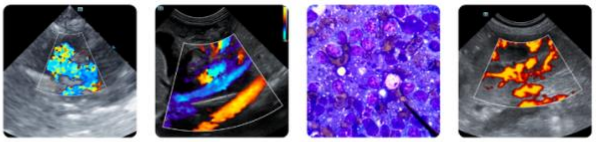


PATIENT

Satin Stahl

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

2.5 Years

WEIGHT

2.85 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary Emergency Center

REFERRING VET

Dr. Logan Law

INVOICE

13964

DATE

02/25/26

PRESENTING CLINICAL SIGNS

- Was found outside in 2023 under owners shed as kitten. 2/9 was seen at rdvm for hyporexia for a few weeks. at that time owner was syringe feeding P. P was having mucous in stools (diarrhea) with strong odor, and straining noted. P was seen at rdvm and diagnostics done. 2/11 P started on azithromycin for 10 days . 2/18 P continuing to have anorexia/hyporexia and not defecating. 2/19 continued mucous abnormal stools. Owner has been syringe feeding P an rx recovery veterinary can diet. Dh with mucous, anorexia, cryptosporidium felis (diagnosed 2/10).
- concern for Febrile, hyperglobulinemia - FIP, Mycoplasma; Anemia - chronic disease, other

PE: Temp 104.1; BCS 4/9 muscle wasting, cachexia; MM pale pk; soft on abd palp, doughy abd; unthrifty/unkempt coat rdvm GI PCR: cryptosporidium felis detected u/a: usg 1.055, pH 6.5, protein 2+, bili 1+, wbc 0-1/hpf, rbc 2-3/hpf, c. oxalate 11-20/hpf, epithelial 0-1/hpf cbc: wbc 16.0, neut 79% H, lymph 18% L, eos 1% L, neu 12,640 H T4: 1.4 chem: TP 8.7 H, alb 2.9, glob 5.8 H, BUN 13 L, Mg 1.4 L felv/fiv/hw: neg X3 rdvm rads: opacity noted in middle left abd; does not appear to be in the gi tract 2/25 Shores: CBC: wbc 20.00 H, NEU 19.34 H, LYM 0.50 L, EOS 0.00 L, hct 23.0% L, HGB 7.9 L, RBC 6.13 L chem: BUN 12.2 L, Creat 0.4 L, TP 8.1 H, Glob 5.8, Alb:Glob 0.38 L rads (review of rdvm images): suspected bates body mid abd; abnormal SI loops cranial to urinary bladder. loss of serosal detail

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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.

Left kidney is normal in size (3.74 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 (3.71 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

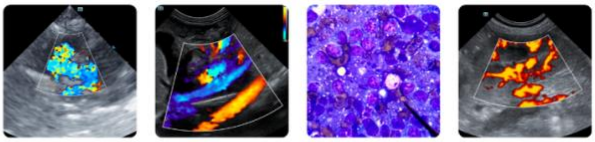
The adrenal glands are unable to be well visualized in these images.

Spleen

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

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



PATIENT

Satin Stahl

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

2.5 Years

WEIGHT

2.85 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary Emergency Center

REFERRING VET

Dr. Logan Law

INVOICE

13964

DATE

02/25/26

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 empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract 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.

In the mid abdomen, there's a loop of bowel that I believe is small bowel that demonstrates a thick hypoechoic wall for approximately 2.1 cm in length with the wall measuring 1.1 cm thick. Loss of layering is noted in this area. Hard shadowing echogenic intraluminal contents are noted in this area and free fluid and enhanced hyperechoic mesenteric fat are noted adjacent to this area.

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 trace free fluid and enhanced hyperechoic fat in the mid abdomen as described above.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- The changes in the small bowel are concerning for a foreign object potentially an obstructive foreign body, although there is no obstructive pattern in the other bowel to indicate a full chronic obstruction. Therefore, a partial obstruction, early obstruction or the result of absolute anorexia may all be possibilities The thick wall in the area could be the primary problem with differentials including both benign and malignant infiltrative disease, resulting in dysfunctional bowel that resulted in the obstruction or the wall changes could be a secondary inflammatory process due to a chronic obstruction, although again, the lack of an obstructive pattern points away from a chronic full obstruction.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

When patient is stable enough to undergo surgery, an exploratory laparotomy for further evaluation of the area described above and likely removal via resection and anastomosis is recommended. Submission of the removed bowel for Histopath to help identify the underlying wall pathology is

PATIENT

Satin Stahl

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

2.5 Years

WEIGHT

2.85 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary Emergency Center

REFERRING VET

Dr. Logan Law

INVOICE

13964

DATE

02/25/26

recommended.

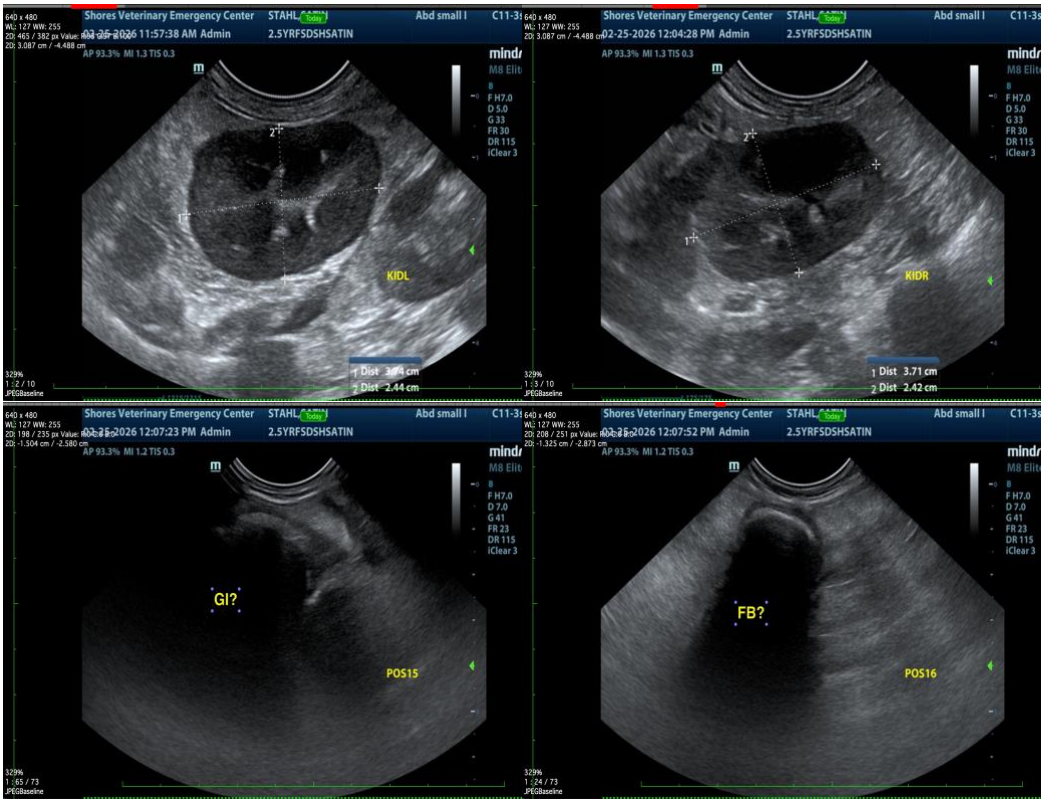
In the meantime, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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.

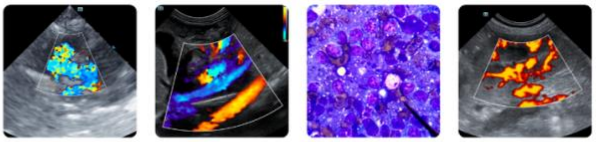
Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Dr. Johnson would very much appreciate any available follow-up on this patient.

Beth.johnson@sonopath.com



SonoPath
FOSTERING THE ART OF VETERINARY MEDICINE™



Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com | info@sonopath.com | 1.800.838.4268

PATIENT

Satin Stahl

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

2.5 Years

WEIGHT

2.85 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary Emergency Center

REFERRING VET

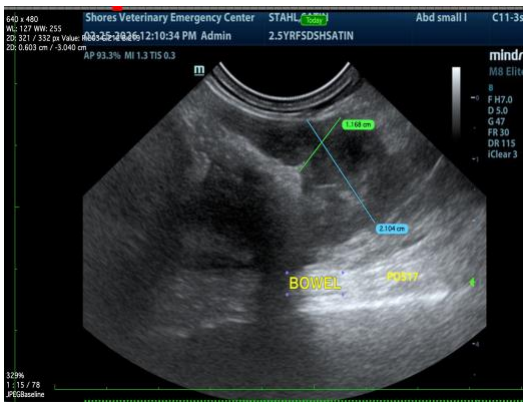
Dr. Logan Law

INVOICE

13964

DATE

02/25/26



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