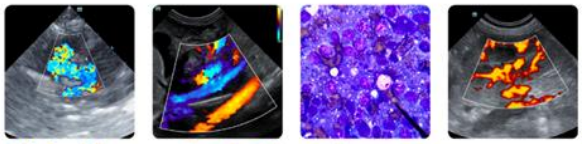


PATIENT

Sugar Saleh

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

7mo

WEIGHT

3.2kg

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Dr. Jill Rankin

HOSPITAL NAME

Seton Vet Clinic

REFERRING VET

Dr. Steven Dillon DVM, MVB

INVOICE
23690

DATE
01/27/2026

PRESENTING CLINICAL SIGNS

- The patient is a cat presenting with a 48-hour history of vomiting, inappetence, and lack of urination, with an unconfirmed suspicion of foreign body ingestion.
- The cat was hospitalized on the previous day and placed on fluids due to persistent vomiting for almost 48 hours, accompanied by inappetence, and a lack of water intake or urination. The owner initially reported a possibly missing string but later could not confirm any foreign body ingestion. Blood work performed at that time was generally unremarkable, with a normal FPL, normal potassium, a hematocrit of 45%, and a phosphorus level just 0.01 above the normal range. An in house ultrasound scan revealed one or two suspicious areas but showed no definitive evidence of a linear foreign body, such as plication. The patient received methadone on the morning of the examination.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Anechoic urine was present in the lumen with no evidence of urine/lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 3.3 cm in length. The right kidney measured 3.7 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

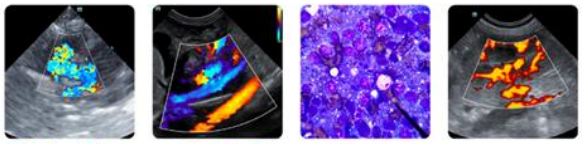
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.31 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.33 cm width.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. Normal vascular volume. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was



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non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The stomach lumen was primarily empty with mild retained non-shadowing chyme and gas. Possible indistinct hyperechoic linear echo at the level of and possibly extending through the pyloroduodenal junction into the upper duodenum.

Hyperechoic lumen interface normally seen with small intestine visualized in segmental empty intestinal segments. The intestinal walls demonstrated intact wall layering and maintained 1:3 muscularis / mucosa ratio. The mucosa exhibited mild decreased echogenicity with occasional mucosal speckling. Generally mild segmental intestinal ileus to the level of the colon including the distal ileum and ileocolic junction was present.

Normal visible colon wall layers were present. The colon was generalized mild distended with non-formed fecal matter.

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

No evidence of peritoneal effusion was present.

Several to multiple primarily mildly enlarged jejunocolic lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was present. An example of lymph node size was 2.0 cm x 0.6 cm.

ULTRASONOGRAPHIC FINDINGS

Primary

- Nonspecific enterocolitis pattern exhibiting mild segmental non-obstructive intestinal ileus and generalized distended colon containing non-formed fecal matter.
- Possible although not definitive non-obstructive pyloroduodenal junction to upper duodenum hyperechoic linear echo.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of gastrointestinal mechanical obstructive pattern or intestinal plication. Dietary indiscretion, infectious disease, enterotoxin, acute inflammatory bowel episode, occult parasitism, all potentials. The jejunocolic lymph nodes are most consistent with associated reactive to mild lymphadenitis or lymphatic hyperplasia with potential for immunologic immaturity. A possible small piece of non-obstructive thread in the upper gastrointestinal tract or possibly non-visualized or passing through the mid to distal small intestine cannot be definitively excluded without overt

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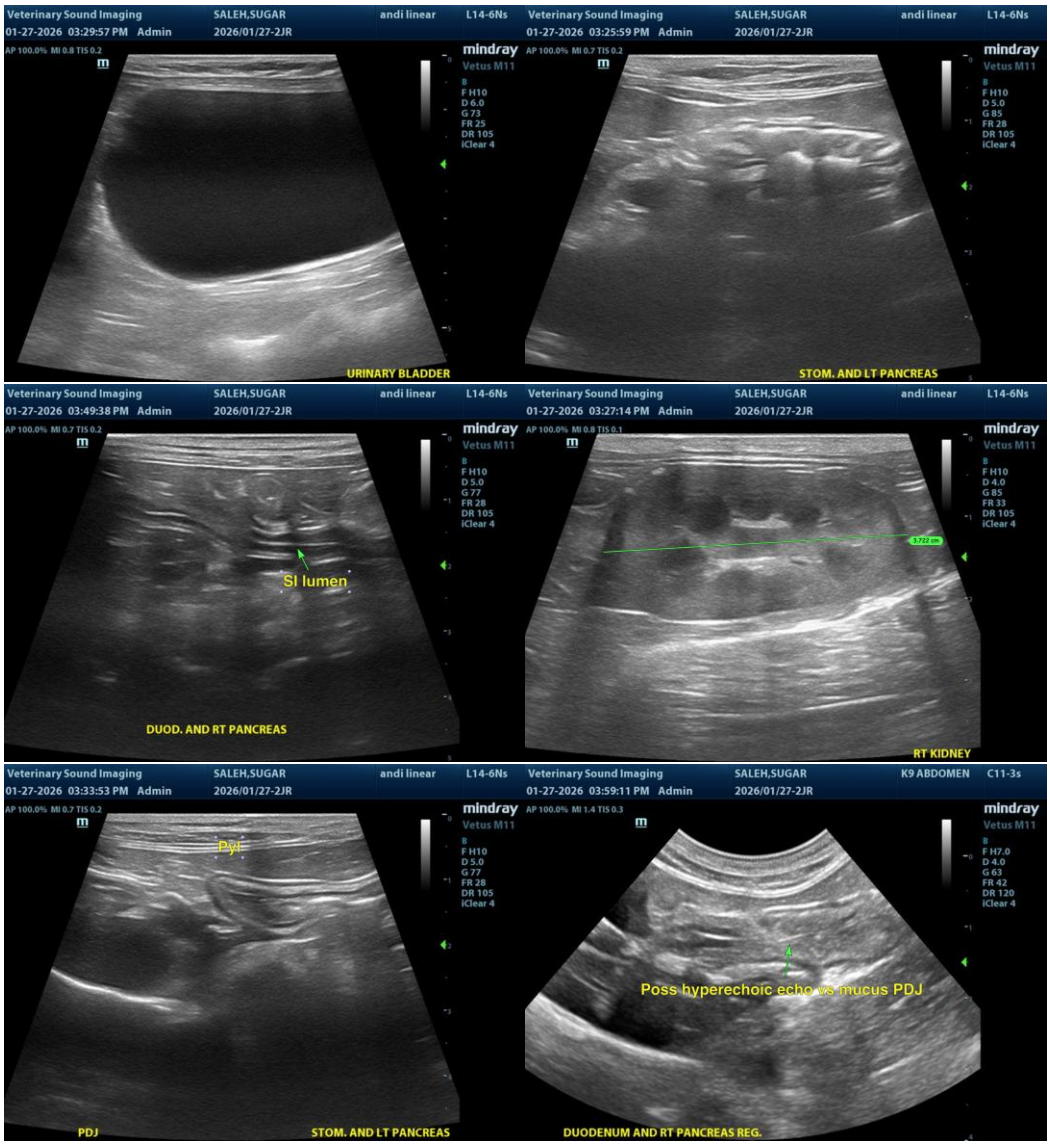
evidence of mechanical intestinal obstructive pattern or intestinal plication.

Gastrointestinal support with clinical and as needed sonographic monitoring is recommended. Sonographic reassessment in 24-48 hours is indicated if non-responsive or progressive gastrointestinal signs or evidence of progressive intestinal ileus.



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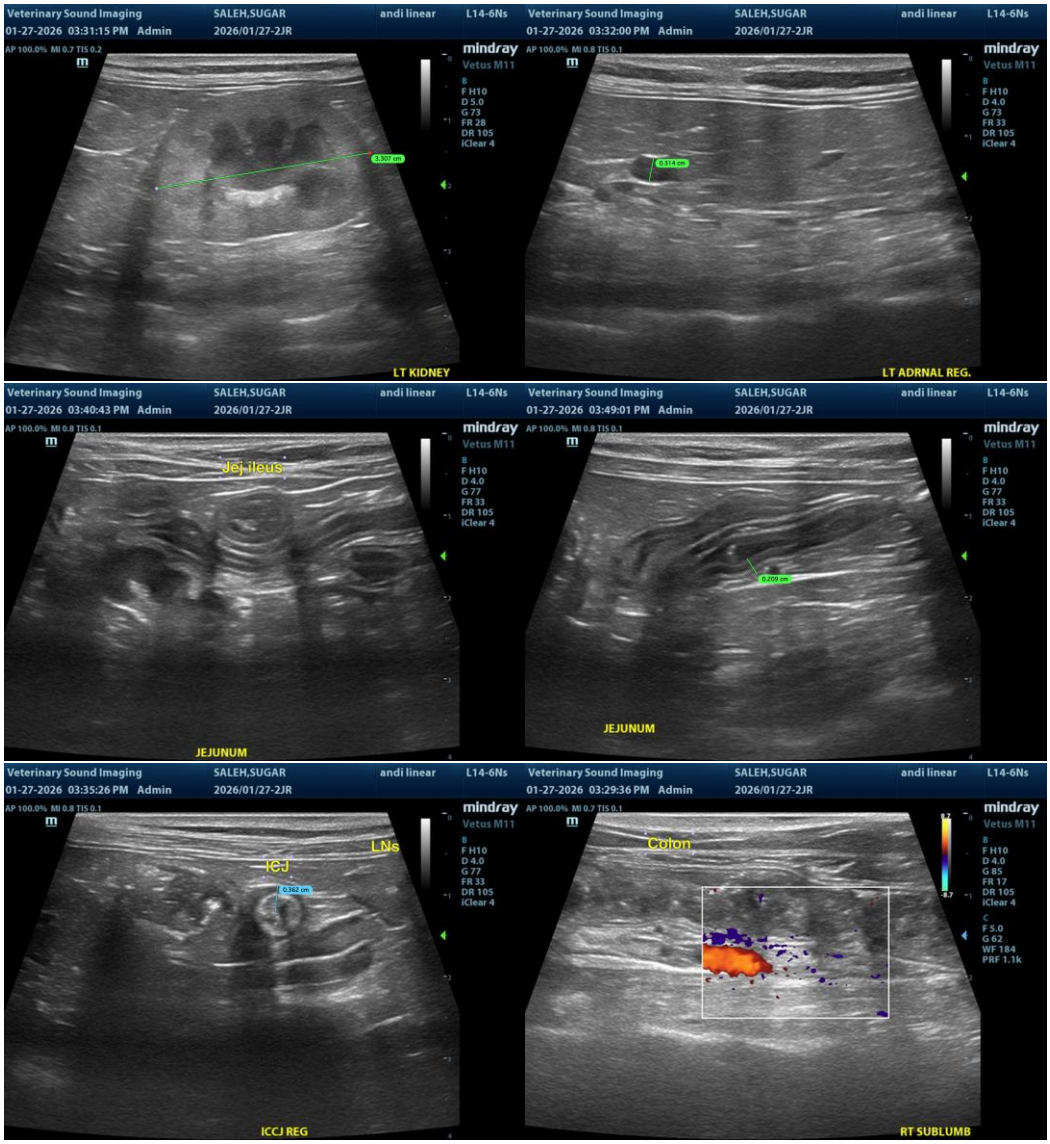

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
info@sonopath.com