



## PATIENT

Lainey Sellers

## SPECIES

Feline

## BREED

DSH

## SEX

FS

## AGE

1.5yr

## WEIGHT

3.99kg

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Lindsay Powell, CVT

## HOSPITAL NAME

Hershey Animal  
Emergency Center

## REFERRING VET

Dr. Kimberly Davidson

## INVOICE

23361

## DATE

12/29/2025

## PRESENTING CLINICAL SIGNS

Recheck for persistent anorexia and decreased drinking since visit on 12/27; owner reports lip licking and hiding suggesting nausea, with urine noted in litter box and no observed bowel movement. PE: 5-6% dehydrated. Tense and uncomfortable on abdominal palpation. Thickened and rope palpating intestines. 12/27 EPOC - pO2 70.3 (H), cSO2 92.5 (H), BE -7.5 (L), K 3.3 (L) At HAEC 12/29 EPOC: hypokalemia (3.5), hyperglycemia (136) PCV/TP: 44/6, clear plasma RDVM 12/29 CBC: thrombocytosis (Platelet 732), otherwise WNL Chem: amylase 1932, otherwise WNL Radiographs: gas distended colon, no obvious obstruction 12/27 CBC: WNL Chem: amylase 1477, hypokalemia (3.5)

Abnormal PE/Chem/CBC/UA Results: 12/27Abd rads : 1. Abd serosal definition is adequate. 2. The stomach is empty. left lat view, a loop of bowel that is superimposed over UB is more distended than the others, measuring 9.3 mm in dia On the right lat view, this loop of bowel measures relatively similar to adjacent loops of bowel. The remainder of the small intestine contains minimal amounts of gas and fluid. No radiopaque foreign material or plication is seen. The colon contains a large volume of gas and small volume of poorly formed fecal material. 3. The liver, spleen, renal silhouettes, and urinary bladder are unremarkable. 4. The remainder of the included structures are unremarkable. 1. Focal small intestinal dilation is more suggestive of focal peristalsis/enteritis rather than partial or early complete obstruction.

## 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 3.2 cm in length. The right kidney measured 3.5 cm in length.

The area of the aortic trifurcation was free of pathology.

### Adrenal Glands

The bilateral adrenal glands were indistinctly visualized without overt pathology.

### 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



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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 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 lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The intestinal walls demonstrated intact wall layers with diffusely thickened walls and altered 1:3 muscularis / mucosa ratio primarily consisting of muscularis hypertrophy. Primarily empty lumen with mild segmental non-obstructive ileus. The small intestinal wall measured 0.32 cm in width.

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

### **Pancreas**

The area of the pancreas was sonographically normal.

### **Free Abdomen**

No omental masses or peritoneal effusion was present.

Intermittent enlarged mesenteric lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly margined. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was present. An example of lymph node size was 2.9 cm x 0.7 cm.

## **ULTRASONOGRAPHIC FINDINGS**

### **Primary**

- Normal empty stomach.
- Intact mildly thickened small intestine exhibiting mild non-obstructive intestinal ileus.
- Normal area of pancreas
- Intermittent mild mesenteric lymphadenopathy.

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The small intestine exhibited mural changes suggestive of inflammatory criteria, i.e. IBD or other inflammatory enteropathy and mild lymphoid hyperplasia or possible lymphadenitis considered most probable. Minor potential for emerging to low-grade intestinal round cell neoplasia or less likely dry FIP with granulomatous or early metastatic lymphadenopathy may present in similar sonographic manner yet felt less likely. Gastrointestinal support is indicated. A definitive diagnosis would require intestinal and lymphatic biopsies for histopathology. Concurrent mild pancreatitis may present sonographically normal and may be suspected if cranial abdomen discomfort is present on palpation. No evidence of gastrointestinal obstruction or foreign material.



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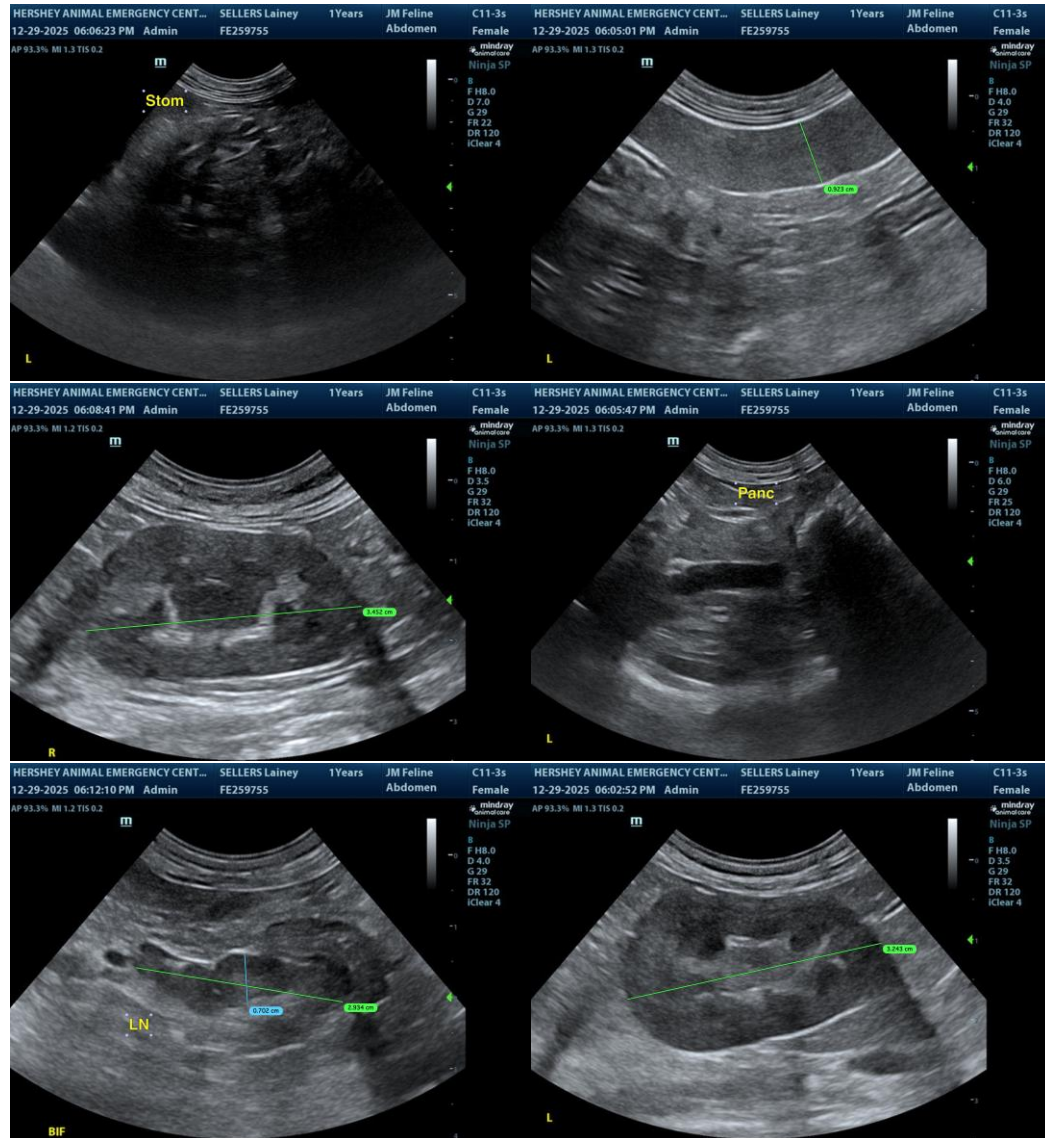
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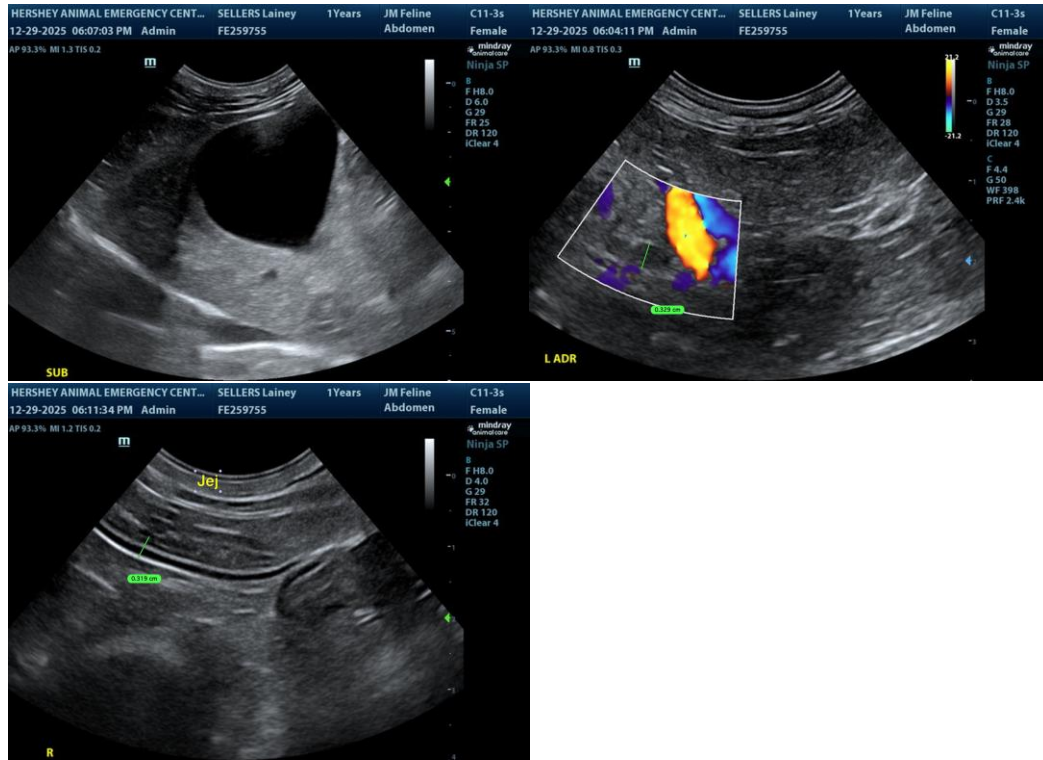
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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