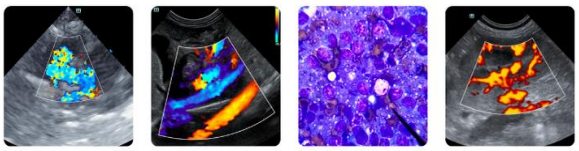


PATIENT
Fitz Hill

SPECIES
Feline

BREED
DLH

SEX
MN

AGE
2yr

WEIGHT
4.6kg

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

IMAGING PERFORMED BY
Kathleen Byrnes

HOSPITAL NAME
Animal Emergency Clinic High Country

REFERRING VET
Dr Wolverton

INVOICE
23834

DATE
02/09/2026

PRESENTING CLINICAL SIGNS

- P presented 2/8 for vomiting and having diarrhea outside litter box since Wednesday and was also vocal and distressed wednesday night, and not eating since Friday. P hasn't urinated in 24 hours. P is urinating at ER. P may have licked Himalayan salt lamp. P defecated yellow stool Friday
- Rad Report- The stomach contains a small volume of fluid/soft tissue opacity interspersed with gas. No evidence3 of mechanical ileus or overt GI foreign material. A small volume of soft tissue opaque foreign material within gastric lumen cannot be completely excluded. Mild diffuse distension of the small bowel suggests functional ileus secondary to non specific enteritis, otherwise normal.

Abnormal PE/Chem/CBC/UA Results: CBC Neu 2 (2.3-10.29) Chem wnl Triple Neg x 3

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.

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. An indistinct hyperechoic corticomedullary band, consistent with a medullary rim sign, was present. This is a nonspecific finding seen in both normal and abnormal kidneys. It may be associated with interstitial renal disease, hypercalcemia, tubular necrosis, lymphoma, and FIP. However, it is a nonspecific finding. Variably sized renal cysts were present with a larger cyst in the caudal left kidney measuring 1.6 cm in diameter. Bilateral minor pyelectasia was present. The left kidney measured 4.7 cm in length. The right kidney measured 4.3 cm in length.

The area of the aortic trifurcation was free of pathology.

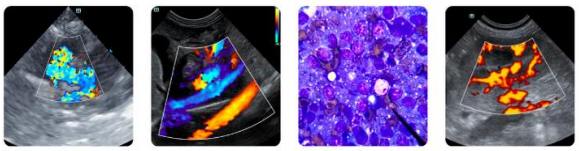
Adrenal Glands

The bilateral adrenal glands were overtly normal in size, position and shape. The left adrenal gland measured 0.3 cm width The right adrenal gland measured 0.28 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



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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 minor non-organized debris. The common bile duct was dilated and mildly tortuous without overt post hepatic obstruction extending from the level of the cystic duct to the approximate level of the duodenal papilla.

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. The duodenum wall measured 0.27 cm width. The jejunum wall measured 0.29 cm width. The ileocolic wall measured 0.43 cm width.

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

Pancreas

The pancreas was normal in size and contour with subtle non-homogenous hypoechoic parenchyma and minor prominent left limb pancreatic duct.

Free Abdomen

No omental masses or peritoneal effusion was present.

Intermittent mildly prominent to enlarged mesenteric 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). An example measured 1.1 cm x 0.53 cm.

ULTRASONOGRAPHIC FINDINGS

Primary

- Normal empty stomach
- Enteropathy exhibiting intact mildly thickened intestine wall
- Current formed fecal matter in colon
- Mild mesenteric lymphadenopathy
- Possible low-grade pancreatitis
- Minor gallbladder debris with non-obstructive common bile duct dilation
- Bilateral variable cystic kidneys exhibiting nonspecific minor medullary rim
- Normal non-distended urinary bladder

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Nonspecific acute enteritis or IBD intestinal pattern criteria is probable. No evidence of mechanical gastrointestinal obstruction or foreign material. Emerging triad disease could be a potential in this patient given short half-life of hepatic enzymes in cats in conjunction with possible mild cholangitis. Emerging to occult intestinal round cell neoplasia thought less likely yet not technically excluded.
A GI panel to include PLI/TLI/Cobalamin/Folate is recommended.

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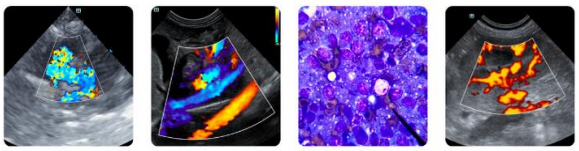

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Educational Teleconsultation Services™

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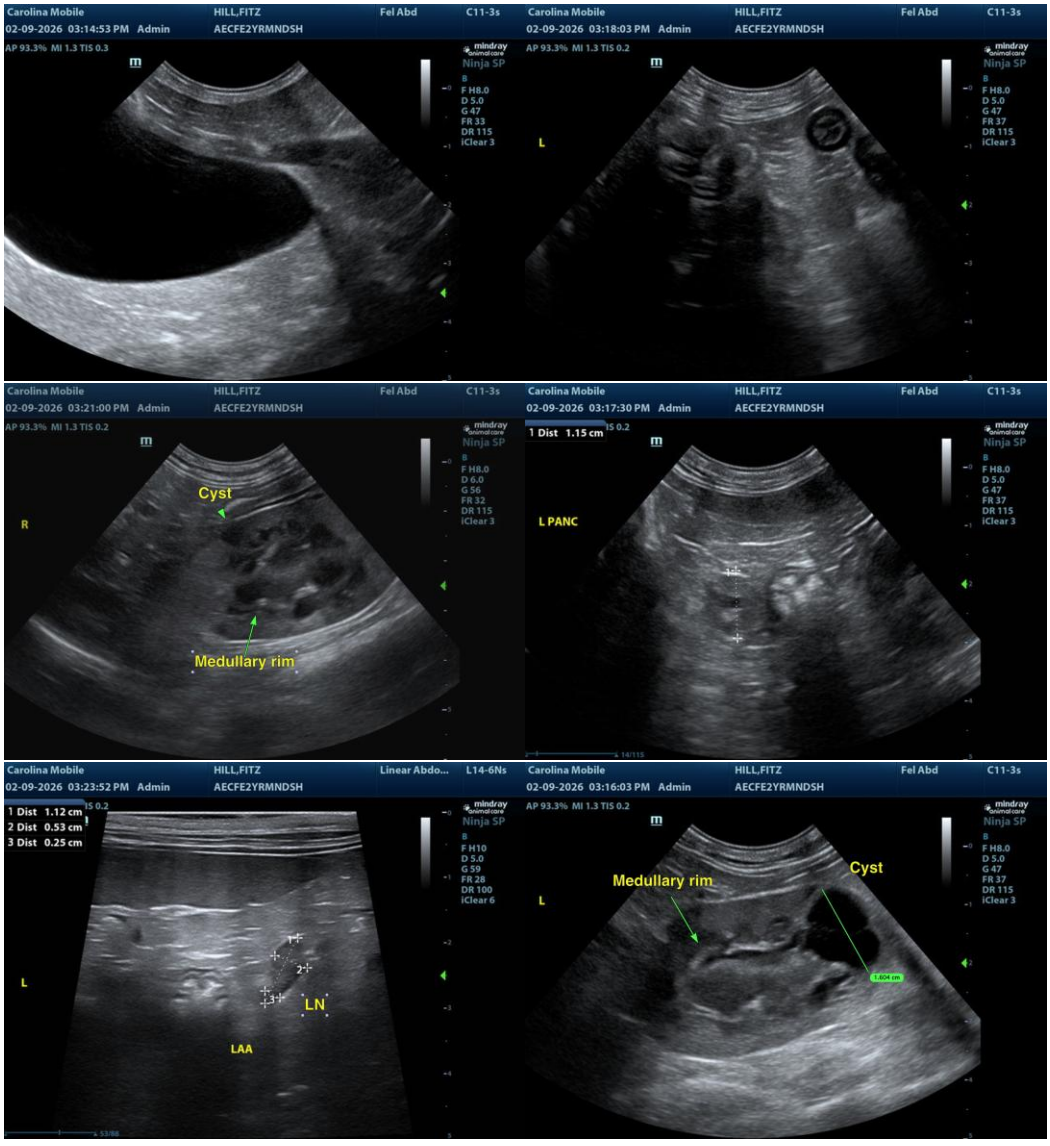
Gastrointestinal support indicated with clinical monitoring and sonographic reassessment if non-responsive or progressive gastrointestinal signs +/- weight loss. Correlation with UA as well as monitoring of renal parameters going forward is recommended.



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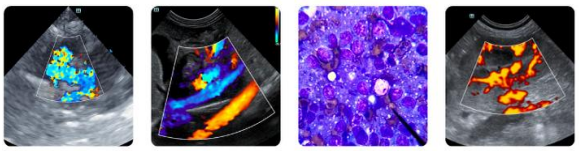

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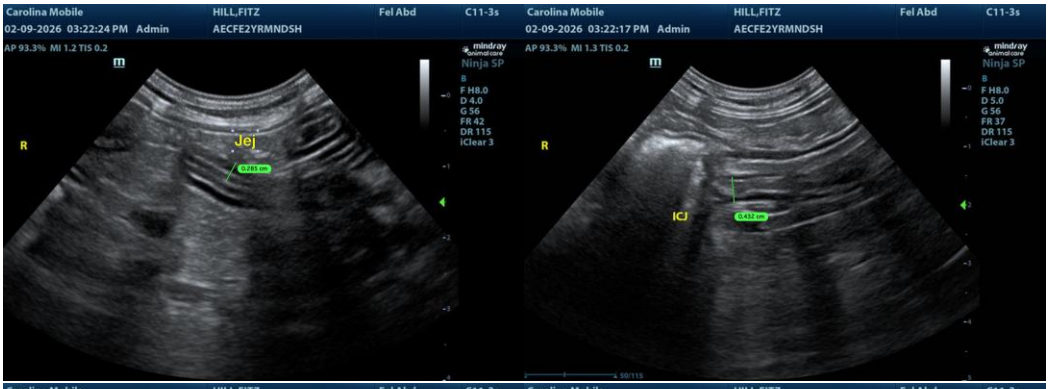

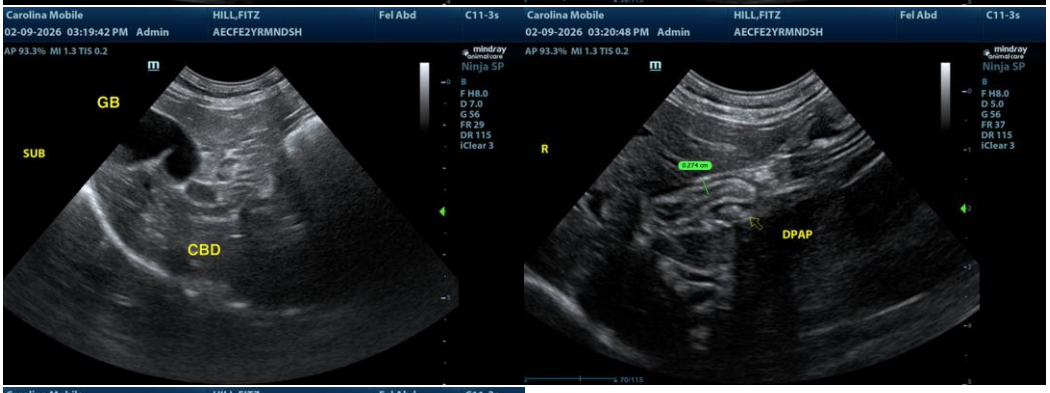

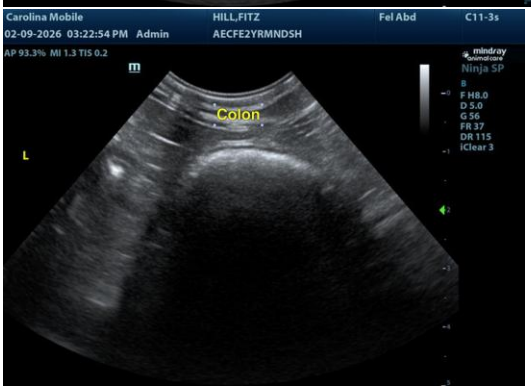

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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