



PATIENT

Rhys Jimenez

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

3 years

WEIGHT

7.1 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Alexandra Pasaturo

HOSPITAL NAME

Greater Staten Island
Veterinary Services

REFERRING VET

Dr. Alexandra Pasaturo

INVOICE

10937

DATE

12/16/2025

PRESENTING CLINICAL SIGNS

Rhys presented to GSIVS as referral for AUS. On Wednesday before Thanksgiving Rhys ingested a toy. Owner went to rDVM that night where they attempted to induce vomiting but was unsuccessful. Rhys was fine up until this past Wednesday when he started to sneeze and have ocular discharge. Saturday Rhys started vomiting and stopped eating that night. In the vomit was a large piece of toy ingested around Thanksgiving. Owner went to primary vet on Sunday 12/14 where abdominal and skull xrays were performed (linked). Rhys was treated with SQ fluids, cerenia, pepcid, forti-flora, and carafate. Rhys still has not eaten since visit. Owner did syringe feed yesterday, but not today. Slightly lethargic. No further vomiting. URI signs improved. Urinating and defecating normally. Indoor only. UTD on vaccines. Hx of allergies and crystalluria. Fed Royal Canin SO. CM: hydroxyzine. Presented for further eval.

Abnormal PE/Chem/CBC/UA Results: Febrile 103.7 (anxious/nervous r/o true fever vs infectious/inflammatory) Mild to moderate dehydration CBC/chem: wbc 17.61 (2.87-17.02), neu 15.10 (2.30-10.29), plt 61 (151-600). pct 0.09 (0.17-0.86), glu 166 (74-159), k 3.2 (3.5-5.8) Abdominal xray 12/14 rDVM: non-specific hepatomegaly, gastric material r/o remaining FM vs ingesta, other.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal is size (3.7 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.

The left kidney is slightly small in size (2.9 cm), shape and echogenicity. While the kidney measures slightly small, it's only visible in a partially transverse view therefore I believe that's an artificially small measurement in a normal kidney. 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

The areas of the adrenal glands are examined without evident adrenal gland pathology.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

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



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The 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.

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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen 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.

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The visible small intestine demonstrates areas of mildly emerging thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

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

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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.

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Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

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ULTRASONOGRAPHIC FINDINGS

- Mild/emerging inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.
- There is no definitive ultrasonographically visible evidence of an obstructive pattern, shadowing, foreign material, etc. present in these images at this time.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Patient's continued inappetence may be resolving gastritis/gastroenteritis from the recent dietary indiscretion, chronic foreign body, etc., that has reportedly and I believe fully visibly resolved with no remaining evidence of foreign material present. Having said that, unrelated early or emerging gastrointestinal disease can't be ruled out.

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Therefore, if continued, supportive/symptomatic medical management of clinical signs does not result in continued improvement/resolution, additional workup of the GI tract may be warranted. Beginning with 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, and ultimately, potentially including biopsies of the GI tract including ileum, if possible.



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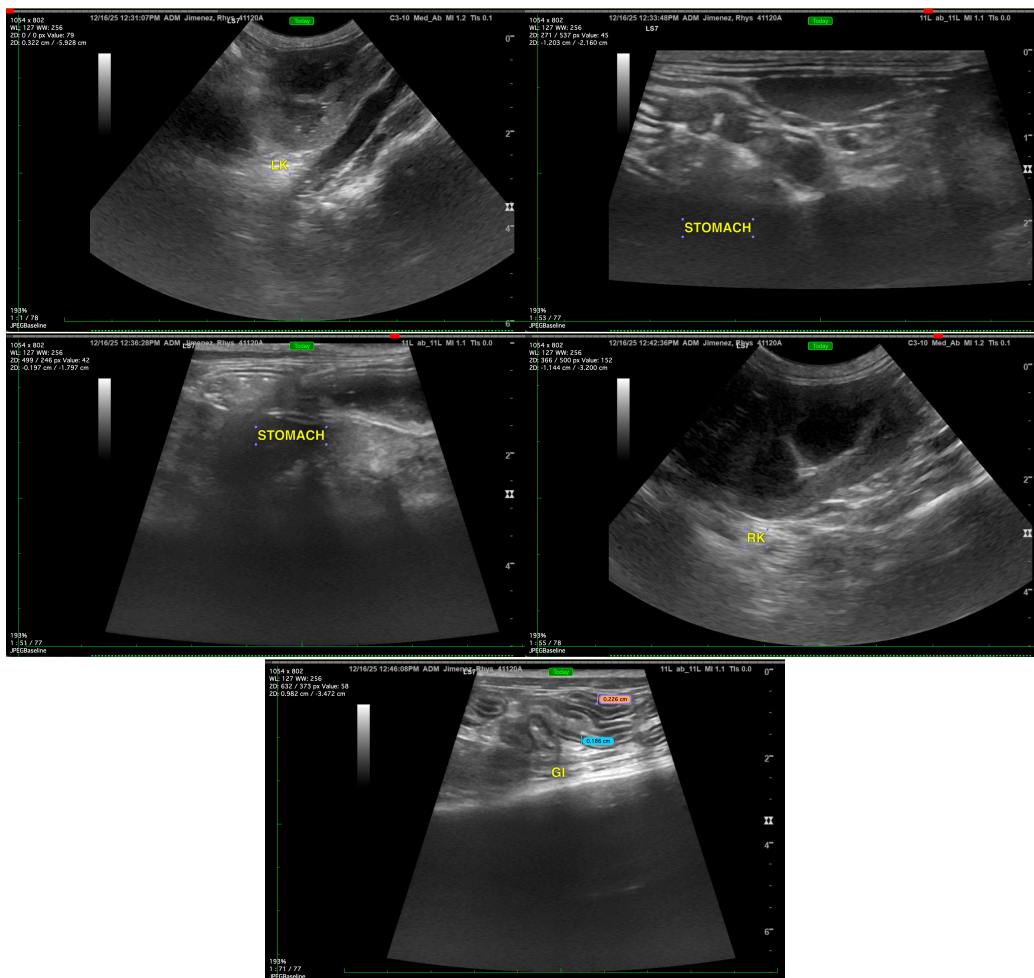
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In the meantime, if vomiting continues or returns, re-check imaging or additional imaging such as contrast radiography, gastroscopy, etc., could be considered.



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