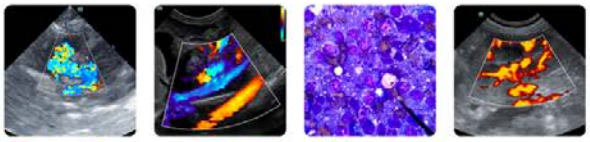


PATIENT

Oscar Froehlich

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

9 Years 7 Months

WEIGHT

10.2 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge Animal Hosptal

REFERRING VET

Dr. Kristen Carpenter

INVOICE

72360

DATE

1/21/26

PRESENTING CLINICAL SIGNS

Hx: Patient was sedated with Butorphanol. Patient diagnosed with presumptive IBD via AUS 3/28/23 and was started on B12, HP, and prednisolone tapering course. Was able to wean patient to 2.5 mg prednisolone ETD as his lowest effective dose and was stable until October 2025. Since October, the patient has lost approximately 3 pounds, is muscle wasted and inappetent. Presented twice in the last 3 months for fever/pancreatitis (diagnosed via high FPL) and responded to hospitalization and supportive care. Bloodwork from last episode of pancreatitis 12/26/25: WNL except fPL 11.9 (normal 0-4.4). Patient is still inappetent and presented for abdominal pain 1/14/26. On exam, patient had a Grd II Heart murmur, muscle wasting, and his abdomen was distended/painful. Recommended AUS to image the pancreas and discussed suspicion of IBD transforming into intestinal LSA. Current meds: Cerenia SID, Prednisolone 2.5 mg EOD, Buprenex for abdominal pain. Current diet: HP

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal is size (4.16 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 (4.07 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 right adrenal gland is normal in size (0.34 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.38 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

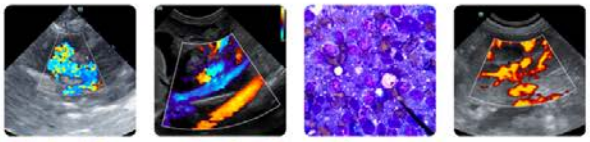
Spleen

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.

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.



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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

Diffusely, the visible small intestine demonstrates areas of markedly/significantly thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic. Focally in the mid abdomen there is a loop of bowel that is focally thicker than the remaining bowel and markedly thick for small bowel, measuring 0.66 cm thick. Layering is not completely lost in this bowel loop, but there are segments of it with a slightly less distinct than normal/small breaks in the submucosal layer. 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

The observed pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Pancreatic duct dilation is noted. Enhanced hyperechoic ill-defined surrounding fat is noted.

Free Abdomen

There is free fluid noted in these images as well as enhanced hyperechoic mesenteric fat adjacent to the pancreas as well as adjacent to the focal bowel loop described above, where early suspected loss of layering is occurring.

Mesenteric lymph nodes are enlarged with swollen irregular capsular contour and loss of normal length to width ratio (rounded in shape). Nodes are hypoechoic with loss of normal parenchymal detail.

ULTRASONOGRAPHIC FINDINGS

- Suspect gastrointestinal lymphoma (suspect) pattern. Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. Given the suspicion for early loss of layering noted, infiltrative neoplasia is considered slightly more likely, but benign IBD cannot be ruled out without tissue sampling.

- Concurrent mild or emerging acute pancreatitis is suspected. Having said that, some of the free fluid and enhanced hyperechoic fat/focal peritonitis could be secondary to the bowel disease versus inflammation from pancreatitis.

- Aggressive mesenteric lymph nodes – concerning for infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

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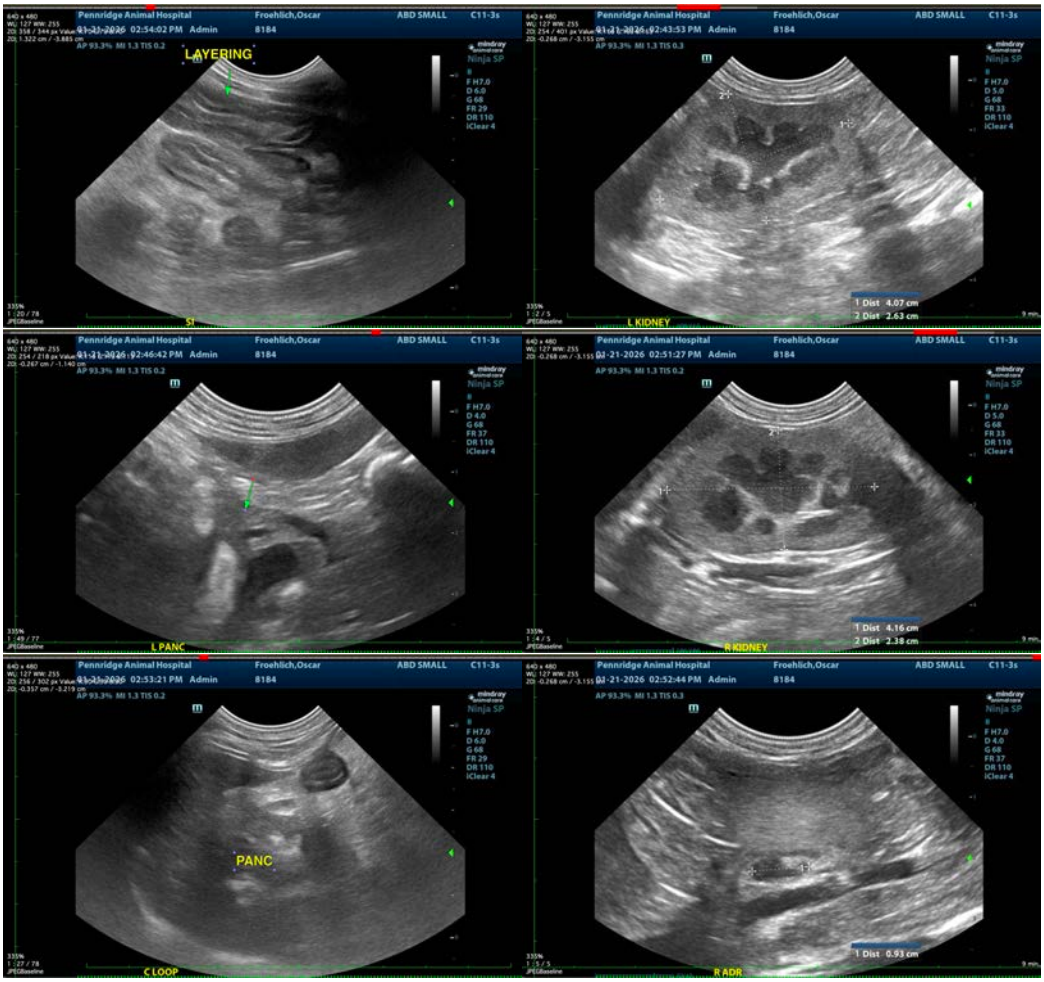
Tissue sampling is recommended. Fine needle aspirates of the focally thick bowel loop +/- the enlarged lymph nodes and/or fluid sampling for cytology could be considered if patient's coagulation status is appropriate. If a cytologic diagnosis is unable to be obtained, however, ultimately biopsies of the GI tract, being sure to include both ileum as well as the focally thick later described above, if possible, may be necessary for definitive diagnosis and therefore to further guide medical management. Intra-op ultrasound may be helpful to identify the most focally affected bowel loop.

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



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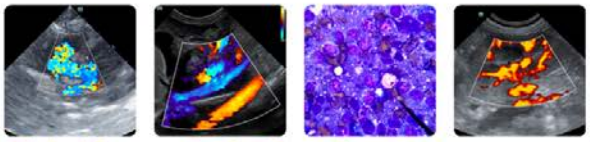

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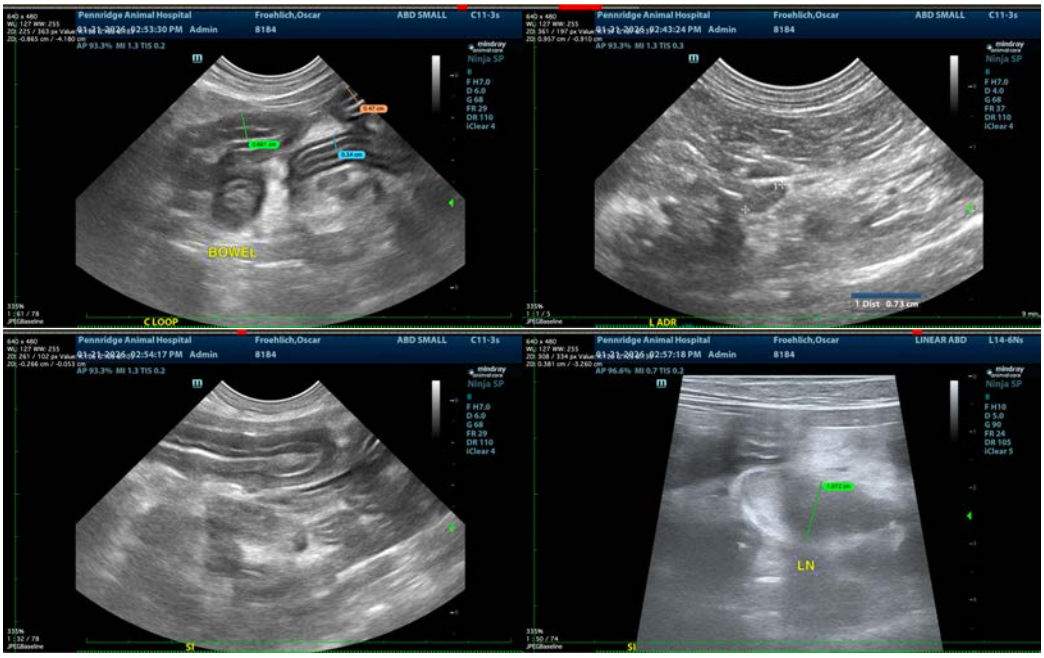

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
info@sonopath.com