



## PATIENT

Ruby Carbonell

## SPECIES

Feline

## BREED

DSH

## SEX

FS

## AGE

2yr

## WEIGHT

3.58kg

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Dr Jill Rankin

## HOSPITAL NAME

Fish Creek Pet Hospital

## REFERRING VET

Dr Claire

## INVOICE 23078

DATE  
12/1/2025

## PRESENTING CLINICAL SIGNS

The patient is a cat who was hospitalized and subsequently re-presented for persistent vomiting and inappetence. During the initial hospitalization for vomiting and inappetence, the patient was noted to be comfortable overnight. She was treated with fluids, Maropitant, gabapentin, and buprenorphine. An enema administered was productive. Diagnostic imaging included serial radiographs, which showed gas in the colon but no obvious obstruction, and an A-fast scan that was negative for abdominal, pleural, or pericardial effusion, though it revealed occasional B-lines bilaterally. A physical exam found her to be stable with no murmurs or arrhythmias. Following the initial hospitalization, the patient re-presented with the same clinical signs. The representing complaint was confirmed to be ongoing vomiting and inappetence.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 cm 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.

Mildly prominent uterine remnant with hyperechoic foci present which may indicate focal fibrosis or scarring. No evidence of a granuloma or stump pyometra criteria. The uterine remnant measured 0.7 cm in diameter.

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 3.6 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 0.43 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.39 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



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and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and minor non-organized debris. The cystic and common bile ducts were normal.

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### **Gastrointestinal**

The stomach presented intact wall layering with a normal wall layer ratio. The stomach was non-distended containing a minor amount of retained non-shadowing chyme. No evidence of mechanical pyloric outflow obstruction or obstructive pyloric mural pathology.

## BREED

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The small intestine presented intact mildly thickened wall with propensity for mildly thickened duodenojejunal mucosa layer. Mild segmental duodenojejunal corrugation and mild non-obstructive ileus was present. The duodenum wall measured 0.28 cm width. The jejunum wall measured 0.28 cm width. The ileocolic wall measured 0.27 cm width. The ileocolic junction was sonographically normal.

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Normal visible colon wall layers were present with semi formed feces in lumen.

## AGE

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### **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**

## WEIGHT

3.58kg

Mild volume peritoneal effusion was present.

Intermittent mildly prominent to enlarged jejunocolic lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5).

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## ULTRASONOGRAPHIC FINDINGS

### **Primary**

- Normal stomach with mild retained non-shadowing chyme
- Non-specific enteropathy exhibiting mild duodenojejunal corrugation / non-obstructive ileus
- Sonographically normal pancreas
- Mild duodenojejunal lymphadenopathy and peritoneal effusion

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### **Secondary**

- Mild gallbladder debris
- Mildly prominent uterine remnant - incidental

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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of mechanical gastrointestinal obstruction, i.e. foreign body, stricture or mass. Dietary intolerance, infectious enteropathy, non-specific inflammatory bowel, occult parasitism, mild pancreatitis which may present sonographically normal, emerging to occult neoplasia or FIP thought less likely yet not excluded possible. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended.

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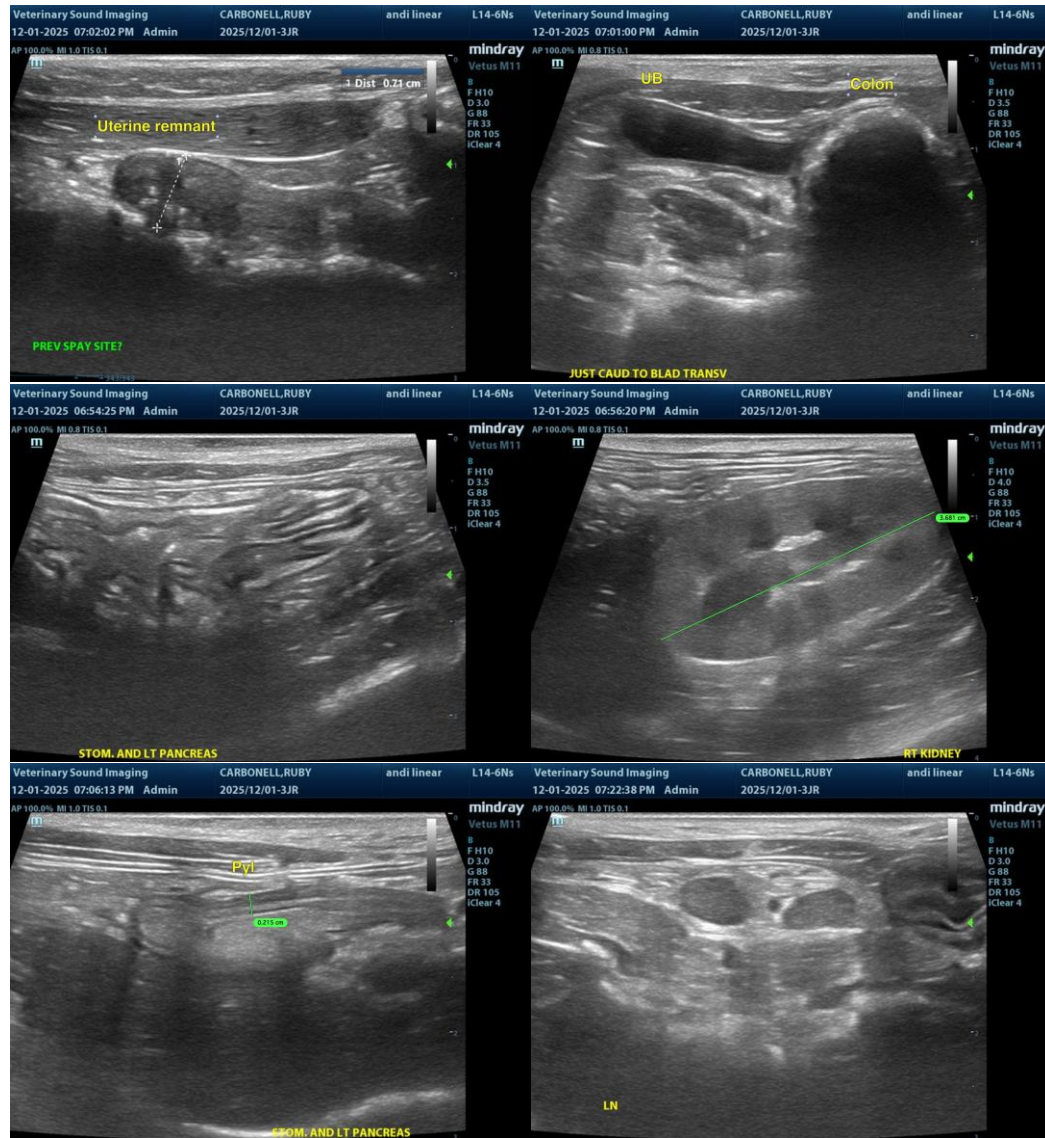
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Effusion analysis and cytology for further clarification recommended. A dietary trial, as needed gastroprotectants, cobalamin supplementation pending assessment of cobalamin level and empirical deworming if clinically indicated is recommended. Intestinal biopsies likely required for a definitive diagnosis.





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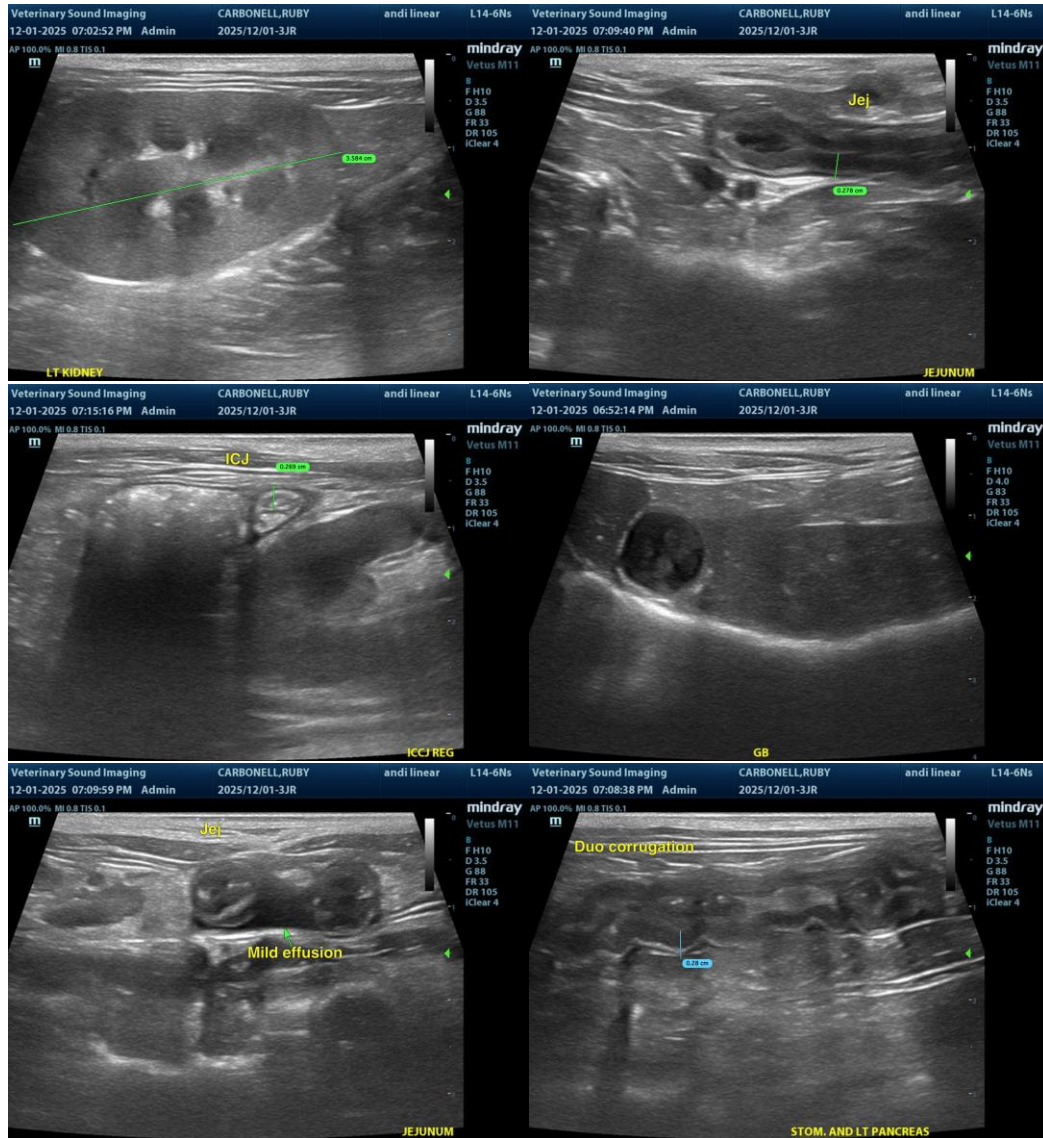
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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