

PATIENT

Elmo Canisius

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

8 years

WEIGHT

6.7 kg

INTERPRETED BY

Eric Lindquist, DMV,
 DABVP, Cert. IVUSS,
 CEO of SonoPath.com

PRESENTING CLINICAL SIGNS

History: Patient presented to the emergency service on 23/05/2026 for acute lethargy, panting, and inappetence. He was discharged with supportive care (SQ fluids, maropitant, gabapentin). Patient re-presented on 24/05/2026 for no improvement. The owner reported he ate a small amount after discharge yesterday but then became more lethargic, weak in the hind end, was hiding, and vocalizing. The owner is a pediatrician and noted he seemed to have abdominal pain. During my phone update on 24/05/2026, the owner recalled that the patient had been chewing on doll veil/mesh material a couple of weeks prior.

Persistent hyperthermia (40.2°C rectally before opioids, 40.6°C after).

Abdominal pain and tension.

Suspected intestinal obstruction (mechanical vs. functional)

Anorexia, lethargy, and weakness

Current Medications

Plasmalyte at 10 mL/hr IV. Methadone 0.2 mg/kg IV q 4-6 hours as needed for pain. Maropitant 1 mg/kg IV q 24 hours. Ampicillin 22 mg/kg IV q 8 hours (started 24/05/2026 due to persistent fever). Urine and blood samples are collected prior to ABX. NPO. Nasogastric tube placed for gastric decompression/aspiration.

Abnormal PE/Chem/CBC/UA Results: BW(23/05/2026): Mild stress leukogram (neutrophilia $11.70 \times 10^9/L$), mild hyperglycemia (11.40 mmol/L), and hyperglobulinemia (60 g/L). Pancreatic lipase WNL. fBNP abnormal. FeLV/FIV/HW SNAP neg UA(23/05/2026): USG >1.050, trace blood and protein. No bacteria or crystals. POCUS (23/05/2026): No B-lines or free abd fluid Recheck POCUS (24/05/2026): Showed delayed gastric emptying, abnormal acoustic shadowing. Tick found 24/05/2026. Pre-antibiotic samples being held
Primary Question to Be Answered: 1-obstruction (e.g., linear foreign body) 2- Functional ileus secondary to pancreatitis, gastroenteritis, cholangitis 3- Infectious (e.g., tick-borne disease, other systemic infection) 4- Cardiac disease (e.g., HCM) given abnormal fBNP 5- Neoplastic (e.g. GI Lymphoma) 6-IBD 7- MSK disease

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal.

The **kidneys** revealed mildly thickened cortices, non-specific with hyperechoic medullary rim sign and mild enlargement. The right kidney measured 5.02 cm. The left kidney measured 5.22 cm.

Adrenal Glands

Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The right adrenal gland measured 0.4 cm. The left adrenal gland measured 0.4 cm.

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Hamilton Region
 Emergency VC

REFERRING VET

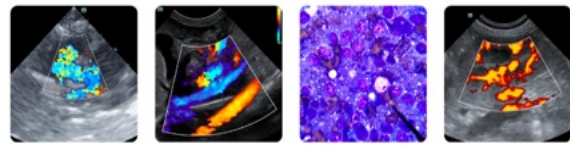
Dr. Yaseen

INVOICE

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Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes was noted.

Liver

The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

Gastrointestinal

The **stomach** in this patient presented mild hairball type density that was non-obstructive. Gastroenteritis pattern was noted throughout the GI tract with minor small intestinal dilation followed by empty small intestine. Reactive mesentery was noted around the small intestine. No overt foreign matter, yet I cannot rule out the potential. Minor reactive mesenteric lymph nodes were noted.

Pancreas

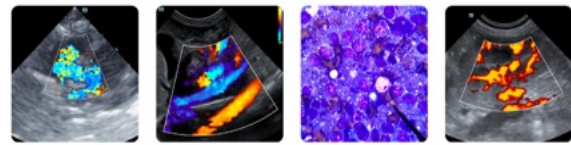
The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

ULTRASONOGRAPHIC FINDINGS

- Gastroenteritis pattern with reactive mesenteric lymph nodes.
- Medullary rim kidneys.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

I recommend medical management in this patient with aggressive IV fluid support and treatment for enterotoxins. Ultrasound-guided FNA of the renal cortex could be considered to assess for granulomatous disease. Medullary rim sign in the kidney can be related to FIP as can the GI presentation. If the partial intestinal dilation pattern is persistently present after 24-36 hours and the patient is not improving, then exploratory surgery would be appropriate as the minor intestinal dilation may be owing adhesions, reactive mesentery, local dysfunctional bowel or non-visible foreign matter. This may be a temporary dilation and partial obstructive pattern. However, if medical management is



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not functioning then surgical approach would be necessary with the objective of obtaining GI biopsies, inspection of the stomach for minor luminal material and any cause of distal small intestinal dilation as well as obtaining renal, GI and lymph node biopsies.

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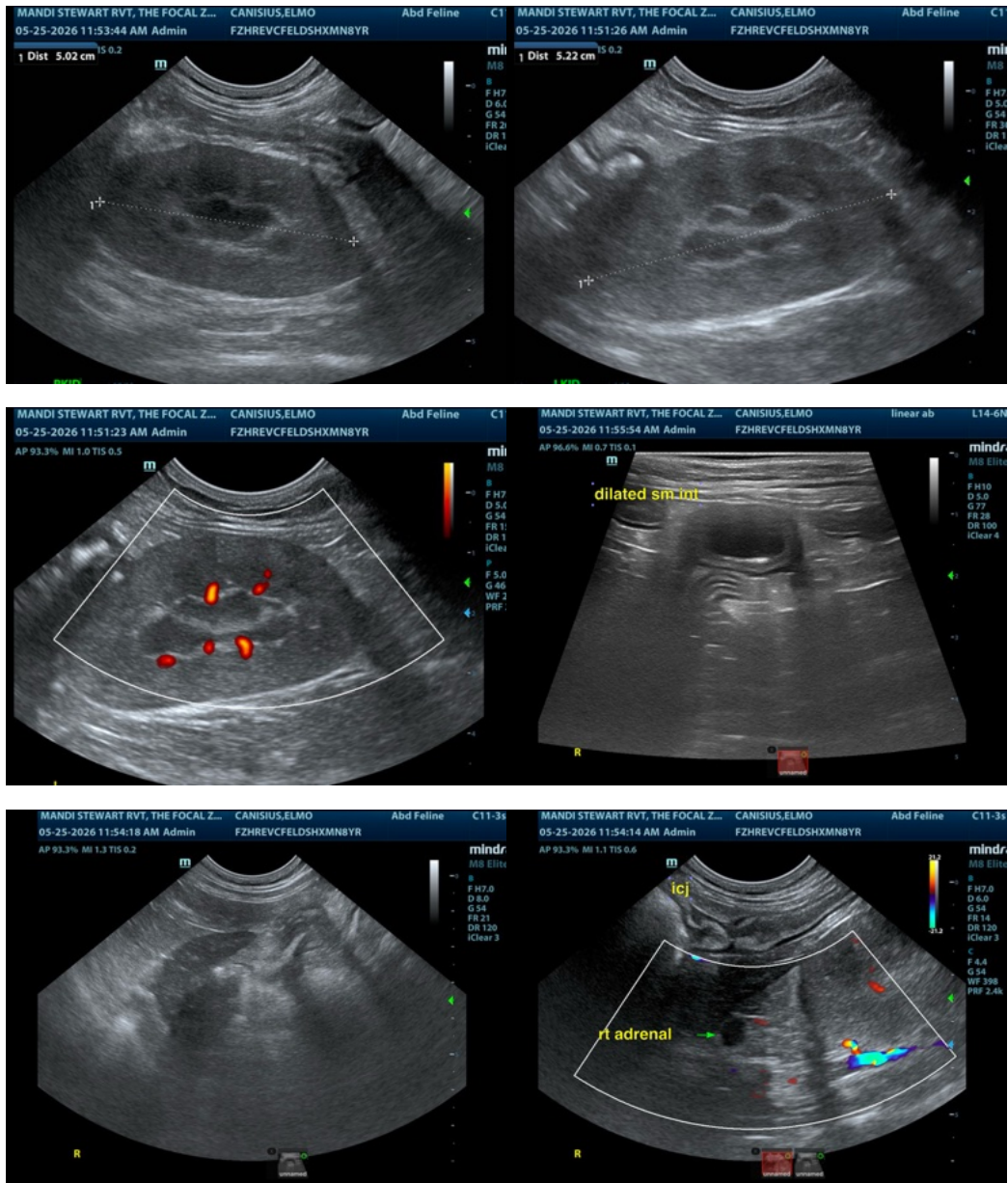
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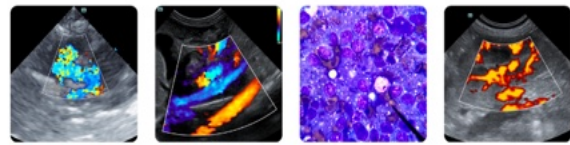
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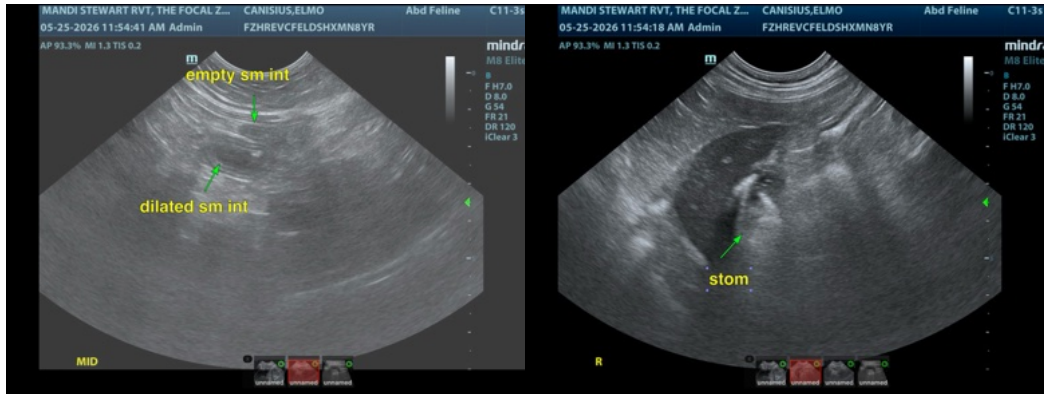
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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