



## PATIENT

Millie Cardoso

## SPECIES

Feline

## BREED

Egyptian Mau

## SEX

Spayed Female

## AGE

3 Years 7 Months

## WEIGHT

4.32 kg

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Dr. Mariusz  
Chmielinski DVM

## HOSPITAL NAME

Apex Veterinary  
Services LTD

## REFERRING VET

Alpine 24/7 ER Doctor

## INVOICE

12687

## DATE

12/15/25

## PRESENTING CLINICAL SIGNS

Acute onset vomiting beginning December 14, 2025, with concern for possible foreign body ingestion given prior history. Long-standing history of intermittent post-prandial regurgitation since kittenhood (q6–8 weeks), less frequent recently.

Abnormal PE/Chem/CBC/UA Results: PE -Weight: 4.32 kilograms Temp: 40.4 HR: 200/bpm Respiratory Rate: 24 Mucous Membranes: pink CRT: unable BP: unable General Appearance/Attitude: BAR - CAUTION Abdominal radiographs: Small amount of gastric fluid, no clear obstruction or radiopaque foreign body; heterogeneous mid-abdominal opacity (likely digesta vs SI content) Gastrointestinal: Uncomfortable on palpation - limited palpation given behavior CBC: WC 19.18, Lymph 9.5, Mono 0.77, Eos 0.16, Plt 27 (clumped), Chem: BUN 4.1, TP 95, Glob 62, ALT 133, ALP <10, Tbili 18, Amyl 355

## 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.

Left kidney is normal in size (3.6 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Right kidney is normal in size (4.4 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

### Adrenal Glands

Left adrenal gland is normal in size (0.43 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.33 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

### Spleen

Spleen is subjectively large in size 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. The spleen measures just at upper ends of normal limits and size measuring 1.0 cm thick.

### Liver

Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and



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homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

### **Gastrointestinal**

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal chyme. There is no evidence of obstruction, foreign material, or infiltrative disease. Pyloric outflow tract appears patent. In some views, there is a very subtle mildly heterogenous echogenic density measuring 0.40 cm x 0.60 cm in size near the area of/within the pylorus, however, this may be a normal gastric fold, normal anatomy, normal patient variant versus a pathologic tissue.

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 very mildly thick just above the upper ends of normal limits for thickness measuring 0.22 cm thick in the descending portions with normal intact layering. The remaining colon is normal in thickness and layering with an empty lumen.

### **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**

Mesenteric and colic lymphadenopathy are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail. Very subtly enhanced hyperechoic fat in the area of the ileocecolic junction.

### **ULTRASONOGRAPHIC FINDINGS**

- Moderate to large amount of echogenic urinary bladder debris.
- Mildly 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.
- Very subtle/mild pyloric changes, very mild descending colon thickening, fat in the area of the ileocecolic junction and very mild lymphadenopathy could indicate some early or emerging inflammatory gastrointestinal disease that trends in appearance toward benign. Infiltrative neoplasia is possible but considered less likely. Similarly, given the very mild/subtle nature of the changes, normal patient variant cannot be ruled out.

### **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**



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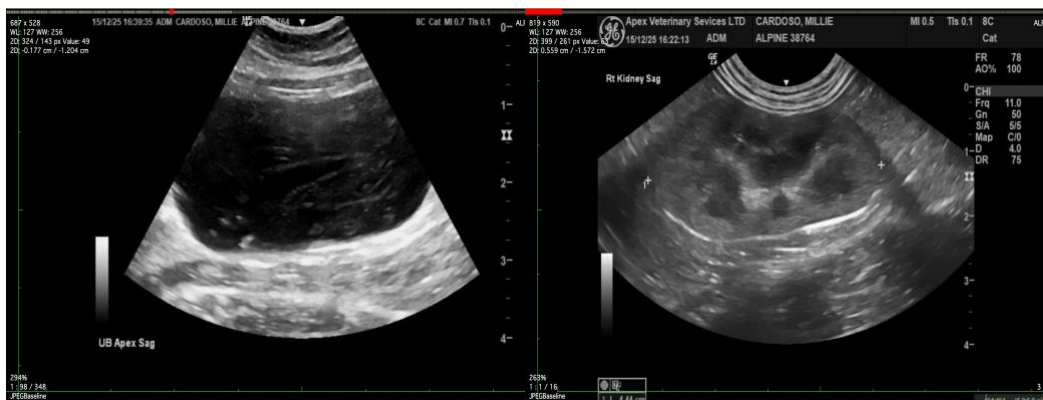
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- If not recently evaluated, urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.
- Fine needle aspirates of the spleen could be considered if patient's coagulation status is appropriate.
- A routine fecal/giardia exam is recommended if not recently evaluated.
- A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.
- +/- A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.
- Given geographical differences in lab work reporting, providing units for the lab work abnormalities or a high, low, or normal indication, reference ranges and/or attaching actual lab work results is helpful for lab work to be considered in further recommendations.
- Ultimately, given patient's clinical history, pending results of above, upper GI gastroscopy/endoscopy as well as colonoscopy could be considered for further evaluation of the pylorus as well as sampling of the stomach, proximal small bowel and colon being sure to include ileum if possible.
- Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.





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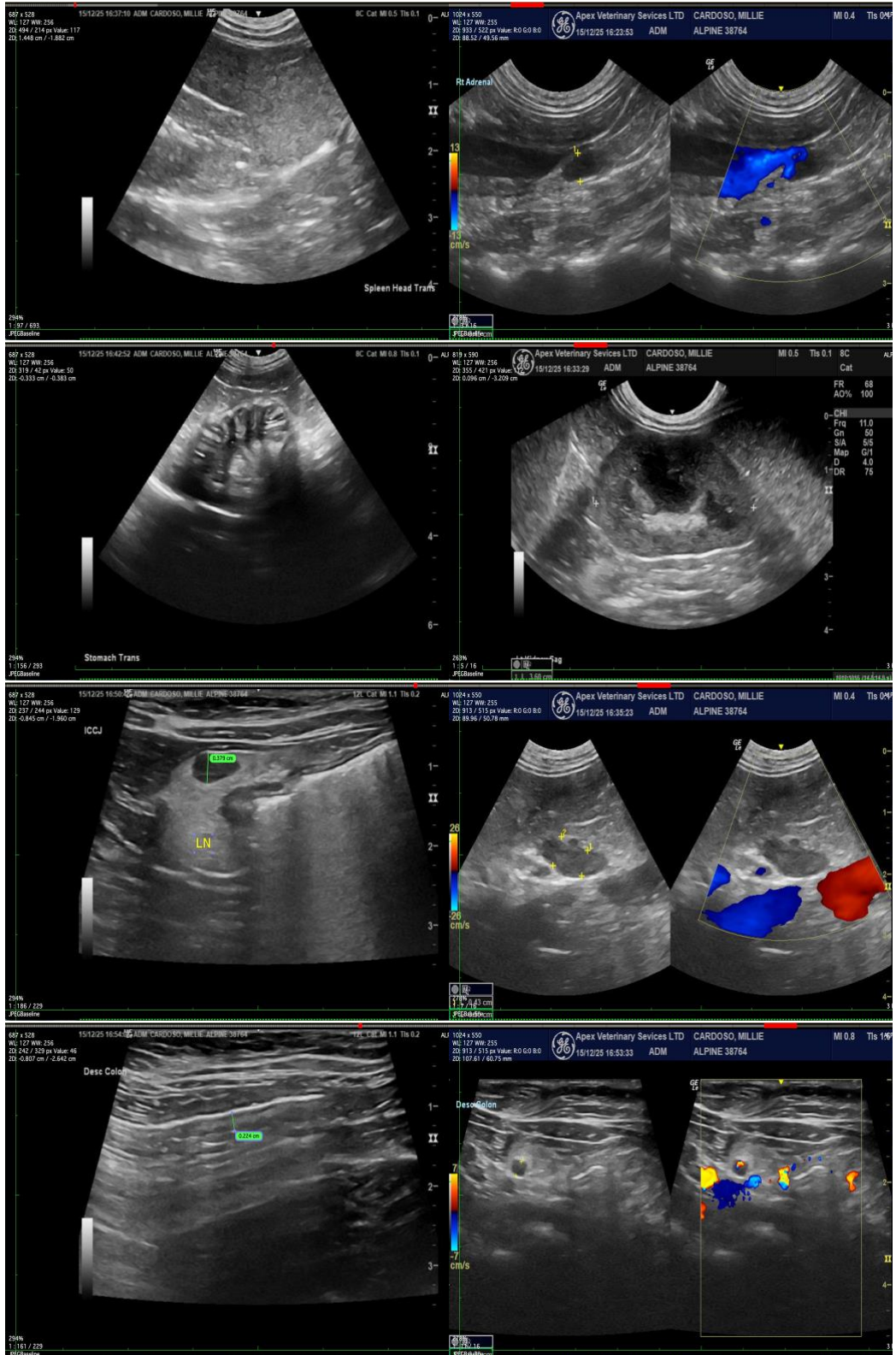
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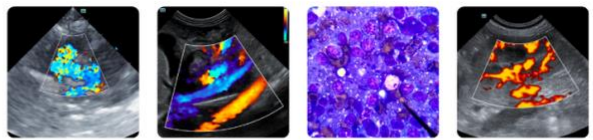
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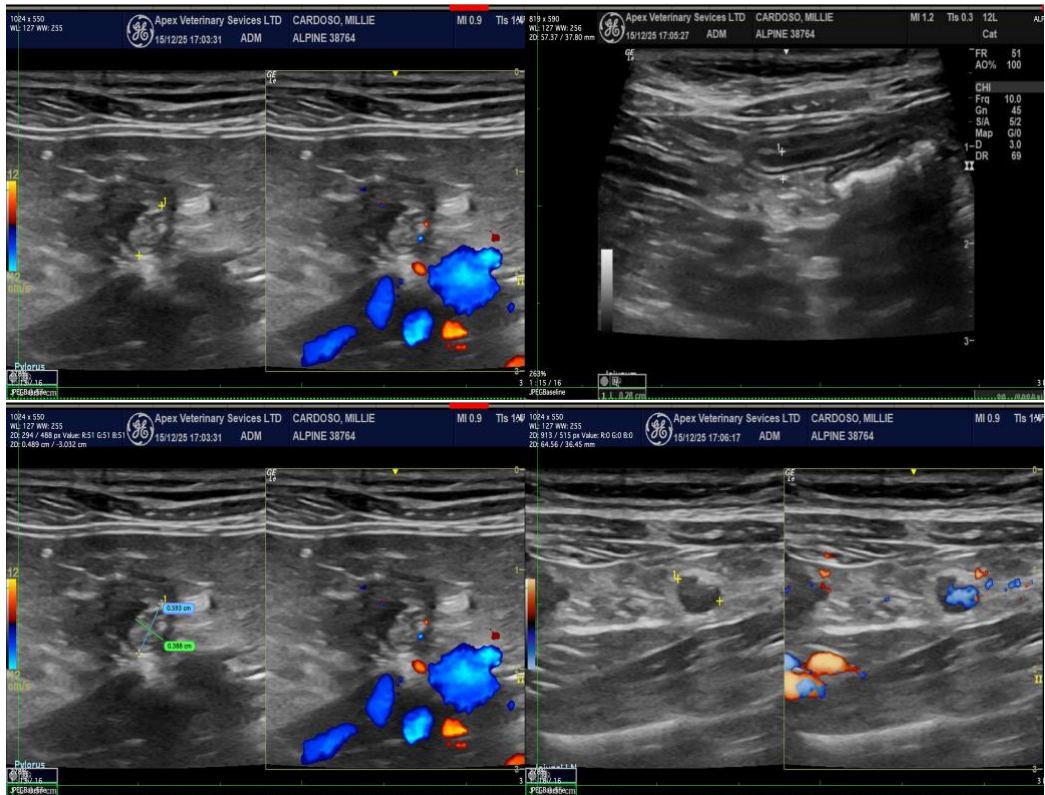
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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**

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