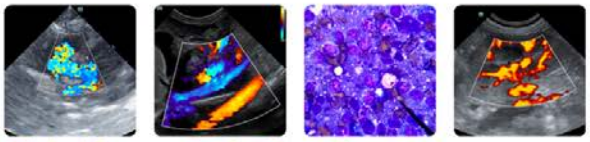

PATIENT

Binx Munjone

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

5 Years

WEIGHT

9.8

INTERPRETED BY

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

IMAGING PERFORMED BY

Grace Jayne, CVT

HOSPITAL NAME

Ark Animal Homecare

REFERRING VET

Dr. Erika De Beckers

INVOICE

72812

DATE

2/9/26

PRESENTING CLINICAL SIGNS

Lethargy/dysrexia 5-6 days. Possible gastric FB on x-ray. A small meal at 4am, otherwise NPO

Abnormal PE/Chem/CBC/UA Results: ALT 140 Platelets 120,000

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. Primarily anechoic urine was present in the lumen. Moderate non-dependent particulate sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were 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. Left kidney measures 3.3 cm. Right kidney measures 4.1 cm.

Adrenal Glands

No obvious pathology in the areas of the left and right adrenal glands.

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

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. 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 mild, progressively shadowing ingesta exhibiting mild near field hyperechogenicity. No obvious visualized obstruction to the pyloric outflow.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Segmental mild, non-shadowing intestinal ingesta noted to the level of the colon. No evidence of obstructive pattern. Duodenum and jejunum wall measured 0.20 cm in width.

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

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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

No overt lymphadenopathy or peritoneal effusion was present.

PRIMARY FINDINGS

- Structurally normal gastrointestinal tract with mild progressively shadowing gastric ingesta.
- Normal area of pancreas.
- Sonographically normal liver/gallbladder- consistent with low-grade benign hepatopathy.

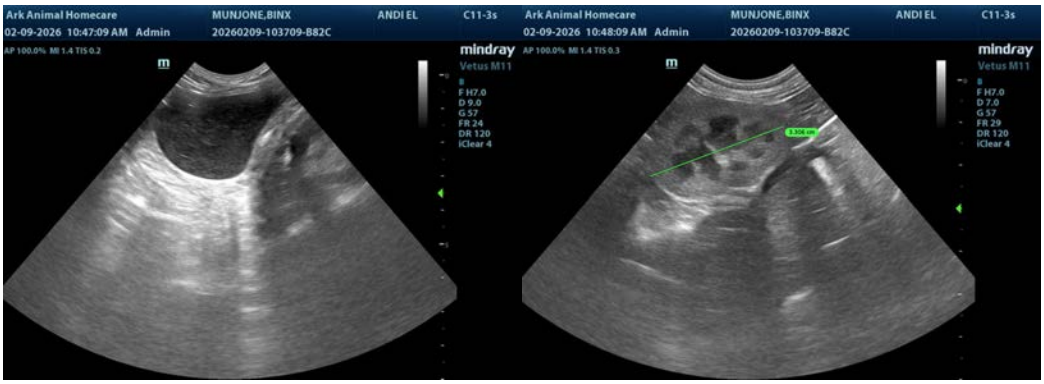
SECONDARY FINDINGS

- Moderate urine sediment.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gastric ingesta is non-specific and may indicate retained variably progressively shadowing food echogenicity, given recent meal ingestion. Potential for intermixed non-obstructive hairball density or similar within gastric ingesta is of concern. No evidence of gastrointestinal obstructive pattern. Underlying non-structural gastrointestinal disease or low-grade pancreatitis may present sonographically normal.

GI panel to include PLI, TLI, cobalamin and folate could be considered. Without definitive gastrointestinal obstruction, hospitalization with documented 12 hour fast, gastrointestinal support, and sonographic reassessment of the gastrointestinal tract would be appropriate. If persistent progressively shadowing gastric ingesta combined with clinical signs, and assuming no pathology on 3-view chest radiographs, upper gastrointestinal endoscopy or direct laparotomy with gastric evacuation may be indicated.



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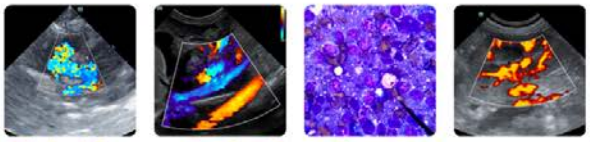

Clinical Sonography & Telecytology
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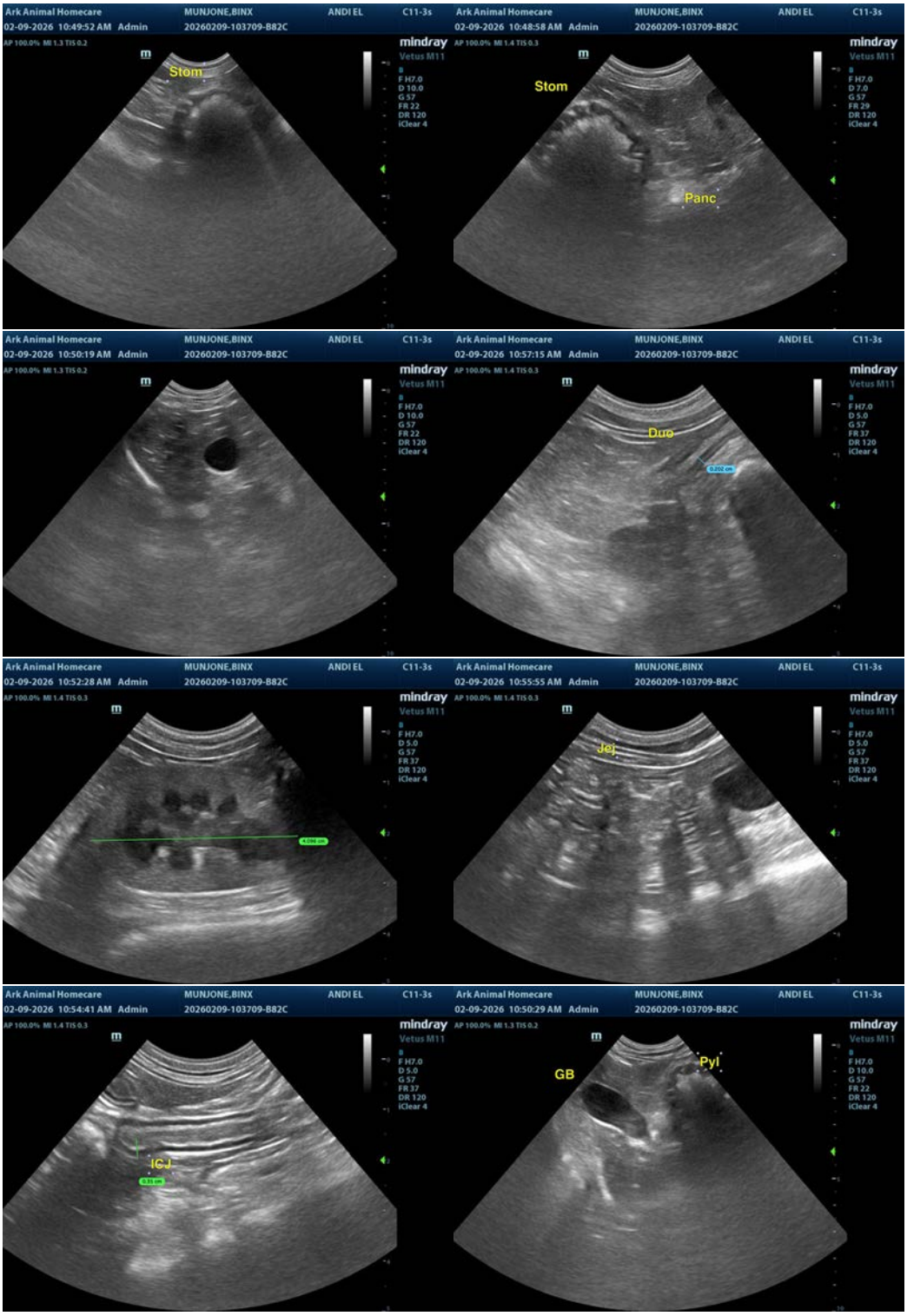

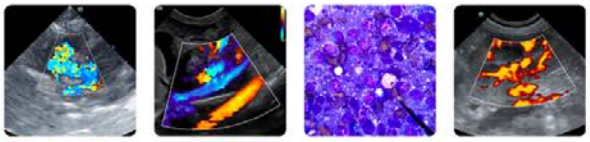

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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