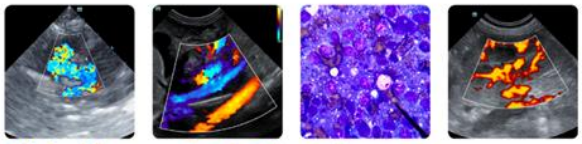




**PATIENT**
Sam Goldsworthy

**SPECIES**
Feline

**BREED**
DSH

**SEX**
MN

**AGE**
7yr

**WEIGHT**
6.09kg

**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 Whale

**INVOICE**
23893

**DATE**
02/16/2026

## PRESENTING CLINICAL SIGNS

- Presented for persistent anorexia and decreased drinking following an initial episode of vomiting, and was found to be severely dehydrated.
- Initially evaluated on the 12th, 13th, and 14th for vomiting. At that time, his blood work was unremarkable, and he was managed as an outpatient. Although the vomiting resolved, he subsequently refused to eat or drink, and a trial of Mirtazapine was ineffective at stimulating his appetite.
- Upon re-presentation, patient was found to have lost one kg of weight, with owners noting some weight loss over the preceding months as well. Examination revealed he was approximately 12% dehydrated, with sunken eyes and a prolonged skin tent. Due to the severity of his condition, he was admitted for hospitalization, IV fluid therapy, and further diagnostic workup.
- On physical examination, a grade III-IV heart murmur was auscultated, and he exhibited pain on palpation of his left cranial abdomen. Repeat blood work showed an elevated hematocrit (54%), neutropenia (0.61), monocytosis, hypoalbuminemia (albumin 17), low total protein, and an elevated urea with normal creatinine. A point-of-care ultrasound revealed steatitis, peritoneal effusion, and a possible jejunal foreign body, as some possible shadowing was seen on AFAST, which corresponded to the area of pain.
- Treatment was initiated with IV fluids, Maropitant, possible ampicillin for the neutropenia, and Methadone for pain.

## 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 mild non-dependent particulate sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Enhanced to mild indistinct corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. Areas of mild medullary mineral. The left kidney measured 4.2 cm in length. The right kidney measured 4.4 cm in length.

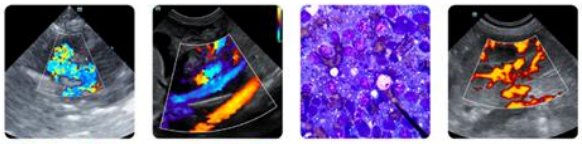
The area of the aortic trifurcation was free of pathology.

### *Adrenal Glands*

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.48 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.54 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.





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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 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 contained minor retained echogenic fluid/ chyme and mild gas with no signs of obstruction or foreign material.

The intestinal walls demonstrated intact wall layering and maintained 1:3 muscularis / mucosa ratio. The mucosa exhibited mild decreased echogenicity with occasional hyperechoic mucosal speckling. A mild segmental ileus pattern is present without obstruction or foreign material. Mild segmental gas. The duodenum wall measured 0.30 cm width. The jejunum wall measured 0.31 cm width. The ileocolic wall measured 0.45 cm width.

The colon walls presented intact yet prominent wall layering with mild thickened to echogenic submucosa. Generalized soft fecal matter was present in the colon lumen with lumen dilation.

### *Pancreas*

The pancreas presented non-homogenous hypoechoic echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia.

### *Free Abdomen*

Minor to mild peritoneal effusion was present.

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 to peri intestinal hyperechoic omentum was present. An example of lymph node size was 1.7 cm x 0.83 cm.

## ULTRASONOGRAPHIC FINDINGS

### Primary

- Mild non-obstructive hypomotile stomach
- Non-specific subjective acute to subacute enterocolopathy exhibiting mild segmental intestinal ileus and soft fecal matter in colon
- Mild to variable mesenteric lymphadenopathy, peri-intestinal/ peri-lymphatic hyperechoic mildly inflamed omentum and minor to mild volume effusion
- Suspect mild pancreatitis

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### Secondary

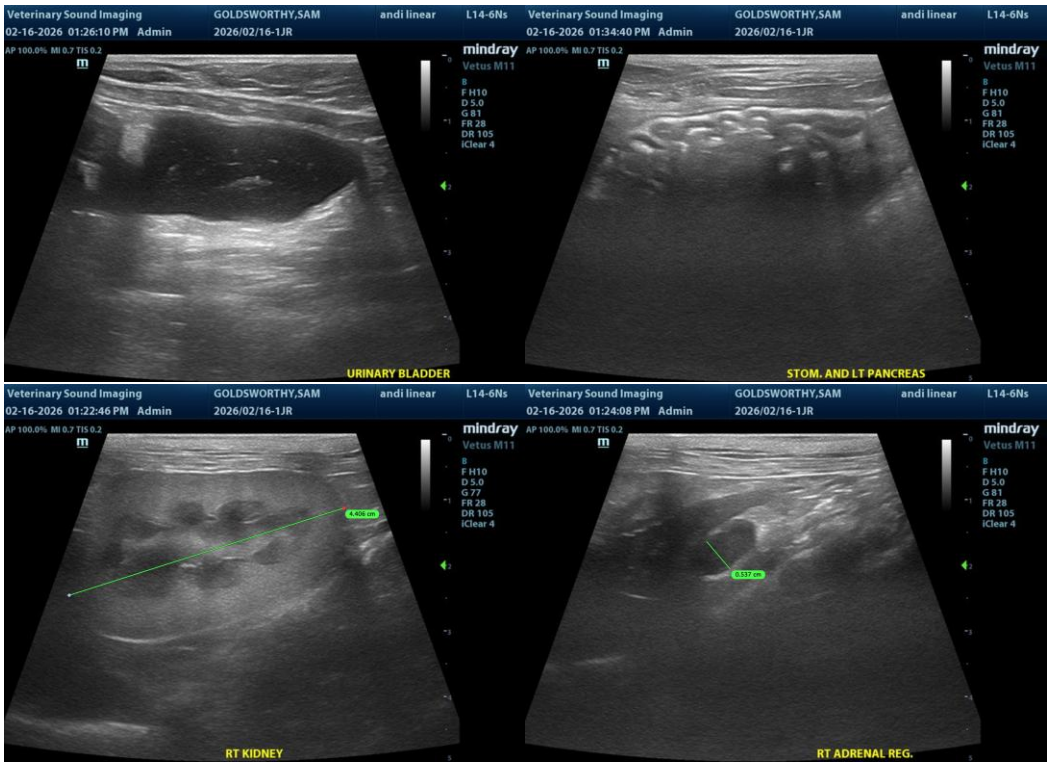
- Nonspecific early to mild chronic renal changes exhibiting mild medullary mineral
- Mild urine sediment

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No overt or definitive evidence of mechanical gastrointestinal obstruction or foreign material. Acute to subacute inflammatory bowel, infectious disease, enterotoxin in conjunction with pancreatitis, occult neoplasia, reactive lymph node hyperplasia, lymphadenitis, or early metastatic lymphadenopathy, all potentials. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended.

Continued gastrointestinal support with clinical and sonographic monitoring pending clinical reassessment is recommended at this stage. FNA cytology of accessible lymph node as well as effusion analysis +/- C/S is warranted for further clarification. Intestinal and lymphatic biopsies may be required for definitive diagnosis and may be considered if non-responsive or progressive gastrointestinal signs.

The urinary bladder sediment may suggest cellular / crystalline debris or mucus. Cystocentesis for UA +/- C/S if evidence of inflammatory cells is recommended.



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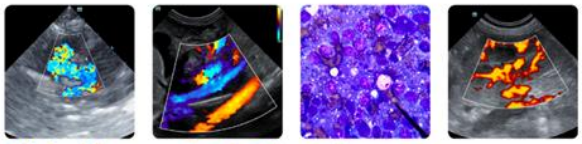

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

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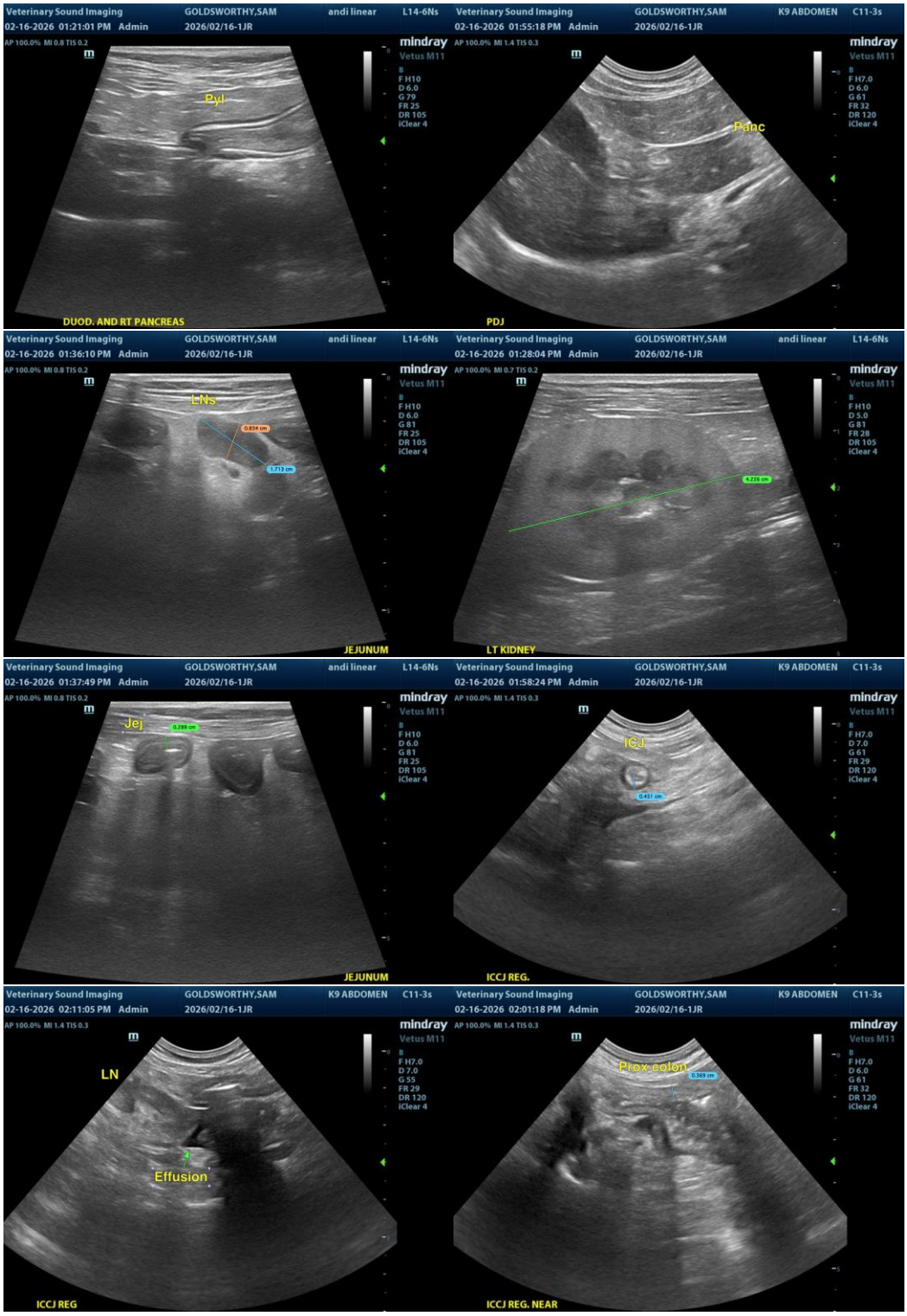

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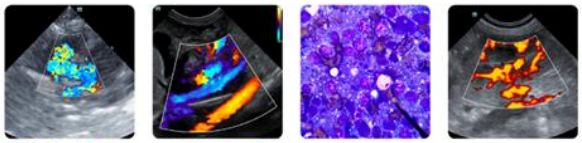

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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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