



## PATIENT

Frieda Houle

## SPECIES

Feline

## BREED

DSH

## SEX

FS

## AGE

5yr

## WEIGHT

5.5kg

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Dr. Mariusz  
Chmielinski, DVM

## HOSPITAL NAME

Apex Veterinary  
Services Ltd.

## REFERRING VET

Save Emergency/ER  
Doctor

## INVOICE

24267

## DATE

03/23/2026

## PRESENTING CLINICAL SIGNS

- Acute vomiting (x5 episodes over ~36 hours), progressing from food - watery -pink/blood-tinged. Associated decreased appetite and water intake.
- Pertinent History:
  - Outdoor cat; hunts and may ingest prey (mice)
  - No known dietary indiscretion
  - No prior medical history
  - No diarrhea
- Abnormal PE/Chem/CBC/UA Results: Physical Exam Findings: BAR, ~8% dehydrated (tacky MM, hemoconcentration) Mild abdominal discomfort on palpation Palpable firm fecal material in colon No palpable masses CBC / Chemistry: HCT 0.61 → hemoconcentration (consistent with dehydration) Mild neutropenia (2.06 x10<sup>9</sup>/L) Mild azotemia (Creatinine 147 μmol/L) → likely pre-renal Radiographs (initial + repeat): Round soft tissue opacity in left cranial abdomen (caudal to liver), surrounded by gas Visible only on VD view More radiolucent on repeat Moderate gas dilation of cranial intestinal loops Minimal progression of gas distally Stomach appears empty on lateral views APOCUS: Stomach empty Gas-distended viscus caudal to stomach (SI vs colon) Liver and GB subjectively WNL Colon: fecal vs empty

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Anechoic urine was present in the lumen with mild non-dependent particulate sediment. 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 3.8 cm in length. The right kidney measured 4.0 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 uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.41 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.

Focal area of similar appearing tissue adjacent to the cranial spleen, measuring 0.81 cm in diameter.

### 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 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 retained gastric fluid without evidence of shadowing content or obstruction to pyloric outflow.

The small intestine presented generalized non-thickened wall exhibiting mild altered wall layer ratio owing to propensity for mildly prominent muscularis layer and segmental mildly prominent submucosa layer. Mild non-obstructive duodenojejunal ileus to level of the ileum and colon. No evidence of pathology in the area of the ileocolic junction. The duodenum wall measured 0.20 cm width. The jejunum wall measured 0.22 cm width. The ileocolic wall measured 0.30 cm width.

Normal visible colon wall layers were present with semi formed to soft 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**

No omental masses or peritoneal effusion was present.

Intermittent mildly prominent to enlarged jejunocolic 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 1.5 cm x 0.43 cm.

## **ULTRASONOGRAPHIC FINDINGS**

### **Primary**

- Acute gastroenteropathy pattern exhibiting mild non-obstructive gastric and segmental intestinal ileus
- Semi-formed/ soft fecal matter in colon
- Intermittent mild jejunocolic lymphadenopathy-suggestive of benign criteria i.e. mild hyperplasia or reactive lymphadenitis
- Normal area of pancreas
- Sonographically normal kidneys

### **Secondary**

- Suspect focal ectopic /accessory spleen- incidental

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Dietary indiscretion, infectious disease, enterotoxin, acute inflammatory bowel or emerging IBD, mild



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pancreatitis which may present sonographically normal, occult parasitism, less likely emerging to occult gastrointestinal neoplasia are all potentials. No evidence of foreign material or obstructive pattern. Gastrointestinal and renal support recommended with clinical monitoring.

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A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Sonographic reassessment indicated if non-responsive or progressive gastrointestinal signs or evidence of weight loss.

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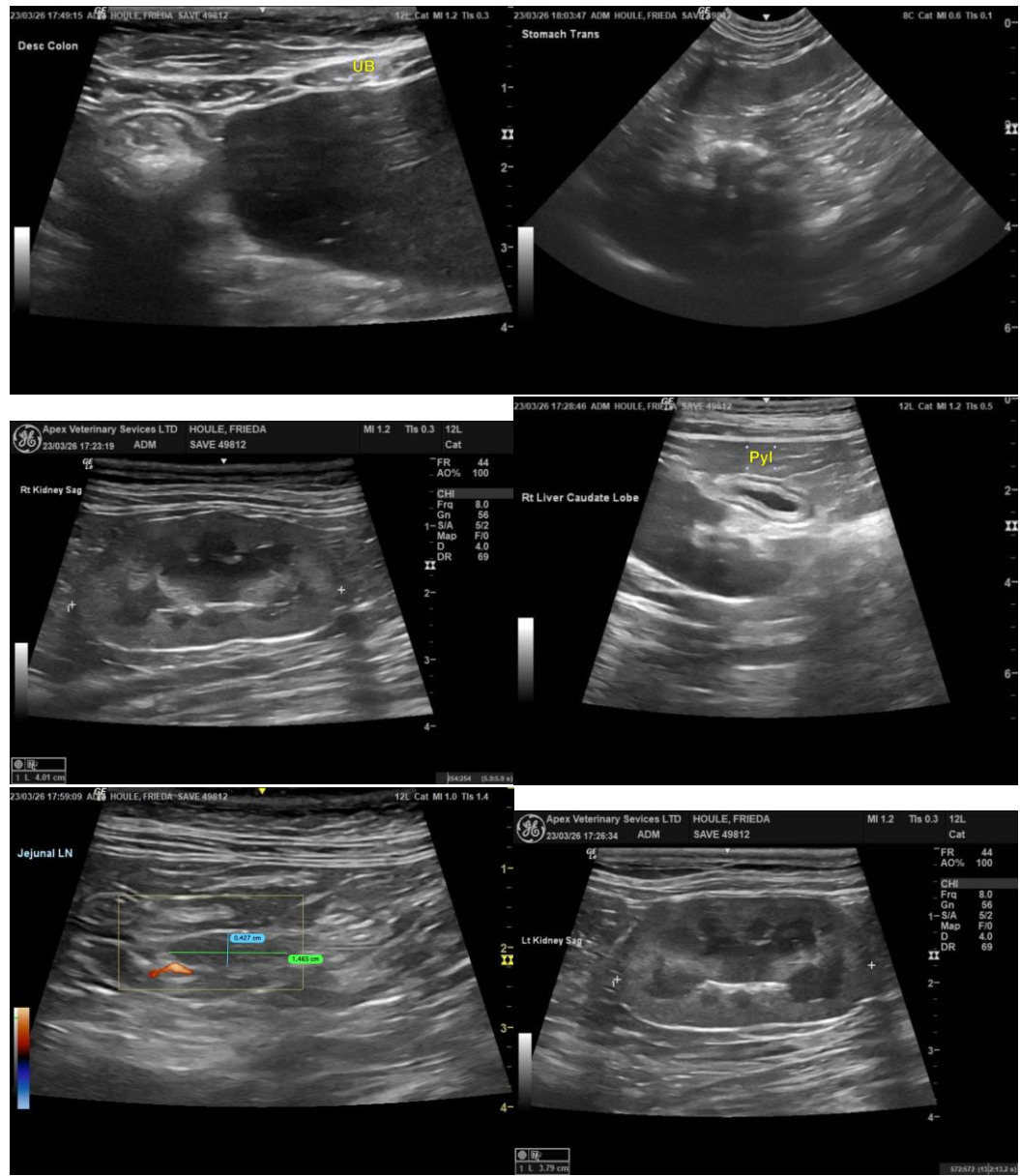
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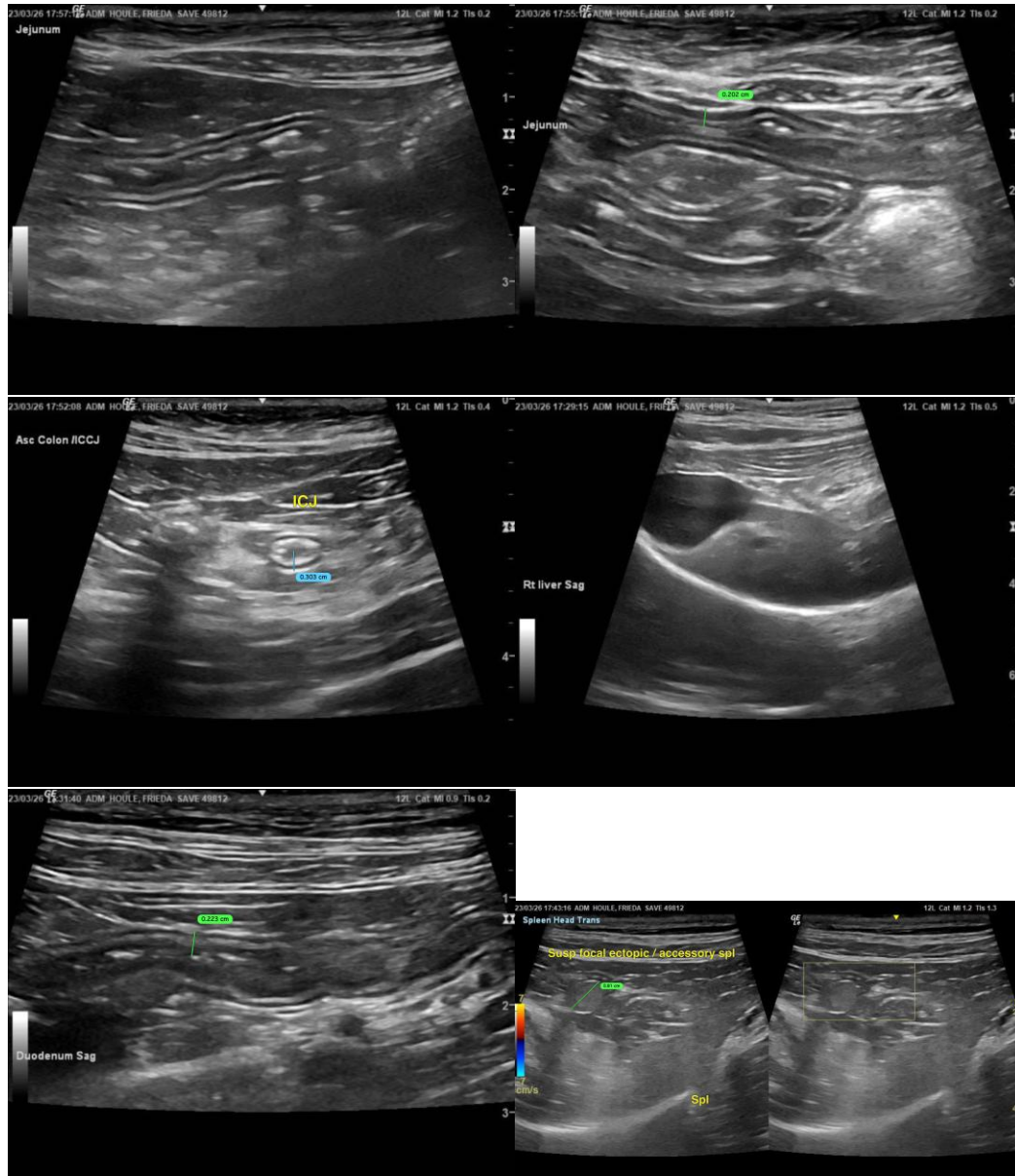
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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