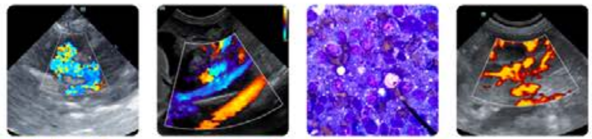


PATIENT
Lucias Hernandez

SPECIES
Feline

BREED
Sphinx

SEX
Neutered Male

AGE
1 Year

WEIGHT
7.92 lbs

INTERPRETED BY
Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY
Dr. Gabriella Iannuzzi

HOSPITAL NAME
Greater Staten Island Veterinary Service

REFERRING VET
Dr. Gabriella Iannuzzi

INVOICE
75282

DATE
5/20/26

PRESENTING CLINICAL SIGNS

Anorexic this morning which is very much not like him - last meal 6 pm yesterday. Defecated 3 small fecal balls with mucus today and vomit found in home this morning. O unsure if Lucias vomited or house mate. Unsure when last urinated but U noted in box last night. 1 other cat in home. No c/s/d. E/dr/u/def normally yesterday. Indoor only. UTD on vaccinations. No HW/F/T prevention. Likes to eat things he shouldn't. Other cat ate cupcake wrapper yesterday and O thinks Lucias may have eaten the wrapper form the other cats vomit. Historical HM

Abnormal PE/Chem/CBC/UA Results: AXR: pockets of gas within intestines, subjective bunching of SI
PE: 3/6 HM, SNP abdomen, no string under tongue

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 (4.1 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 normal is size (3.8 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

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.

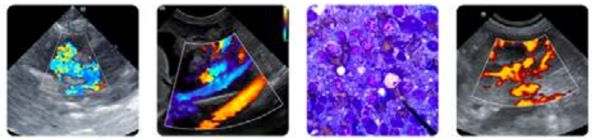
Liver

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.

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. *This is an incidentally bilobed gallbladder, which is an incidental normal anatomic variant.

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



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normal chyme. There is 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). In some views there is a very subtle short area of small bowel that appears within another bowel loop, consistent with an intussusception. An intermittent or sliding intussusception can't be ruled out. The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The colon is mildly to moderately thick, measuring 0.44 cm thick with normal intact layering. The lumen is empty.

Pancreas

The observed pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Pancreatic duct dilation is noted. Enhanced hyperechoic ill-defined surrounding fat is noted.

Free Abdomen

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

Mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

ULTRASONOGRAPHIC FINDINGS

- Suspect small bowel intussusception – An intermittent or sliding intussusception can't be ruled out. There is no definitively visible foreign material, shadowing, etc. present, but non-shadowing or subtle partially obstructive or early obstruction from foreign material can't be definitively ruled out.
- The mildly thick colon trends in appearance toward benign as is seen with parasitic, infectious, or other benign inflammatory disease, with infiltrative neoplasia being considered much less likely.
- Moderately reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Concurrent mild or emerging acute pancreatitis can't be ruled out.

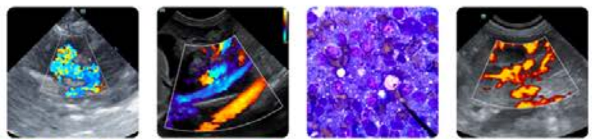
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a general metabolic health screen (CBC, chemistry panel with electrolytes and urinalysis) is recommended.

A routine fecal/giardia exam could be considered 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.



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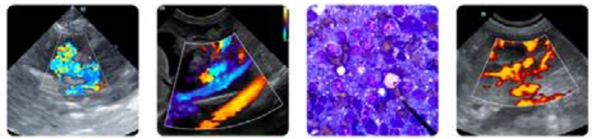
Those recommendations are due to the mildly thick colon and to rule out emerging or underlying parasitic, infectious, or other bowel disease, as well as further investigation of the possible low-grade smoldering pancreatitis. Recommendations for the suspected intussusception, however, are as soon as patient is stable enough for further, an exploratory laparotomy for further evaluation and correction of intussusception, any concurrent foreign material found, sampling of abnormal appearing bowel, etc.



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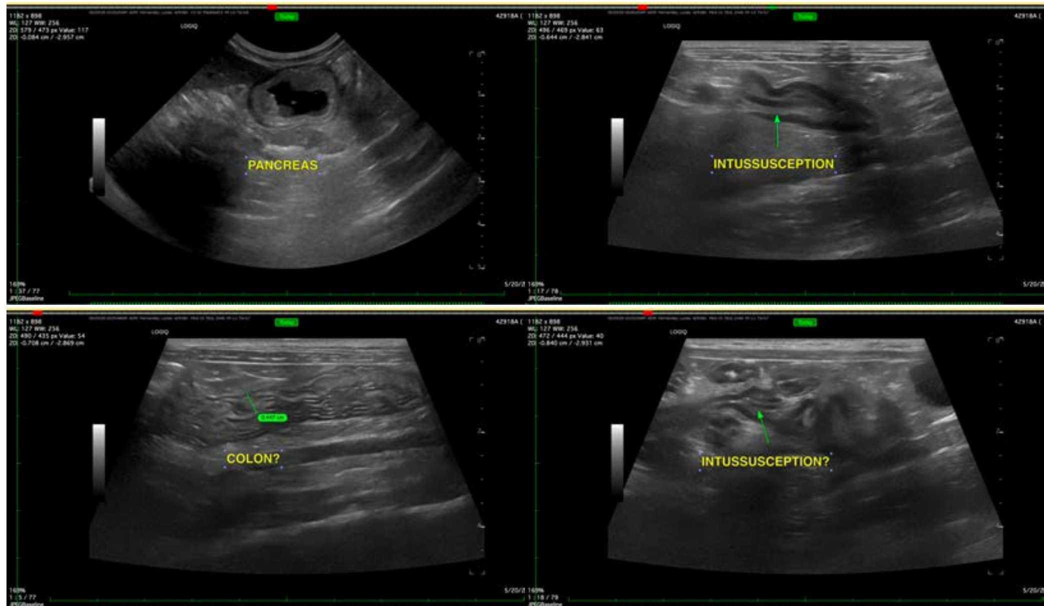

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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