



PATIENT

Hector Granado

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

2Y

WEIGHT

5.3kg

PRESENTING CLINICAL SIGNS

Presented initially on May 24, 2026 after vomiting food and tinsel. Owner suspected ingestion occurred the previous evening. At that time patient was otherwise BAR with normal appetite, activity level, urination, and defecation.

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On May 29, 2026:

Vomited food twice, Developed acute diarrhea progressing from soft stool to liquid diarrhea. Vocalized prior to vomiting episodes. No tinsel observed in current vomitus or stool. Appetite remains good; ate breakfast and retained it. Activity level remains normal. No observed straining to urinate or defecate. Multiple (approximately three) abrupt diet changes over the past week. Famotidine discontinued Wednesday after apparent clinical improvement

Abnormal PE/Chem/CBC/UA Results: Physical Examination: BAR Temperature: 38.3°C, HR: 200 bpm, Hydration: Adequate, Abdomen not overtly painful, Dark brown diarrhea present on rectal thermometer. Repeat Abdominal Radiographs (May 29, 2026): Stomach empty, Small amount of soft tissue opacity in pyloric region, possibly ingesta, Small intestines appear fluid-filled with a mildly bunched/plicated appearance. No significant small intestinal gas dilation, Single small metallic opacity noted and considered incidental/non-obstructive, Colon contains liquid to soft fecal material consistent with diarrhea

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. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible, which is normal. No evidence of inflammatory or neoplastic changes was noted.

The area of the residual prostate appeared normal and free of pathology.

No evidence of pathology in the area of the aortic trifurcation.

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 4.2 cm in length. The right kidney measured 3.9 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.39 cm. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.49 cm.

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

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

Alpine 24/7 / ER
doctor

INVOICE

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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. Normal hepatic vascular volume was present. 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 minor retained pyloric fluid without evidence of retained ingesta or foreign material.

The small intestine presented overall intact wall layering with maintained wall layer ratio in the duodenum and jejunum. Soft to nonformed ingesta/chyme present in the distal jejunum and ileum with hyperechoic linear distal jejunum to ileum lumen echo. The duodenum wall measured 0.25 cm. The jejunum wall measured 0.25 cm. The ileum wall presented intact and mildly thickened to the level of the ileocolic junction. The ileocolic junction wall measured 0.40 cm. No evidence of intestinal obstructive pattern.

The colon walls presented intact yet mildly thickened wall layering. Semi formed to soft fecal matter was present in the colon lumen with concurrent proximal to transverse hyperechoic linear echoes. The colon wall measured 0.2-0.25 cm.

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 were evident.

Free Abdomen

Mild peri ileocolic hyperechoic omentum and mild irregular nonhomogeneous colic lymphadenopathy was present. An example of a colic lymph node measured 2.5 x 0.44 cm. Very scant peri ileocolic effusion was seen.

ULTRASONOGRAPHIC FINDINGS

- Ileocolitis with persistent nonobstructive distal jejunum/ileum and segmental colon linear foreign bodies.
- Mild peri ileocolic inflammation and colic lymphadenopathy.
- Minor retained pyloric fluid.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Without evidence of small intestine obstruction, the persistent distal small intestine occult foreign bodies may be passing. Secondary or associated distal small intestine and colon inflammation are probable in conjunction with the patient's gastrointestinal signs. Recommend hospitalization with 24-hour IV fluid gastrointestinal support and sonographic reassessment. If persistent or progressive clinical



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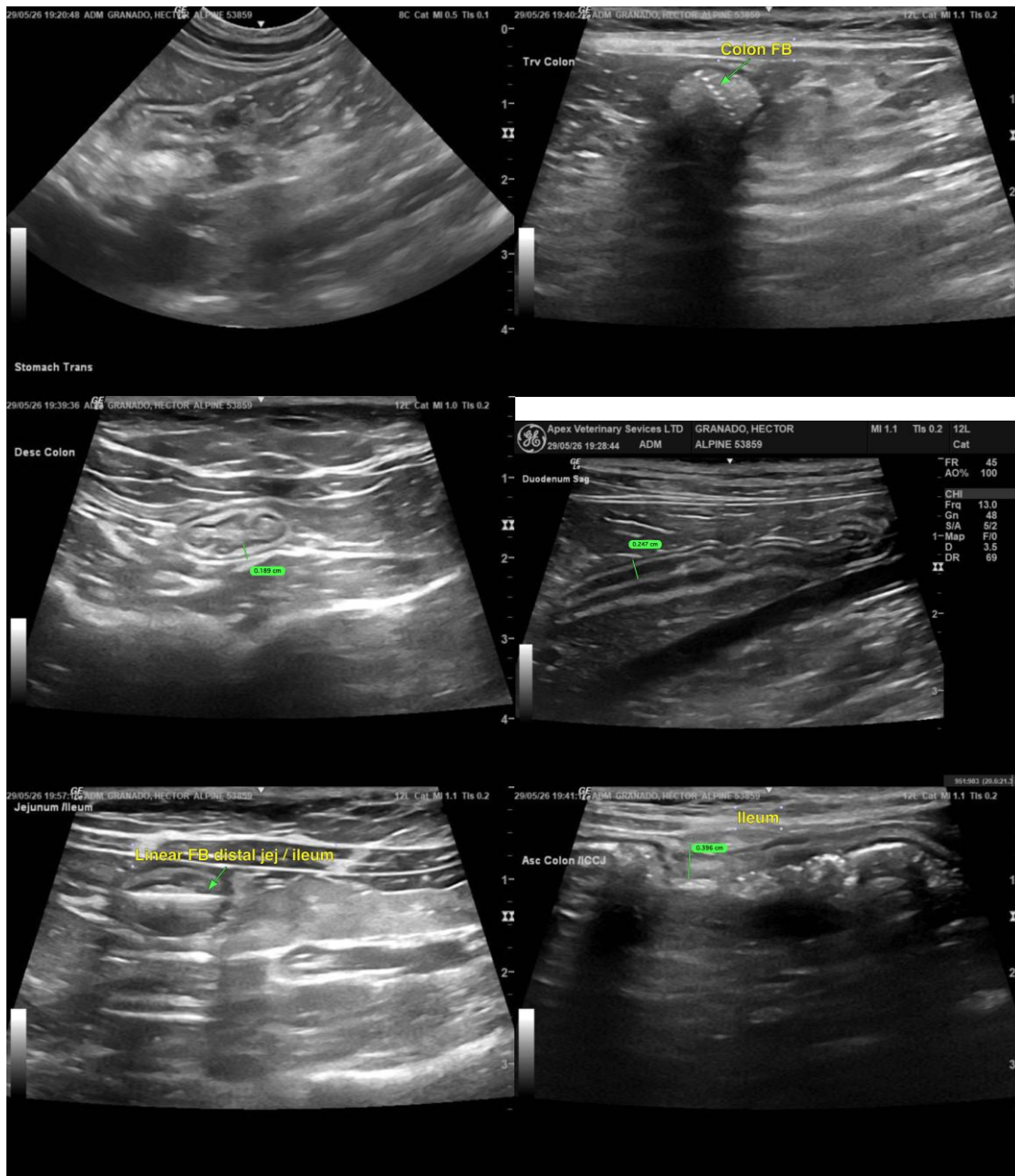
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signs or evidence of nonmoving distal small intestine foreign material, exploratory laparotomy with distal enterotomy and concurrent biopsies may be indicated.





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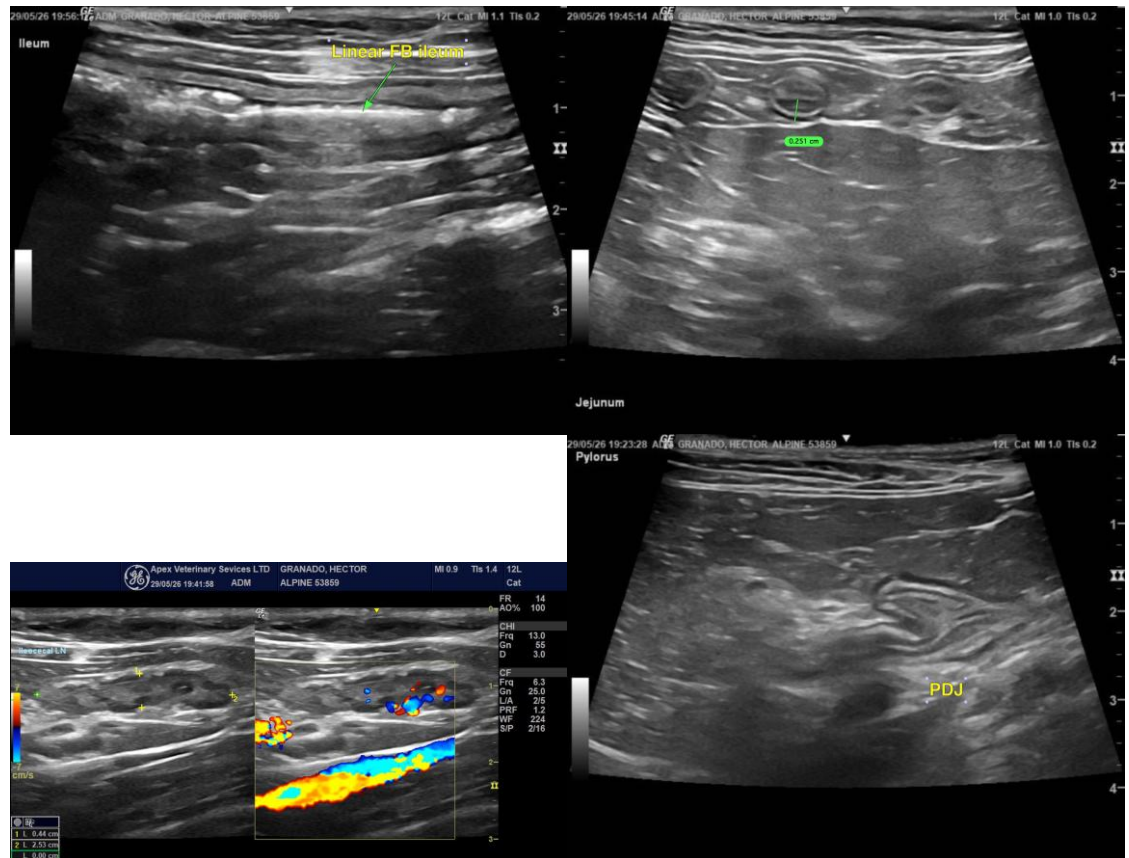
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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