



**PATIENT**

Wildchild Tiernery

**SPECIES**

Feline

**BREED**

Domestic Longhair

**SEX**

Spayed Female

**AGE**

15 Years

**WEIGHT**

Not Provided

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Meghan Morse, LVT,  
CVT

**HOSPITAL NAME**

All Animal Veterinary  
Services

**REFERRING VET**

Dr. Acworth

**INVOICE**

72343

**DATE**

1/21/26

**PRESENTING CLINICAL SIGNS**

Losing weight, vomiting, bloody stools. Small amount of feces in colon, arthritis in back

Current meds: Laxative, albon liquid 4.5mls SID

**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.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measured 3.4 cm. Right kidney measured 3.5 cm.

**Adrenal Glands**

The right adrenal gland is normal in size (0.33 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.36 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**

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. 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. The cystic and common bile duct, while not visibly dilated in these images at this time, are diffusely tortuous in appearance.

**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.

The visible small intestine demonstrates areas of mildly 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 is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is no evidence of obstruction, foreign material or infiltrative disease.



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The visible colon is normal in wall thickness (< 0.2 cm) and layering. The lumen is subjectively diffusely moderately distended with very hard shadowing stool. This partially limits thorough evaluation of the gastrointestinal tract adjacent to colon shadowing.

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**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. No pancreatic duct dilation is noted.

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**Free Abdomen**

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

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There is no apparent pathologic lymphadenopathy noted in these images.

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**WEIGHT**

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**PRIMARY FINDINGS**

- Chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- Given the subtle hepatobiliary changes, concurrent cholangiohepatitis/ "Triaditis" is a consideration. However, infiltrative disease (benign, infectious, inflammatory) as well as infiltrative neoplastic disease affecting the liver, while thought less likely, can't be definitively ruled out.
- 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.
- Suspect constipation, although this finding should be confirmed either radiographically or clinically, as ultrasound is not the most specific diagnostic for constipation.

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**SECONDARY FINDINGS**

- Age related kidney changes.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Further gastrointestinal workup recommendations include:

- If not recently evaluated, a general metabolic health screen (CBC, chemistry panel with electrolytes and urinalysis) is recommended.
- A routine fecal/giardia exam.
- 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.
- A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long

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to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

Additionally, if patient is clinically or radiographically constipated, management of constipation could be considered, as it could be contributing to patient's reported hematochezia, nausea, and potentially weight loss.

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



