



**PATIENT**

Wally McNulty

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

12 Years

**WEIGHT**

N/A

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Kelly Vazquez

**HOSPITAL NAME**

New Bridge VP

**REFERRING VET**

Dr. Abina Glenn on

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20864

**DATE**

1/31/23

**PRESENTING CLINICAL SIGNS**

History: Vomiting and chronic weight loss. No current meds.

Abnormal PE/Chem/CBC/UA Results: CBC/Chem: WNL.

**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 occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal is size (3.3 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.

Right kidney is normal is size (3.49 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 area of both adrenal glands is examined without evident adrenal gland pathology.

**Spleen**

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 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.

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 of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines demonstrate areas of mildly to moderately thick muscularis layer, relative to mucosa, most appreciated at the level of the ileum. The small bowel is diffusely mildly fluid distended without evidence of an obstructive pattern, plication and/or visible foreign material present. Small intestinal hyperperistalsis is noted.



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The visible colon is normal in wall thickness and layering. Contents are consistent with liquid stool.

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**Pancreas**

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The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Feline

**Free Abdomen**

**BREED**

There is no evidence of peritoneal effusion. Prominent hypoechoic mesenteric lymph nodes are noted.

DSH

**ULTRASONOGRAPHIC FINDINGS**

**SEX**

**Primary Findings**

Neutered Male

- Mild to moderate inflammatory bowel disease (IBD) pattern with evidence of concurrent gastroenteritis – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No aggressive lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling. The concurrent gastroenteritis pattern is consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other. Diarrhea is suspected based on these images.

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- Mesenteric lymphadenopathy, both reactive lymphadenopathy, as well as infiltrative neoplasia are differentials, and cannot be differentiated without tissue sampling.

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**Secondary Findings**

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- Urinary bladder debris

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

**IMAGING PERFORMED BY**

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.

Kelly Vazquez

Given the suspicion for diarrhea, a fecal exam is recommended, if not recently evaluated, as is a fecal enteropathogen PCR panel to Texas A&M GI Laboratory, for further evaluation of possible infectious disease.

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

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Dr. Abina Glenn on

Ultimately, pending results of the above and patient progression, etc., biopsies of the gastrointestinal tract may be necessary, including ileum, if possible, to definitively diagnose and therefore manage the suspected infiltrative bowel disease. Prior to that, if possible to safely reach, and patients coagulation status is appropriate, a fine needle aspirate of the enlarged mesenteric lymph nodes could be considered to try to rule out infiltrative neoplasia, such as lymphoma prior to more invasive biopsies.

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In the meantime, empirical deworming with a 5-day course of Panacur is recommended, as is supportive/symptomatic therapy, including a probiotic, such as Visbiome or Provable, cobalamin supplementation, unless not warranted based on gastrointestinal malabsorption panel results, an antiemetic, and if tolerated, transition in diet, beginning possibly with a hydrolyzed protein diet or

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potentially proceeding to a fiber response colitis diet, ultimately based on trial-and-error patient response.

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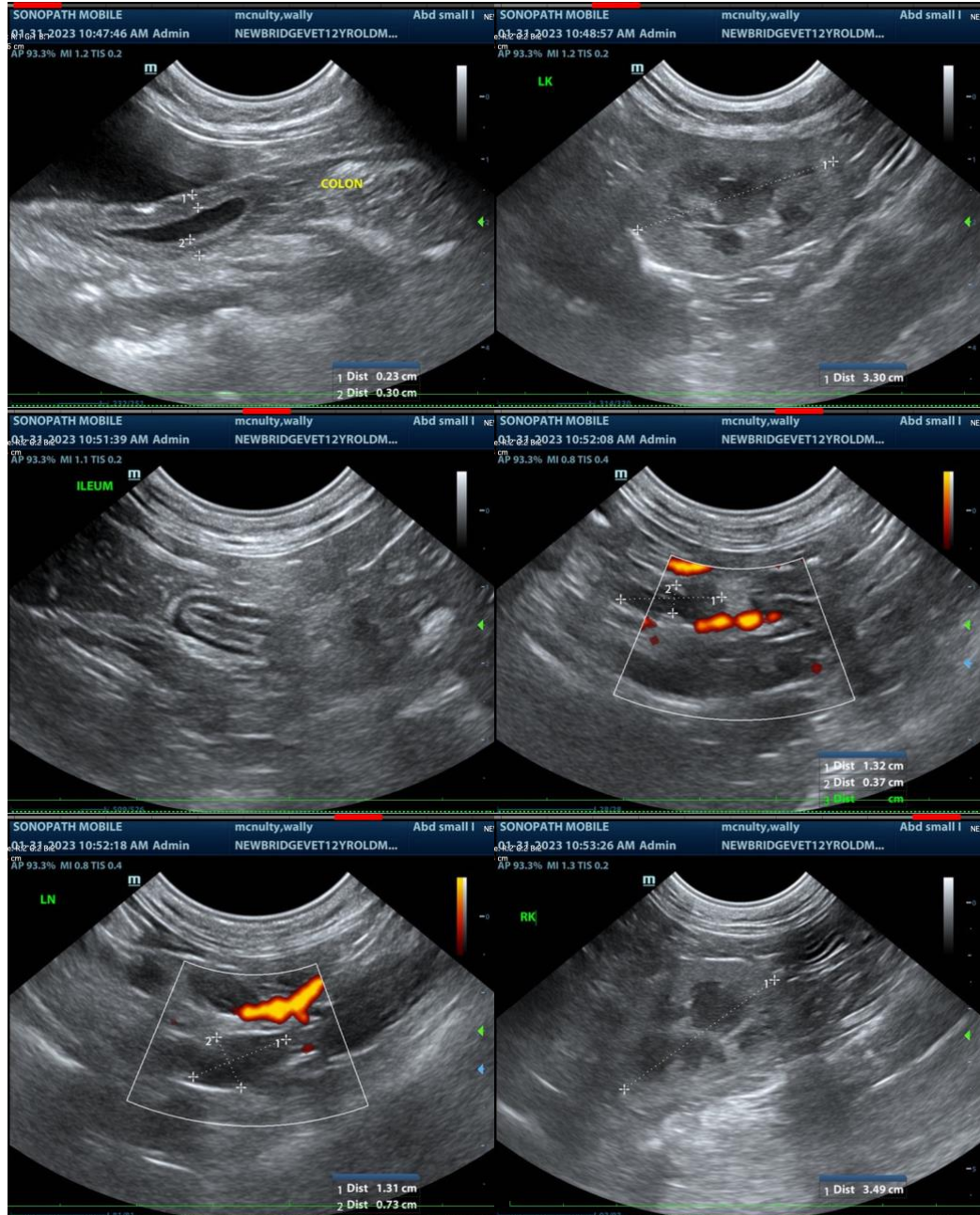
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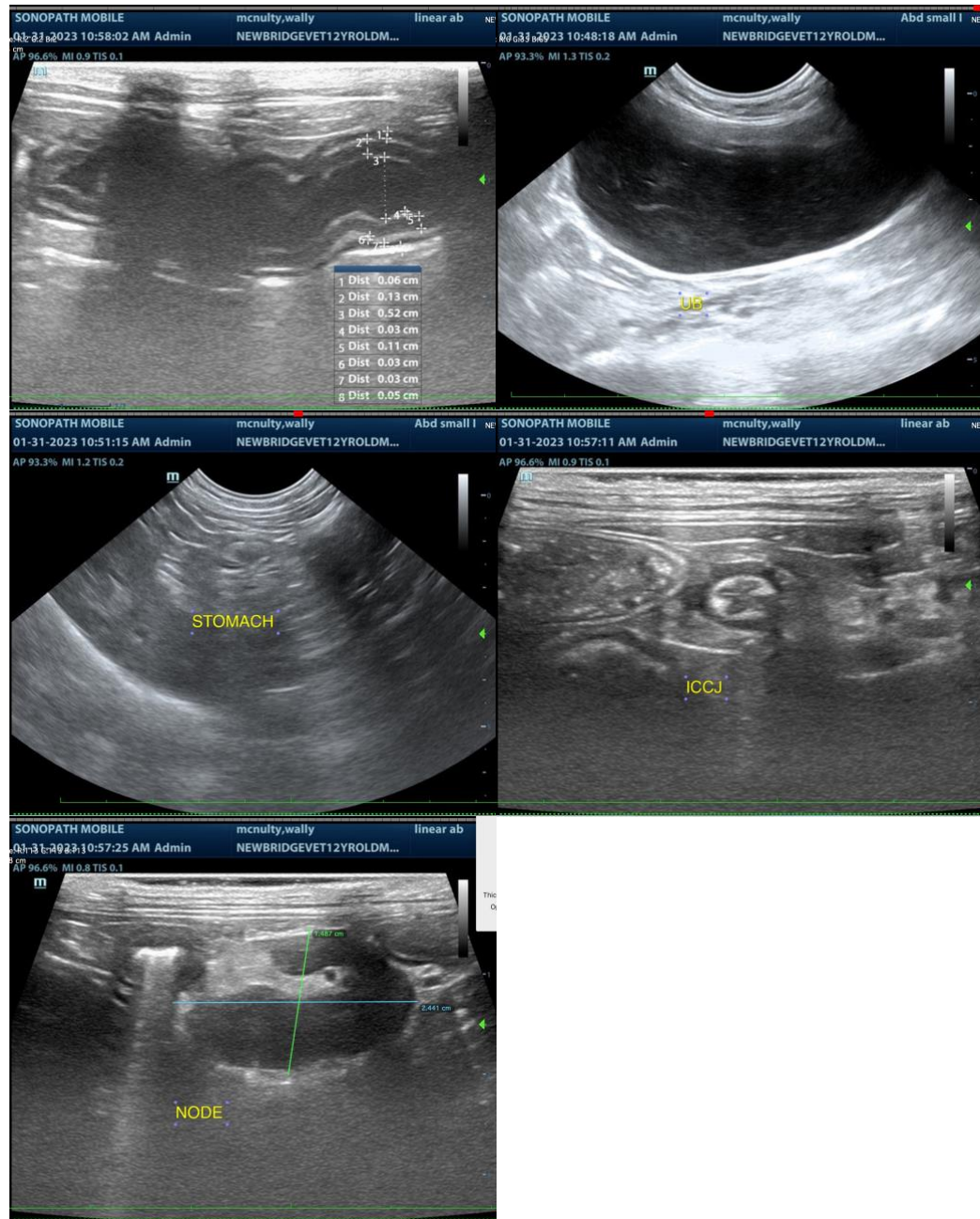
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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**



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Beth.Johnson@SonoPath.com

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