



## PATIENT

Aisha Laird

## SPECIES

Feline

## BREED

DLH

## SEX

Spayed Female

## AGE

12 Years

## WEIGHT

3.4 kg

## INTERPRETED BY

Brad Harris, DVM,  
DACVECC, DACVIM  
(cardiology)

## IMAGING PERFORMED BY

Dr. Sarah Barthelemy

## HOSPITAL NAME

Fish Creek Pet Hospital

## REFERRING VET

Dr. McNicol

## INVOICE

74583

## DATE

4/18/26

## PRESENTING CLINICAL SIGNS

Acute onset diarrhea, lethargy, inappetence. No blood in stool. Was straining overnight passing small amounts. Family moved house recently and after that Aisha had some inappropriate defecation and over-grooming tummy.

Abnormal PE/Chem/CBC/UA Results: Mild basophilia

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder, trigone, and pelvic urethra are unremarkable with normal wall thicknesses and normal tone. The ureters were not visualized, which is a normal finding. The bladder is minimally distended with anechoic urine. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size. The cortices are hyperechoic with a loss of corticomedullary distinction. The cortex to medulla ratio is appropriate. No pyelectasis or pelvic dilation noted. The renal capsules are mildly irregular bilaterally. Left kidney measures 4.0 cm. Right kidney measures 3.75 cm.

### *Adrenal Glands*

Both adrenal glands are visualized and have normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The adrenals measures 0.34 cm bilaterally.

### *Spleen*

The spleen is enlarged, with a smooth and homogeneous parenchyma. It is hyperechoic to the liver and renal cortex. The capsule is mildly irregular. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis. The spleen measures 1.36 cm at the hilus.

### *Liver*

The liver is subjectively normal liver size, contour, and structure. Parenchymal echogenicity is naturally coarse and hypoechoic to the spleen. Vasculature is within normal limits with no evidence of congestion. The gallbladder has thin walls which contain anechoic bile. There is no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal. No hepatic lymphadenopathy is documented. There is no overt structural evidence of inflammatory, infiltrative or regenerative pathology evident.

### *Gastrointestinal*

The gastrointestinal tract is non-distended and free of stasis, with adequate peristaltic activity. The gastric mucosa is mildly irregular with a patent pylorus and pyloroduodenal junction. The small intestine has a mildly irregular submucosal layer with subtle, ill-defined hypoechoic nodular changes throughout. There are multifocal regions with a prominent muscularis layer that distorts the normal 1:3 muscularis to mucosal ratio. The ileoceocolic junction is patent. The colon contains normal shadowing feces. There are portions of the colonic wall that appear mildly thickened with maintenance of normal wall layering.



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## **Pancreas**

The base and limbs of the pancreas are isoechoic to surrounding omental fat. The pancreatic duct and capsular contour are normal. There is no overt evidence of active inflammatory or neoplastic disease.

## **Free Abdomen**

There are prominent mesenteric, ileocecolic, and iliac lymph nodes with normal length to width ratio and isoechoic parenchyma. There is a scant volume of anechoic free fluid near the caudal aspect of the spleen.

## **ULTRASONOGRAPHIC FINDINGS**

- The kidneys are relatively normal in size and structure, and cortex:medulla ratio (cortex 1/3 of medulla) is essentially maintained. There is age-related loss of the normal smooth capsular contour and C/M junction definition. The cortices are largely uniform in texture with mild hyperechogenicity expected for this patient's age. There is no evidence of pelvic dilation present.
- The spleen is enlarged with a subjectively normal parenchyma. This is concerning for potential infiltrative disease such as round cell neoplasia.
- The intestinal submucosa is slightly irregular, thickened and hyperechoic suggestive of low grade, chronic disease. There is mild uniform prominence of the gastric mucosa as well as areas of "ropey" small intestinal wall with slight disruption of the normal 1:3 muscularis/mucosal ratio. This is most consistent with chronic enteropathy. No concerning lymphadenopathy or evidence of mechanical obstruction is present. Chronic inflammatory bowel disease is likely with a low possibility of an early neoplastic event such as lymphoma.
- The slightly prominent mesenteric, ileocecolic, and iliac lymph nodes display no loss of parenchymal detail or change in echogenicity. This is most consistent with reactive lymphadenitis or lymphatic hyperplasia.

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

A urinalysis and urine culture via cystocentesis are recommended to evaluate the urinary tract changes for potential urinary tract infection.

Fine needle aspirates of the spleen with cytology are recommended. A coagulation profile and platelet estimate prior to sampling are indicated to ensure the absence of coagulopathy. Occasionally some tissues are poorly exfoliative, or cytology is non-specific, in which case biopsy with histopathology may be required for a definitive diagnosis.

A gastrointestinal panel (TLI, PLI, B12, folate) via Texas A&M gastrointestinal laboratory is indicated to further evaluate for potential chronic enteropathy. Ultimately, gastrointestinal biopsies may be required for a definitive diagnosis.



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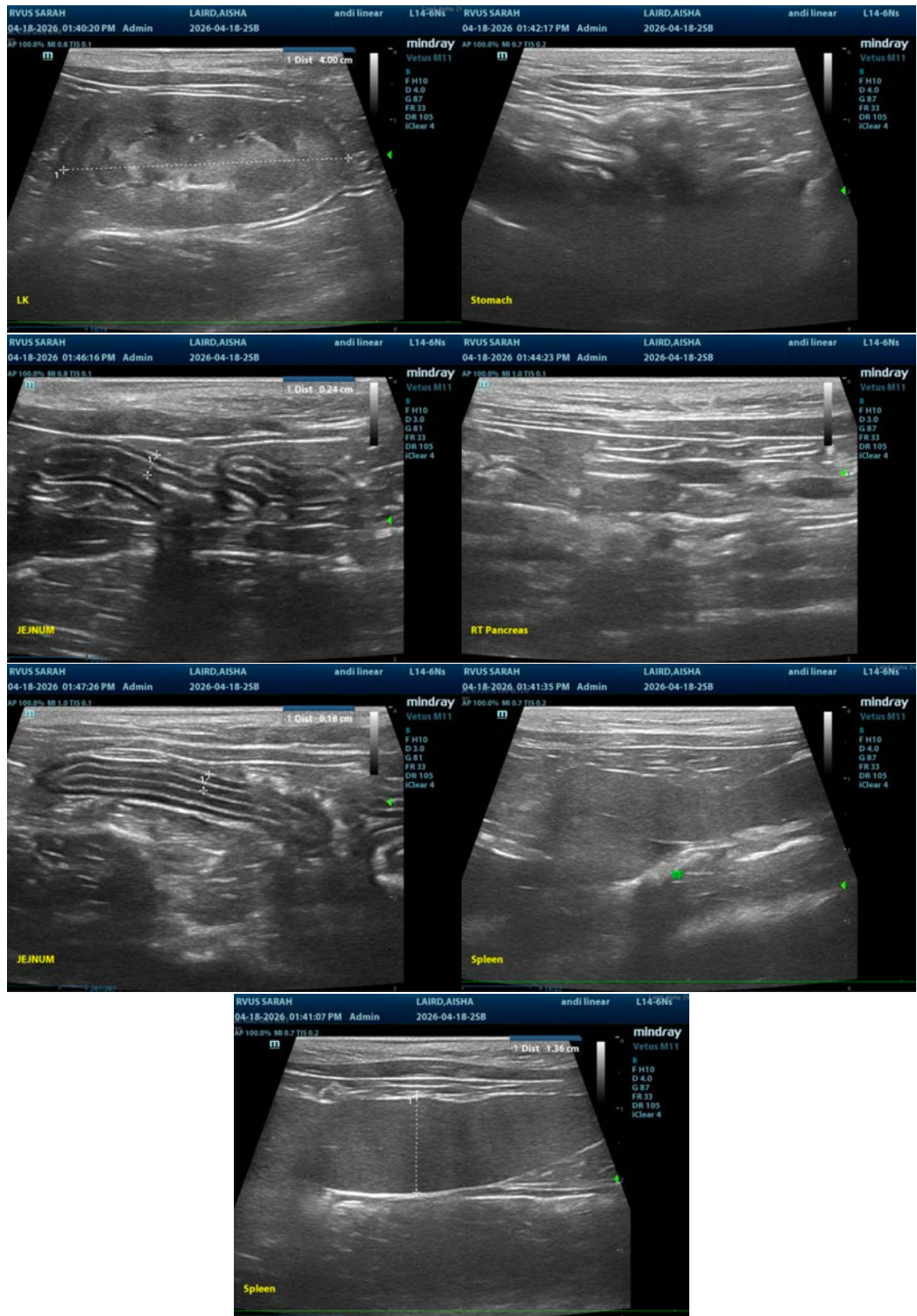
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**Brad Harris, DVM, DACVECC, DACVIM (cardiology)**

[info@SonoPath.com](mailto:info@SonoPath.com)