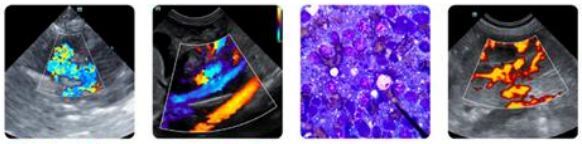


PATIENT

Misty Noggle

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

4yr

WEIGHT

3.26kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Lindsay Powell, CVT

HOSPITAL NAME

Hershey Animal Emergency Center

REFERRING VET

Dr. Lydia Coogan

INVOICE
24056

DATE
03/02/2026

PRESENTING CLINICAL SIGNS

- v+ on/off for about 3 weeks, was yellow foam now brown liquid in litter box today, losing weight not eating since yesterday
- PE:Oral Cavity: Mucous membranes pink/moist, CRT <2s, severe periodontal disease; sublingual clear Abdominal: Slightly reactive on deep palpation, doughy irregular empty intestines palpated, no obvious mass noted
- BP: 146 CBC: HCT 27.7 (L) Hemo 9.6 (L) WBC 29.51 (H) Neut 15.35 (H) Lymph 12.95 (H) Mono1.07 (H) Eos 0.07 (L) Plt 50 (L) Pltcrit 0.09 (L)
- In-vue: HCT 27.7 (L) WBC 29.51 (H) ImmNeut 1.3% Neut 26.98 (H) Imm Neut 0.40 Lymph 0.56 (L) Mono 1.37 (H) Eos 0.18 (n) Plt Est>150 (Adequate)
- EPOC: pO2 153.0 (H) cSO2 99.2 (H) BE,ECF -9.3 (L) Na 145 (L) iCal 1.17 (L) Lac 6.16 (H) BUN 33 (H) Glu 256 (H)
- Chem15: Glu 233 (H) Glob 5.6 (H) GGT 13 (H) fel Triple: negative x 3 Panc Lipase: 1.4 (n)
- UA: USG 1.048, pH 6.5, Pro 30, Bld 250, Bili 3, urobili 8, WBC 3/HPF, RBC >50/HPF, Squamous epi cells <1/HPF, Non-squamous epi cells 1-2/HPF
- Abnormal PE/Chem/CBC/UA Results: Rads 2. Moderate accumulation of fluid and gas in the small intestines, accumulation of large amounts of fluid and stippled mineral opacities throughout the intestines. 3. Multiple stippled mineral opacities throughout the intestines. Consider recent ingestion of bony material or grit/sand. 4. Intervertebral disc disease at the L1-L3 intervertebral disc space. no definitive evidence of a complete mechanical obstruction, a developing impaction in the large intestines is not able to be excluded repeat abd rads should be performed after strict fasting for 6 to 8 hours to monitor

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 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 3.2 cm in length. The right kidney measured 3.8 cm in length.

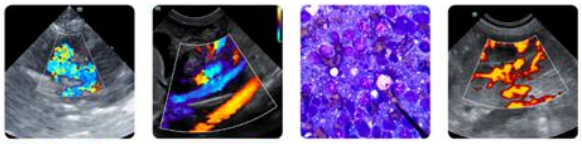
The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.36 cm width. The right adrenal gland was not definitively visualized, no overt pathology in the area of the right adrenal gland.

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



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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 mild non-organized debris. 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 moderate retained anechoic fluid without overt visualized obstruction to pyloric outflow.

The small intestine exhibited diffuse to variable distension with primarily non-shadowing to focally shadowing ingesta/chyme. Segmentally thickened small intestinal wall exhibiting indistinct to loss of mural echogenicity, including segmental intestinal mural mass was present. Thickened intestinal wall measured 0.34 cm, the intestinal mural mass wall width measured 0.5 cm.

The colon was difficult to delineate from ingesta/ chyme distended small intestine. The visible descending colon was empty in appearance, cranial to and at the level of the urinary bladder.

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Moderate retained gastric fluid
- Diffuse to variable distended intestine with primarily non-shadowing to focally shadowing ingesta/ chyme
- Segmentally thickened small intestine with segmental intestinal mass
- Empty visible descending colon
- Mild heterogeneous left pancreas
- Mild gallbladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The retained gastric fluid and diffuse intestinal distention with retained ingesta is consistent with mechanical intestinal obstruction secondary to intestinal mural pathology and segmental intestinal mass. Neoplasia, inflammatory/ infectious disease, granulomatous disease (FIP) are all potentials.

Definitive diagnosis would require exploratory laparotomy with gross inspection of the gastrointestinal tract, biopsies and potential resection and anastomosis, which is recommended. Three view chest

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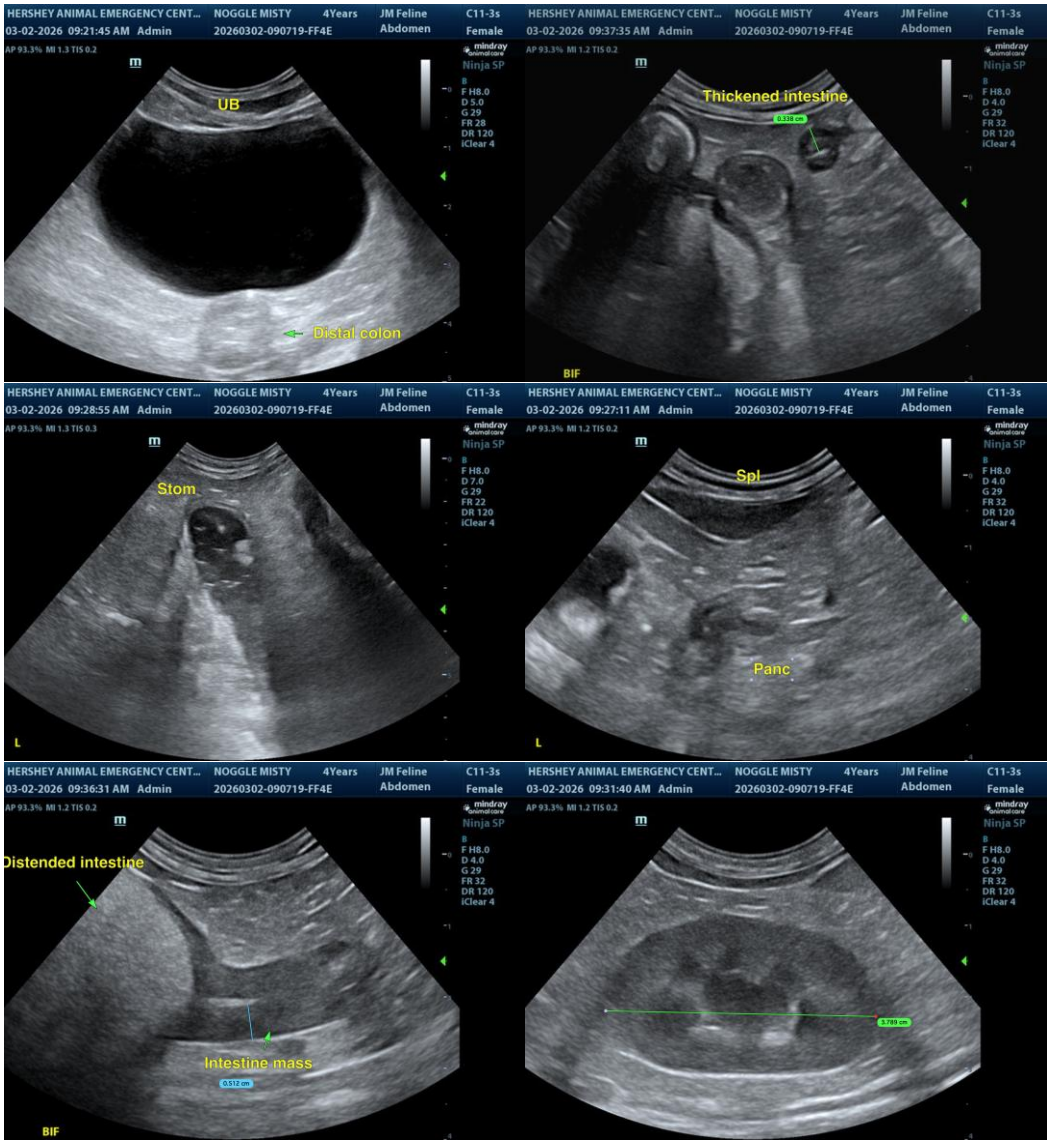
radiographs suggested prior to surgical considerations. Potential for multifocal intestinal mural disease is possible. Therefore, abdominal CT could be considered for further clarification, surgical planning and assessment for non-sonographically evident metastasis.



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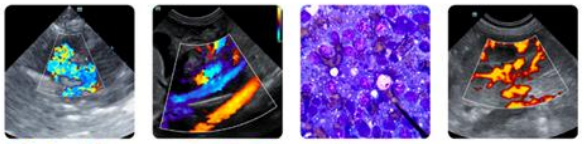

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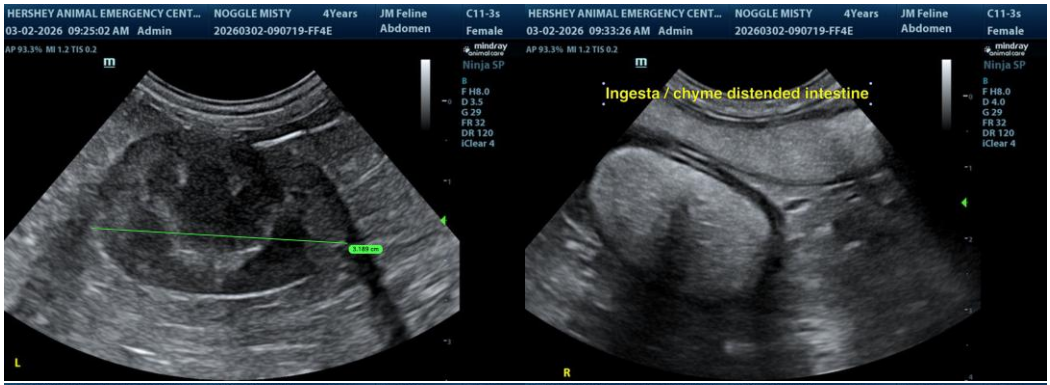

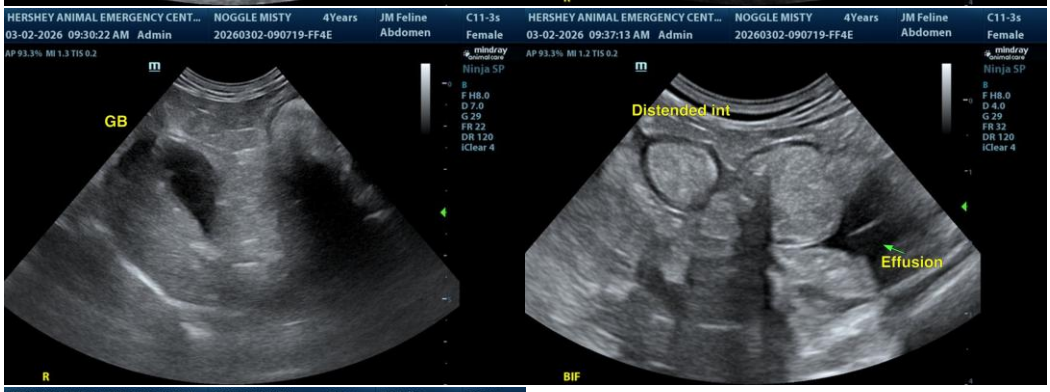

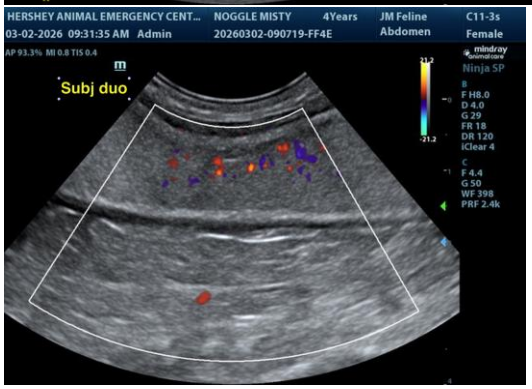

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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