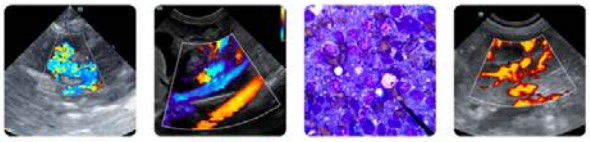

PATIENT

Sheba Canales

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

12 Years 2 Months

WEIGHT

9.63 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Carthleen Whitcraft, DVM

HOSPITAL NAME

Craig Road Animal Hospital

REFERRING VET

Hailee Sims, DVM

INVOICE

75585

DATE

5/31/26

PRESENTING CLINICAL SIGNS

Presented for acute vomiting 2 days ago, CBC/Chemistry clinically unremarkable. Abdominal x-ray found segmental dilation of small intestine with no radiopaque material, antech suspected trichobezoar vs partial obstruction. P represented today for vomiting food and bile. PE unremarkable.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Left kidney measured 3.5 cm. Right kidney measured 3.7 cm.

Adrenal Glands

The adrenal glands were not definitively visualized.

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

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. 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

Thickened stomach wall noted, primarily owing to subjectively thickened gastric mucosa. Mild retained fluid noted in the stomach. Intact to mildly indistinct gastric wall layer detail. Stomach wall measured 0.40 cm.

Diffusely thickened small intestinal wall noted exhibiting intact to segmentally indistinct wall layer detail. Primarily empty small intestinal lumen with mild segmental jejunal ileus. Duodenum wall measured 0.31 cm. Jejunum wall measured up to 0.32 cm. Ileocolic wall measured 0.30 cm. Mild peri intestinal to perilymphatic hyperechoic omentum noted.

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

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Pancreas

The pancreas was normal in size with capsule asymmetry. Non-homogeneous hypoechoic parenchyma with mildly prominent pancreatic duct noted. Subtle peripancreatic hyperechoic omentum noted.

Free Abdomen

Mildly asymmetrical enlarged non-homogeneous hypoechoic jejunocolic lymph nodes were noted. Example measured 1.1 cm x 0.66 cm.

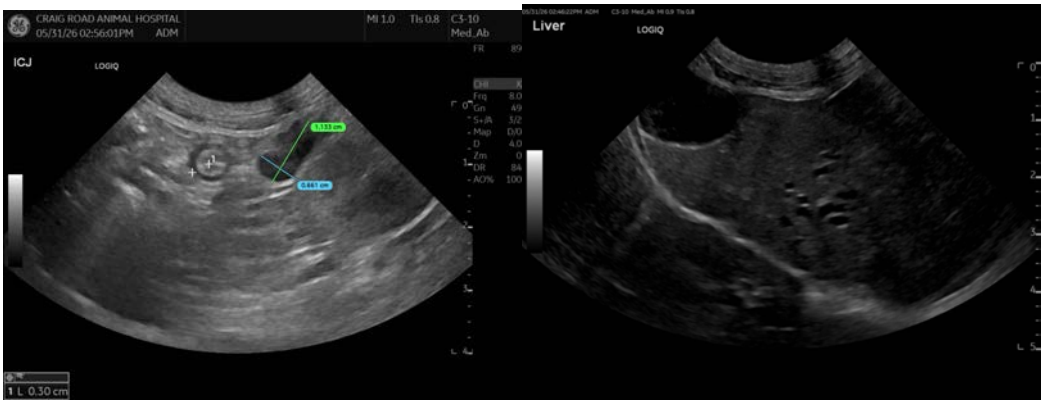
No effusion.

ULTRASONOGRAPHIC FINDINGS

- Gastroenteropathy with mild gastric and segmental intestinal non-obstructive ileus.
- Mild non-homogeneous, hypoechoic jejunocolic lymphadenopathy. J
- Non-homogeneous, hypoechoic pancreas.
- Mild chronic renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Acute gastroenteritis i.e., dietary indiscretion, infectious disease, etc., IBD, or other inflammatory enteropathy or occult intestinal neoplasia are primary differentials in conjunction with evidence of chronic to chronic active pancreatitis. No overt mechanical obstruction or foreign material. FNA cytology of accessible lymph node +/- culture and sensitivity could be considered for initial clarification. Intestinal and lymphatic biopsies may be required for definitive diagnosis. Gastrointestinal support with clinical and sonographic monitoring indicated. Correlation with GI panel to include PLI, TLI, cobalamin and folate recommended. Recheck sonogram if persistent or progressive gastrointestinal signs despite supportive care or if evidence of weight loss.



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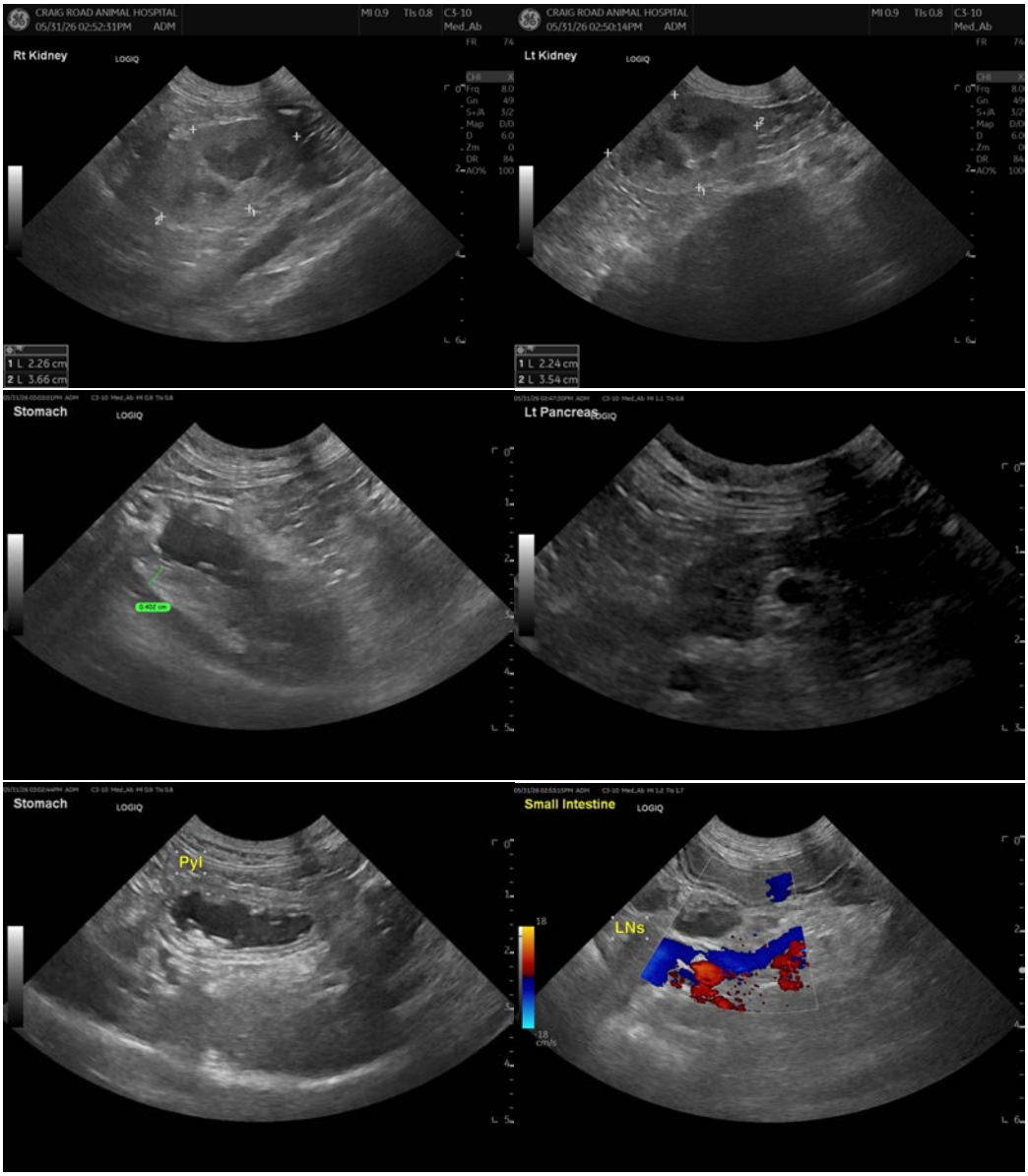

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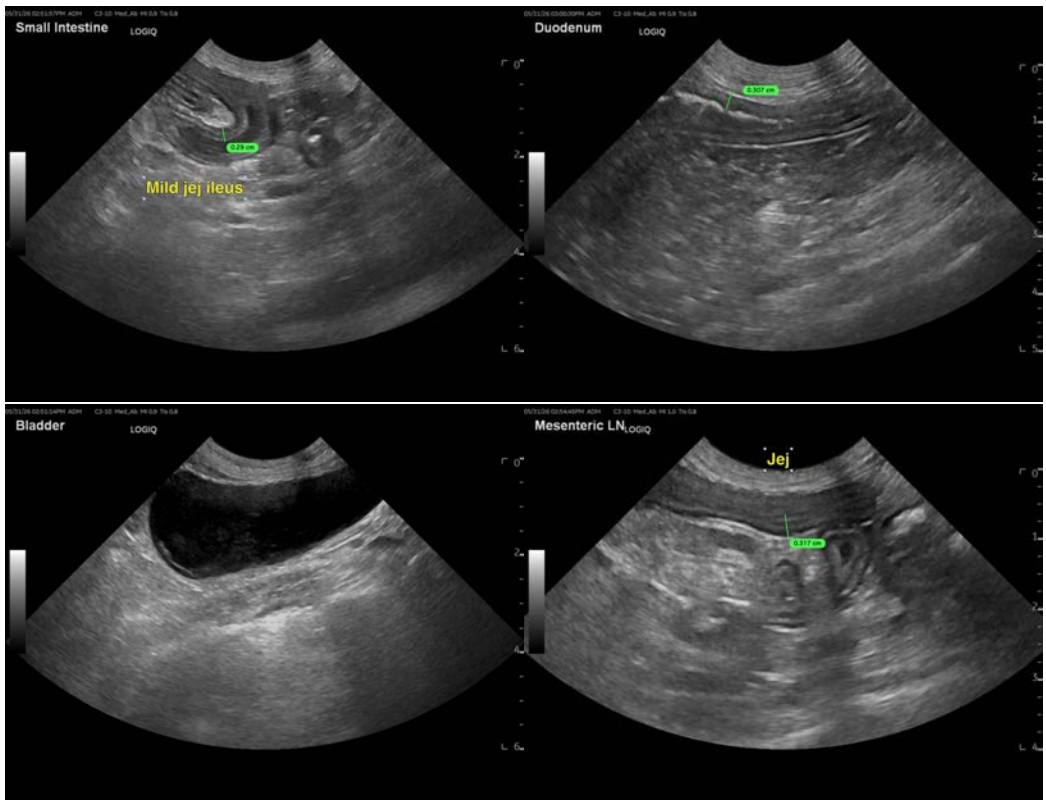

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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