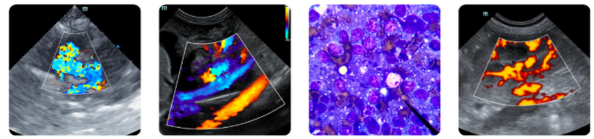


PATIENT
Toro Tran

SPECIES
Feline

BREED
Domestic Shorthair

SEX
MN

AGE
5 years

WEIGHT
14.2 lbs

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Dr. Jazmin Munoz Gonzalez

HOSPITAL NAME
Oakridge Veterinary Clinic

REFERRING VET
Dr. Jazmin Munoz Gonzalez

INVOICE
11170

DATE
1/20/2026

PRESENTING CLINICAL SIGNS

- Toro is presented for vomiting approximately 3 times per week, increased from his baseline of once per week. Vomiting typically occurs 15 to 20 minutes after eating and consists of undigested food with gagging and retching. He has always had underlying indigestion since being obtained as a stray.
- Previously fed Royal Canin hydrolyzed dry food and Royal Canin GI wet food without significant improvement. Currently fed Sheba wet food (tuna, salmon flavors) and Everclear dry food (allergy formula). Owner reports he tolerates the fish-based Sheba wet food better and does not appear to have a protein allergy as he has been fed chicken and beef without specific reactions. indoor/outdoor
- Recent bw revealed lymphocytosis 7.601, chem wnl, TT4 1.8, felv/fiv/hw neg

Abnormal PE/Chem/CBC/UA Results: Recent bw revealed lymphocytosis 7.601, chem wnl, TT4 1.8, felv/fiv/hw neg.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a large amount of echogenic non-shadowing debris, most consistent with exfoliated cells, crystals, mucous and/or small blood clots likely combined with incidental suspended lipid. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal is size (4.3 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (4.5 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

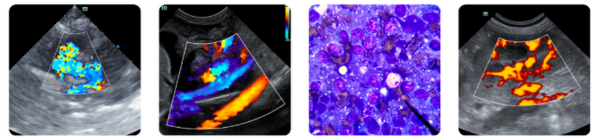
The areas of the adrenal glands are examined without evident adrenal gland pathology.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.



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The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen is mildly distended with primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal chyme. There is no evidence of obstruction, foreign material, or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestine demonstrates areas of mild thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

Pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. Medial to the right kidney, there's a tortuous hypoechoic tubular like structure measuring 0.55 cm in diameter, that I believe is a dilated, tortuous pancreatic duct.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

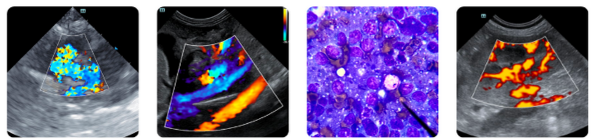
ULTRASONOGRAPHIC FINDINGS

- Mild/emerging inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.
- Chronic low grade smoldering pancreatitis with a dilated, tortuous pancreatic duct is suspected. Having said that, other differentials for the tubular structure, including vessel versus other, while thought less likely can't be definitively ruled out.
- Moderate to large amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

Further evaluation of the reported lymphocytosis is recommended, beginning potentially with a pathology review of the CBC.



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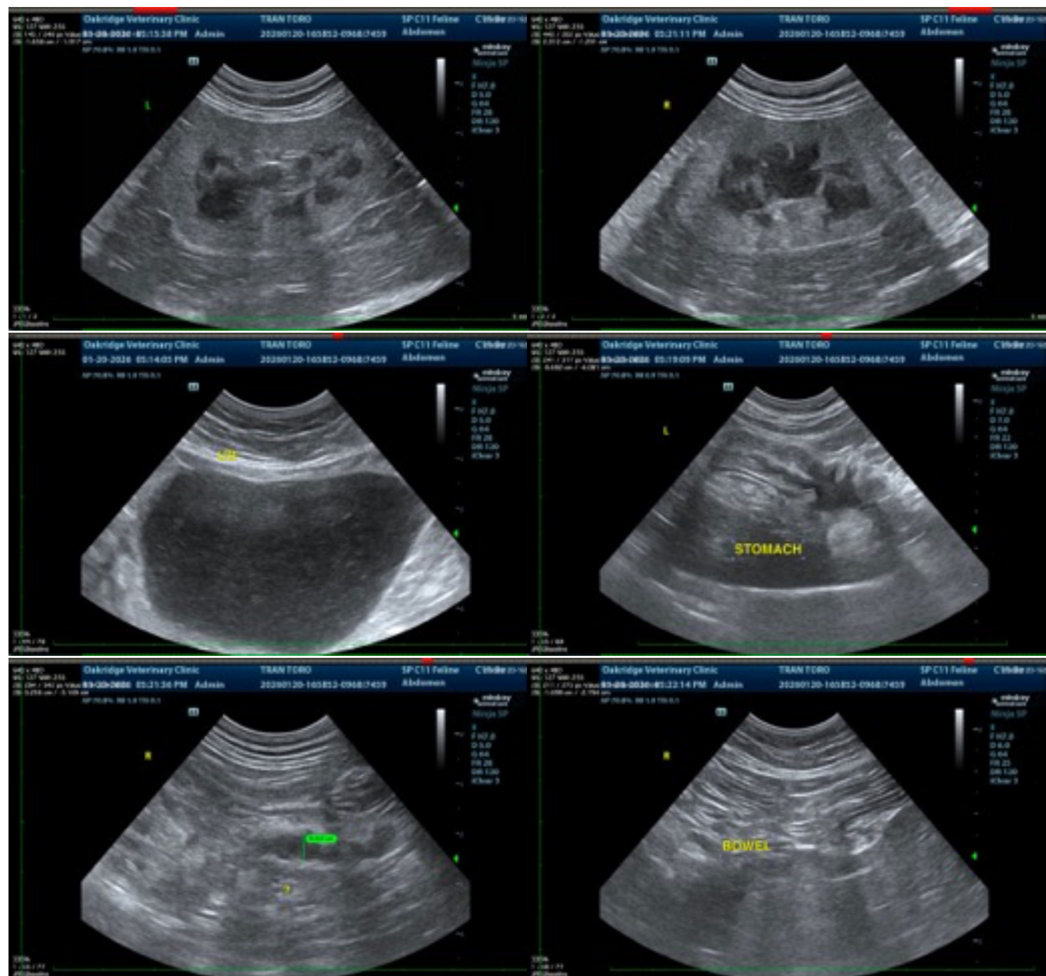
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Ultimately, tissue sampling may be warranted. Fine needle aspirates of the pancreas could be considered if patient's coagulation status is appropriate, or biopsies of the GI tract, being sure to include ileum, may ultimately be necessary for a definitive diagnosis and therefore to further guide medical management.

Other than supportive/symptomatic medical management of clinical signs, further diagnostic and treatment recommendations are largely dependent on results of the above.



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.

Beth Johnson, DVM, DACVIM info@sonopath.com