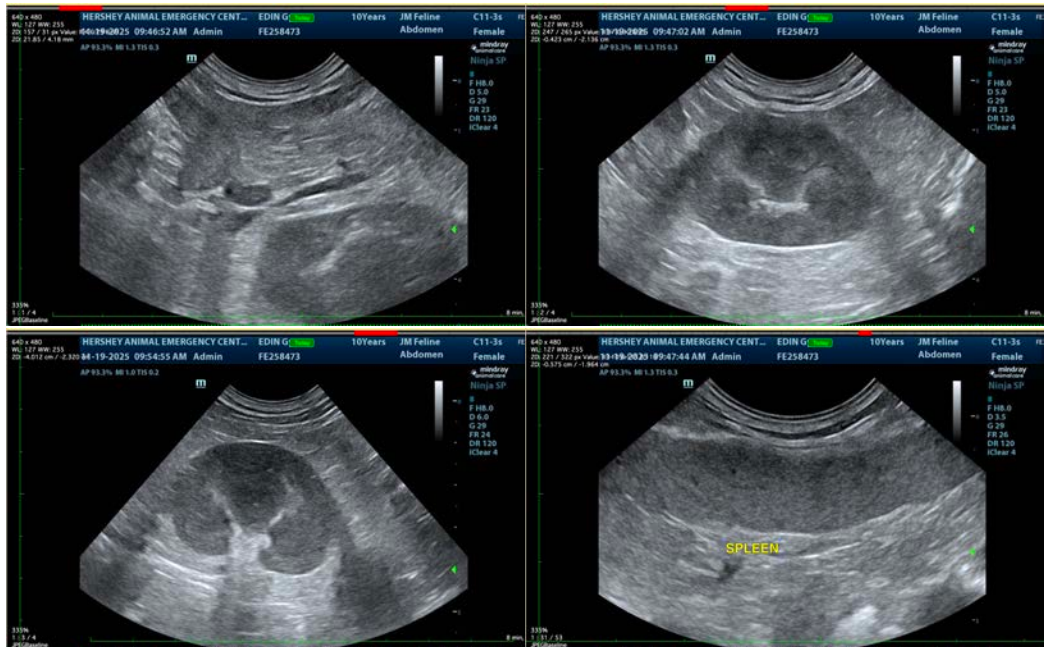
- Age related kidney changes.
- A very large amount of echogenic urinary bladder debris.

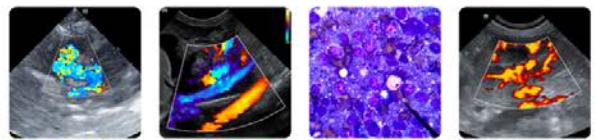
**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Fine needle aspirates of the spleen and liver could be considered if patient's coagulation status is appropriate.

In the meantime, in addition to supportive/symptomatic medical management of clinical signs, placement of a nasogastric tube could be considered to alleviate the gastric distention, which may offer some therapeutic patient relief, as well as offer better imaging of the stomach for diagnostic purposes. Additionally, alternative imaging such as contrast radiography of the stomach could be considered.

Ultimately, however, if clinical signs persist and a diagnosis is not obtained, especially if there is any concern at all for free gas in the abdomen as imaging is monitored, an exploratory laparotomy may be warranted.





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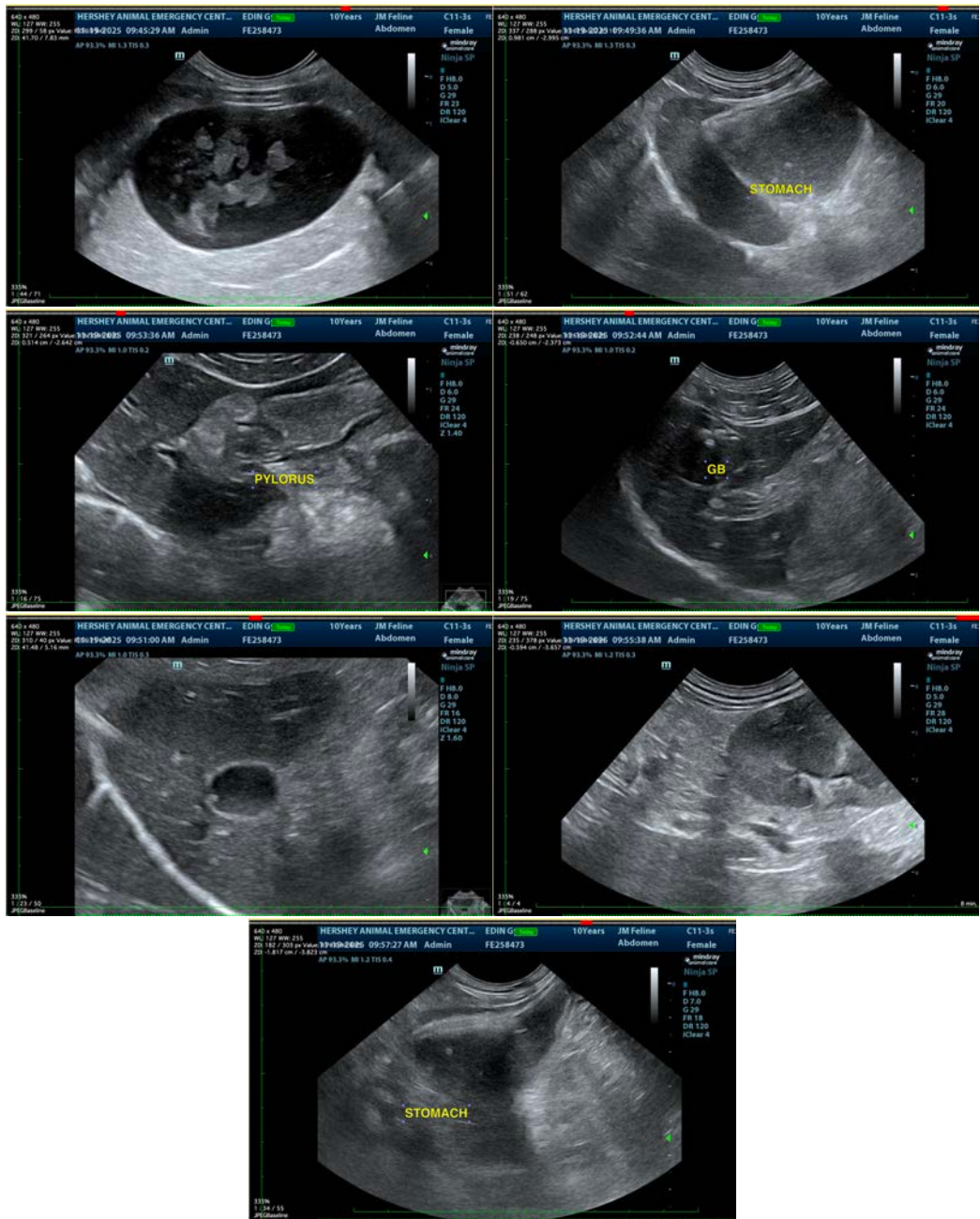
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**Beth Johnson, DVM, DACVIM** info@sonopath.com