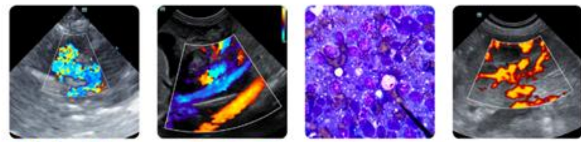


PATIENT
Jasper Meek

SPECIES
Feline

BREED
DSH

SEX
MN

AGE
1yr

WEIGHT
12.8

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

IMAGING PERFORMED BY
Jimmerson

HOSPITAL NAME
Willamette Veterinary Hospital

REFERRING VET
Jimmerson

INVOICE
24068

DATE
03/02/2026

PRESENTING CLINICAL SIGNS

- Presented 3/1 PM on medical progress exam for ongoing V+ after eating and drinking. defecated day prior to presentation. Pt interested in eating/drinking but is V+ shortly afterwards. Hair material present in one vomitus.
- 3 view abdominal rads with STAT consultation:
- CONCLUSIONS:
- The small amount of heterogeneous material in the stomach could be normal ingesta, but a mixture with gastric foreign material should also be considered.
- The appearance of the intestines is most consistent with a functional ileus, such as from gastroenterocolitis (e.g., dietary indiscretion, infectious causes, or acute hemorrhagic diarrhea syndrome) or systemic/metabolic disease. There is no evidence of intestinal obstruction or intestinal plication.
- Appearance of the colon is compatible with evidence of colitis, and suggestive of eminent diarrhea.
- Abnormal PE/Chem/CBC/UA Results: t-bili 1.1 (H)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 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.

Borderline enlarged size and symmetrical 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 4.6 cm in length. The right kidney measured 4.5 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

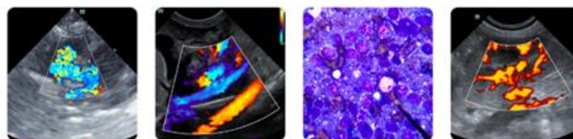
The left and right adrenal glands were not definitively visualized. No obvious pathology was present in the area of the bilateral adrenal glands.

Spleen

The spleen exhibited borderline enlargement (1.0 cm at the mid spleen) with 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

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



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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. Empty lumen without mechanical metabolic intestinal ileus to the level of the colon. The small intestinal wall measured up to 0.37 cm wall width.

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

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

Intermittent mildly prominent to enlarged mid abdomen 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 1.6 cm x 0.63 cm.

Scant peri-intestinal effusion.

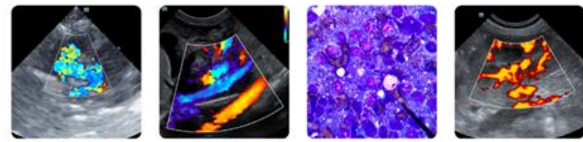
ULTRASONOGRAPHIC FINDINGS

Primary

- Normal empty stomach
- Intact thickened small intestine exhibiting altered wall layer ratio
- Intermittent primarily mild homogenous mesenteric lymph nodes
- Borderline splenomegaly
- Bilateral borderline renomegaly exhibiting intact normal renal architecture
- Scant peri-intestinal effusion

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of gastrointestinal obstruction, foreign material or current hairball. The appearance of the small intestine is compatible with infiltrative enteropathy. Primary considerations may include inflammatory infiltrative enteropathy such as IBD or neoplastic infiltrative enteropathy with round cells such as lymphoma or mast cell disease among potential etiologies. Dry form FIP may also present in this manner. Associated mesenteric lymph node hyperplasia, lymphadenitis or early metastatic lymphadenopathy possible. Diagnosis would require biopsies for histology, obtained either via endoscopy or, ideally, full thickness biopsies via laparotomy. A GI Panel to include PLI/TLI/Cobalamin/Folate is recommended. If additional diagnostics are not elected, empirical medical therapy for IBD which may include dietary therapy, cobalamin supplementation, probiotics +/- steroids trial with assessment of clinical response and monitoring of body weight could be considered.



SonoPath.com info@sonopath.com 1.800.838.4268

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If the patient is non-sedated, mild splenic hyperplasia, hematopoiesis, inflammation with potential for early splenic round cell neoplasia possible. Assuming normal clotting status and if patient is non-sedated, splenic FNA cytology using a 25ga needle is recommended.

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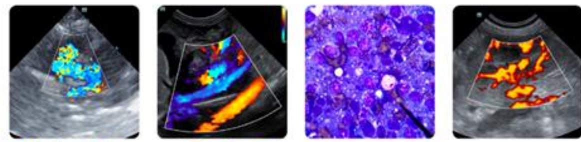

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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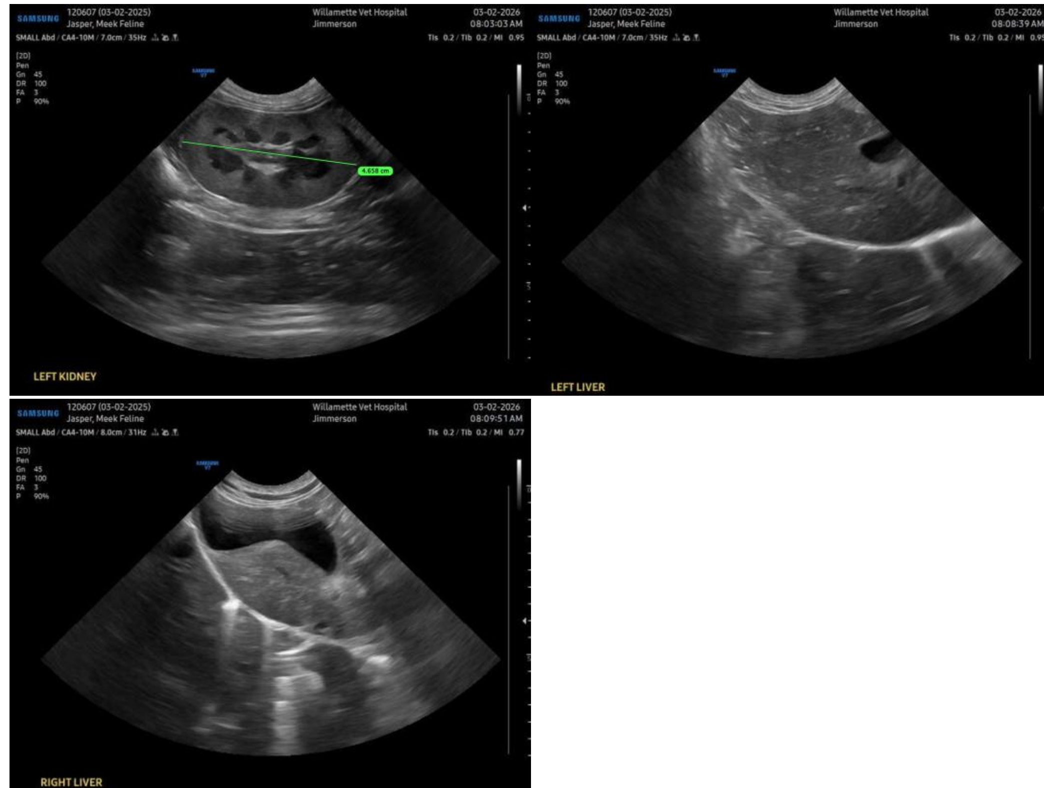

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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