



PATIENT

Munchkin Young

SPECIES

Feline

BREED

DSH

SEX

Female (possibly spayed)

AGE

6 Years

WEIGHT

5.2

INTERPRETED BY

R. McKenzie Daniel,
DVM, DABVP (Canine
/ Feline Practice)

IMAGING PERFORMED BY

Dr. Hannah Fearing

HOSPITAL NAME

Lanier Animal Hospital

REFERRING VET

Dr. Hannah Fearing

INVOICE

13627

DATE

02/05/26

PRESENTING CLINICAL SIGNS

- Munchkin is an adult, female, domestic shorthair cat of unknown age who was adopted as a stray about two years ago. The presenting complaints are anorexia, vomiting, and lethargy. She was eating well on Tuesday but has refused all food for the past two days, including palatable pureed chicken treats. Vomiting has recurred; yesterday the patient vomited kibble and a large amount of water. There has been no vomiting observed today. The owner is limiting water access to prevent further vomiting. One small stool was produced yesterday. A significant change in behavior has been noted, with the cat hiding and sleeping more frequently. There is a suspicion of increased water consumption and urination, as the litter box pad appears more saturated than usual. The patient was last seen on the 3rd for vomiting and on the 27th of the previous month for a wound near the anus. At the visit on the 27th, the patient received Convenia. Following that visit, she was lethargic for a few days before developing a voracious appetite that lasted until this Tuesday.

Abnormal PE/Chem/CBC/UA Results: BW from 1/27/26: cbc: Mild leukocytosis (19.5) chem: mild hypokalemia (3.3), mild hypochloremia (108), mild hypoalbuminemia (2.5), mildly elevated ALP (63) - suspect low K and Cl are due to GI loss (history of vomiting), ALP is secondary to GI inflammation, and low albumin is either negative acute phase protein from wound on tail or inflammation within the GI tract

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic change were noted.

No obvious pathology in the area of the uterine remnant.

The area of the aortic trifurcation was free of pathology.

Normal size and margination was 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 3.4 cm in length. The right kidney measured 4.0 cm in length.

Adrenal Glands

The adrenal glands were overtly normal in size, position and shape. The left adrenal gland measured 0.40 cm width. The right adrenal gland measured 0.41 cm width.

Spleen

The spleen presented normal in size with mild medial capsule asymmetry exhibiting mild homogenous hypoechoic parenchyma. The spleen measured 0.74 cm width level of the mid spleen.

Liver & Gallbladder



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The liver was subjectively borderline enlarged in size. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion.

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The gallbladder was non distended in size with mild nondependent nonorganized biliary sludge with suspect peripheral lumen congealed to possibly adhered debris with potential for emerging gallbladder polyp. The proximal common bile duct was dilated and mild tortuous without overt post hepatic obstruction.

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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.

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The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty without mechanical/metabolic ileus to the level of the colon. Mild segmental jejunal corrugation. The duodenum wall measured 0.22 cm wall width. The jejunum wall measured 0.25 cm wall width.

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

Pancreas

The visualized pancreas exhibited normal size, symmetrical contour and mild nonhomogenous hypoechoic parenchyma compared to adjacent mildly hyperechoic peripancreatic omentum.

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Free Abdomen

No visualized significant omental lymphadenopathy or peritoneal effusion was present.

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- Structurally unremarkable empty gastrointestinal tract with mild segmental jejunal corrugation- nonspecific possibly acute or recurrent enteritis, nonstructural IBD or other inflammatory enteropathy with no overt suspicion of intestinal neoplasia.
- Possible mild pancreatitis.
- Borderline hepatomegaly.
- Nondependent to peripherally congealed gallbladder debris with possible gallbladder polyp.
- Nonobstructive common bile duct dilation.
- Overtly normal area of uterus/uterine remnant.
- Sonographically unremarkable bilateral kidneys and adrenal glands.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Assuming normal clotting status and using 25-gauge needle, hepatic FNA cytology could be considered primarily to assess for inflammatory criteria given gallbladder presentation and short half-life of hepatic enzymes in cats. A GI panel to include PLI, TLI, cobalamin and folate is recommended.

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No evidence of gastrointestinal obstructive pattern or overt neoplasia. Pending additional diagnostics, empirical therapy for non-specific inflammatory bowel, possible mild pancreatitis, +/- potential cholangiohepatitis with clinical monitoring and sonographic reassessment if progressive clinical signs is recommended.



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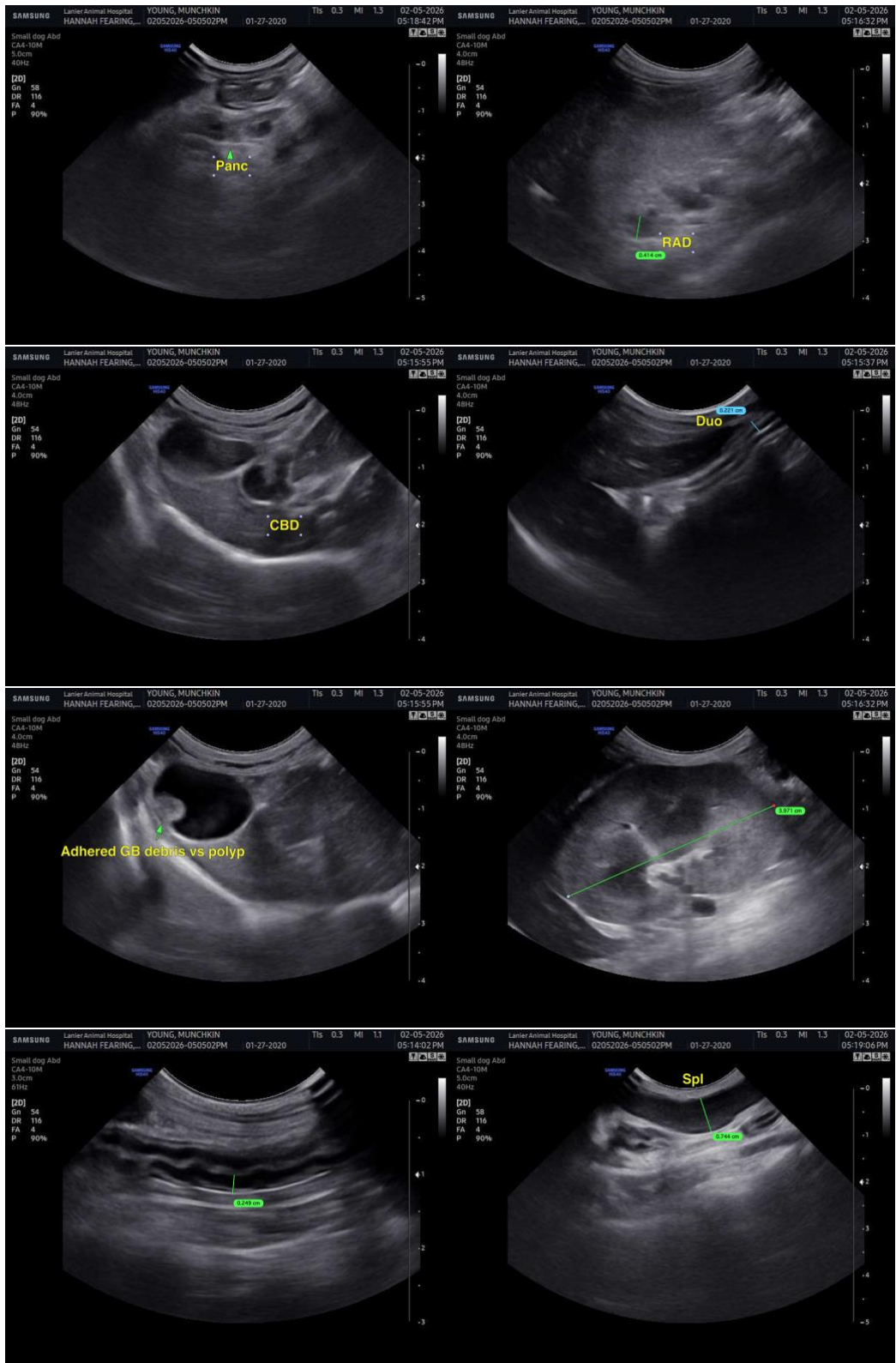
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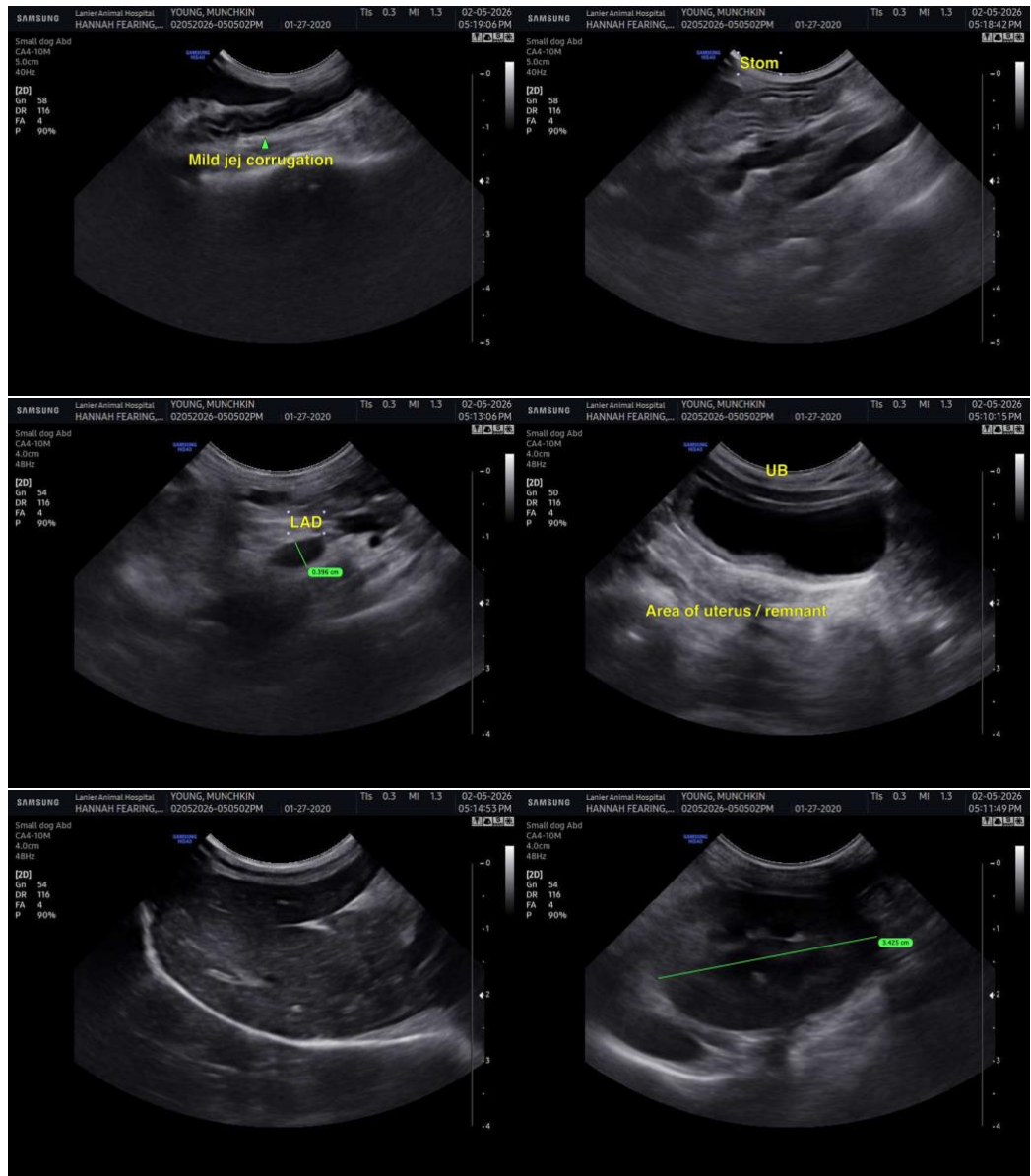
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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