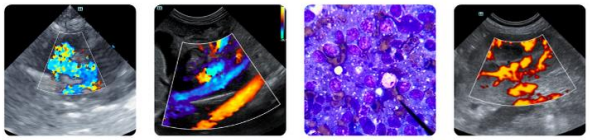




**PATIENT**

Judy Rylance

**SPECIES**

Feline

**BREED**

DLH

**SEX**

FS

**AGE**

13 y

**WEIGHT**

5.27 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Michelle DeMelo, RVT

**HOSPITAL NAME**

Woodstock VH

**REFERRING VET**

Dr. Esther Duschinsky

**INVOICE**

10950

**DATE**

6/3/26

## PRESENTING CLINICAL SIGNS

Presented 3 days ago for a 1 week history of reduced appetite and energy and 2 days history of vomiting and anorexia. After further discussion, Os say that she has been a "chronic vomiter" who vomits once to 3 times weekly.

Initial diagnostic testing was all normal - CBC, profile, electrolytes, spec FPL in clinic, u/a showed quite a few RBC - this was attributed to cystocentesis. Survey radiographs showed a possible gas pattern - we were uncertain whether this was in the small intestines or the colon. So some barium was administered. Over the next 36 hours the barium passed slowly with a coating of barium being retained in the small intestines (dose of barium was a bit low). Cobalamin level was tested and was well within the normal range. Treatments up until now have been supportive care with SQ fluids, Cerenia and mirtazapine. Within the past 24 hours with the slow GIT transit on the barium series, she was treated for ileus with oral metoclopramide at 0.5 mg/kg BID.

## 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 were noted.

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 was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 3.4 cm in length. The right kidney measured 3.9 cm in length.

### *Adrenal Glands*

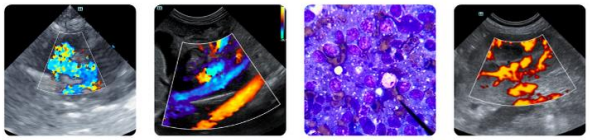
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.35 cm width. The right adrenal gland was not definitively visualized owing to overlaying gastrointestinal artifact.

### *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/ 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





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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 overall normal intact visible wall. The stomach contained a moderate amount of retained anechoic to echogenic fluid and nonshadowing, primarily gravity-dependent chyme. There was no overt visualized obstruction to pyloric outflow. The pylorus wall width measured 0.21 cm in width.

The small intestine presented primarily intact wall layering with a non-thickened wall and maintained wall layer ratio. The duodenum wall measured 0.25 cm width. Normal appearing jejunum wall measured 0.21 cm width. A segment of mildly thickened midabdomen intestine consistent with jejunal location exhibited intact to potential mild indistinct wall layer detail, with thickened segmental jejunum wall measuring 0.35 cm width. Generalized intestinal ileus was noted containing retained echogenic fluid, gas, and probable mild segmental barium to the level of the colon. The ileocolic junction was not definitively visualized.

Normal visible colon wall layers were present with strongly shadowing fecal matter and probable barium.

### *Pancreas*

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

### *Free Abdomen*

Midabdomen peri intestinal mildly hyperechoic omentum was present. There was no overt visualized significant omental lymphadenopathy. No evidence of peritoneal effusion was noted.

## ULTRASONOGRAPHIC FINDINGS

- Diffuse gastrointestinal ileus exhibiting retained gastrointestinal fluid, chyme, and segmental intestinal gas / likely barium
- Strongly shadowing fecal matter in colon – consistent with passed barium
- Subjective mildly thickened midabdomen jejunum with mild peri intestinal hyperechoic omentum
- Mild nonhomogeneous remodeled pancreas
- Mild chronic renal changes

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Diffuse gastrointestinal ileus or inefficient peristalsis are possible potentially secondary to underlying gastrointestinal disease. The mildly thickened midabdomen jejunum did not overtly appear to be mechanically obstructive, yet the potential for emerging partial obstruction or nonobvious partial fluid-absorbing intestinal material is not definitively excluded, given the degree of gastrointestinal ileus. An exploratory laparotomy with gastrointestinal biopsies (considered essential), in conjunction with diffuse gastrointestinal ileus, is warranted. Continued supportive care with clinical and serial sonographic monitoring would be more conservative. Chronic pancreatitis as a contributing factor is thought less likely, given normal spec fPL and lack of overt sonographic pancreatic pathology.

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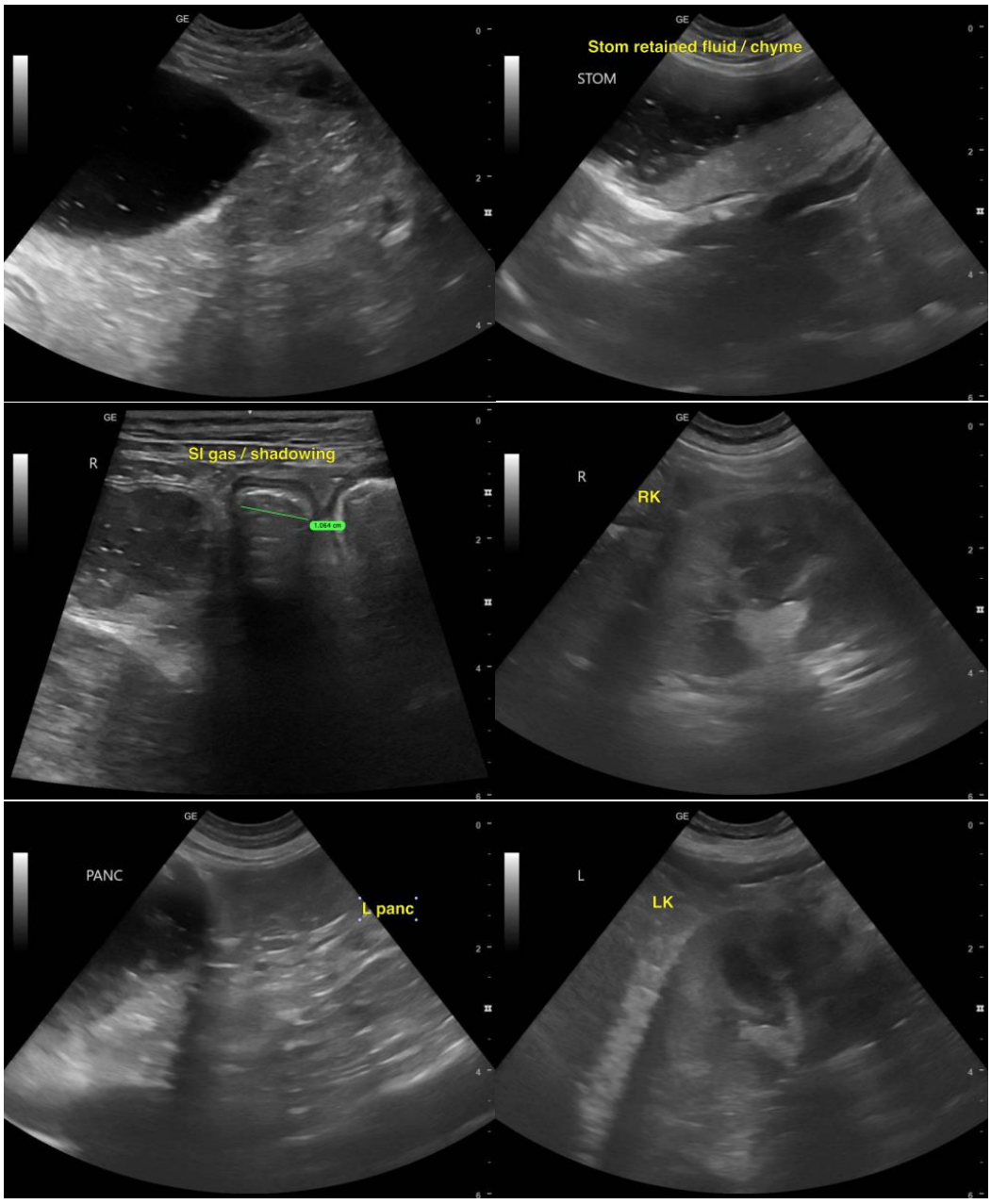

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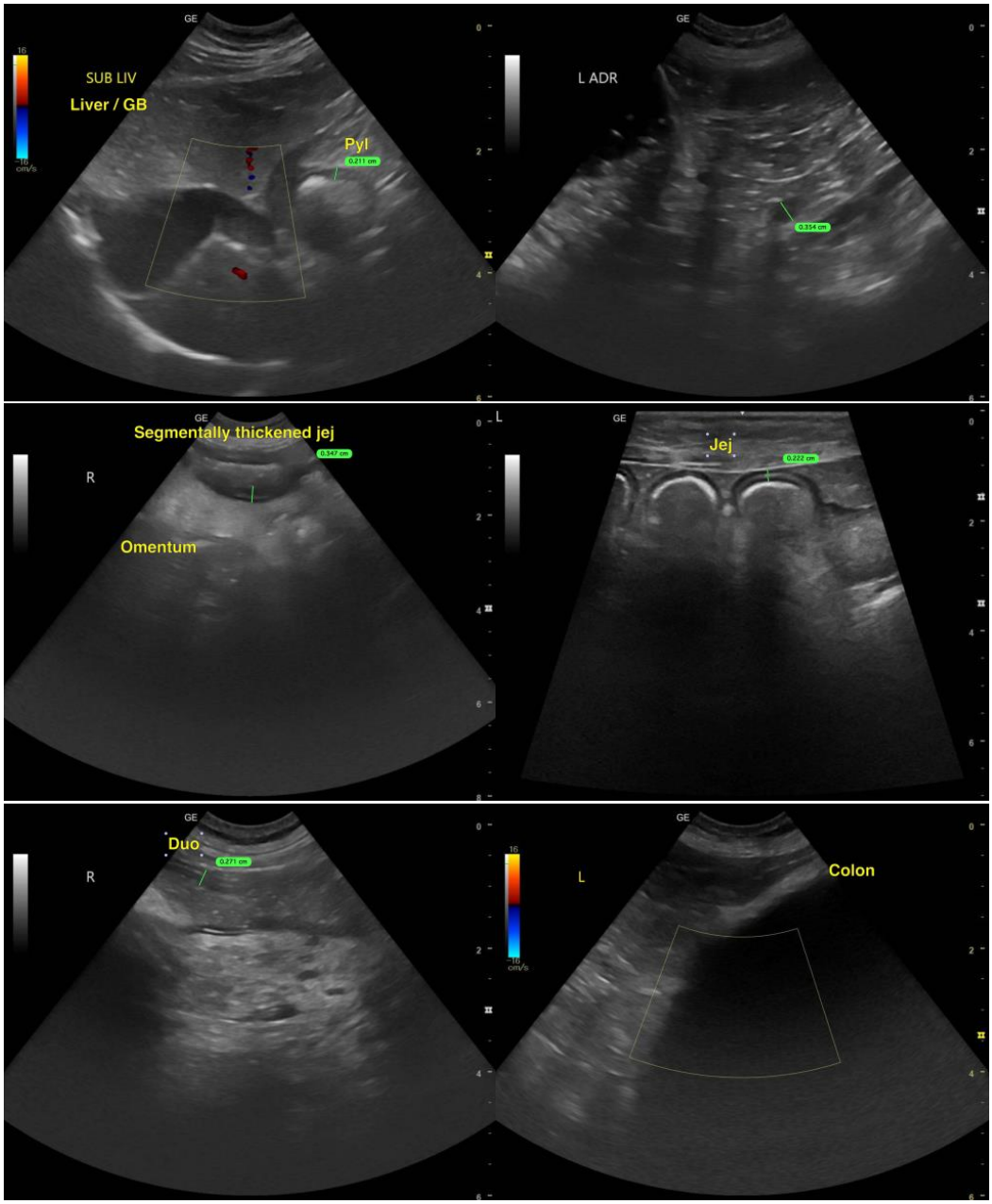


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

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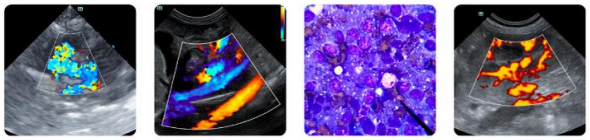

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SonoPath.com info@sonopath.com 1.800.838.4268

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