



**PATIENT**

Xander Rosen

**SPECIES**

Feline

**BREED**

DMH

**SEX**

Neutered Male

**AGE**

14 Years

**WEIGHT**

8.8 lbs

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Rebecca Hamilton

**HOSPITAL NAME**

Hello Vet Pet Wellness  
Center

**REFERRING VET**

Dr. Stern

**INVOICE**

72033

**DATE**

1/7/26

**PRESENTING CLINICAL SIGNS**

Chronic vomiting, acute diarrhea. Meds: Methimazole SID, Gabapentin PRN, Z/D diet (fasting for ultrasound - did not give meds this AM)

Abnormal PE/Chem/CBC/UA Results: Faster true 12 hours, no meds. Hyperthyroid - well managed on methimazole, heart murmur - stable, muscle atrophy, suspect OA, managed with Soleniasia

**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 measures 3.84 cm. Right measures 4.45 cm.

**Adrenal Glands**

The right adrenal gland is normal in size (0.31 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.25 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

**Spleen**

Spleen is subjectively large 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). Multifocal discrete homogeneous hyperechoic nodules are noted throughout the parenchyma. Splenic vasculature appears normal. The spleen is folded upon itself, which is a positional non-pathologic variant.

**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.

**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.



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The visible small intestine demonstrates areas of moderately 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 measures at the upper ends of normal limits for thickness (right at 0.20 cm thick), primarily proximally. Contents are consistent with normal formed feces and gas.

***Pancreas***

Pancreas is markedly prominent (enlarged) in size, primarily the left pancreas, and hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. The pancreatic duct measures right at the upper ends of normal limits at 0.20 cm thick.

***Free Abdomen***

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

Medial iliac lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

**PRIMARY FINDINGS**

- Moderate 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.
- The same etiology may be contributing to the colon diffusely, but primarily proximally, measuring at the upper ends of normal limits for thickness.
- Moderately reactive medial iliac lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Chronic low-grade smoldering pancreatitis is suspected. Infiltrative neoplasia or another process causing the pancreatic enlargement can't be ruled out but is considered less likely.
- Splenomegaly– can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- Hyperechoic splenic nodules – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.

**SECONDARY FINDINGS**

- Age related kidney changes.



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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

If not recently evaluated, a general metabolic health screen (CBC, chemistry panel with electrolytes and urinalysis) is recommended.

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.

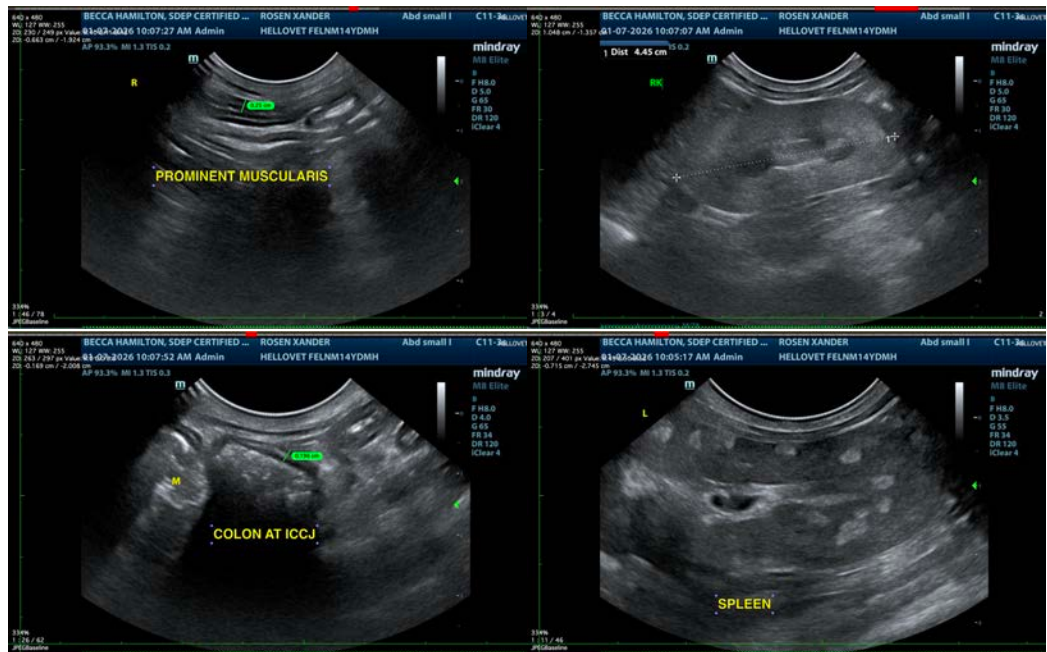
Additionally, a routine fecal/giardia exam is recommended if not recently evaluated.

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

Fine needle aspirates of the spleen +/- pancreas +/- medial iliac lymph nodes could be considered if they can safely be reached and if patient's coagulation status is appropriate.

In the meantime, supportive/symptomatic medical management of clinical signs is recommended, including a probiotic (such as visbiome or proviable), empirical deworming with a 5-day course of Panacur and, if tolerated, a transition in diet, based on trial-and-error response, beginning possibly with a gastrointestinal biome diet vs a hydrolyzed protein diet vs other. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several brand attempts may be required.

If clinical signs persist and a diagnosis is not made, ultimately biopsies of the GI tract, being sure to include ileum, if possible, may be necessary for a definitive diagnosis and therefore to further guide medical management.





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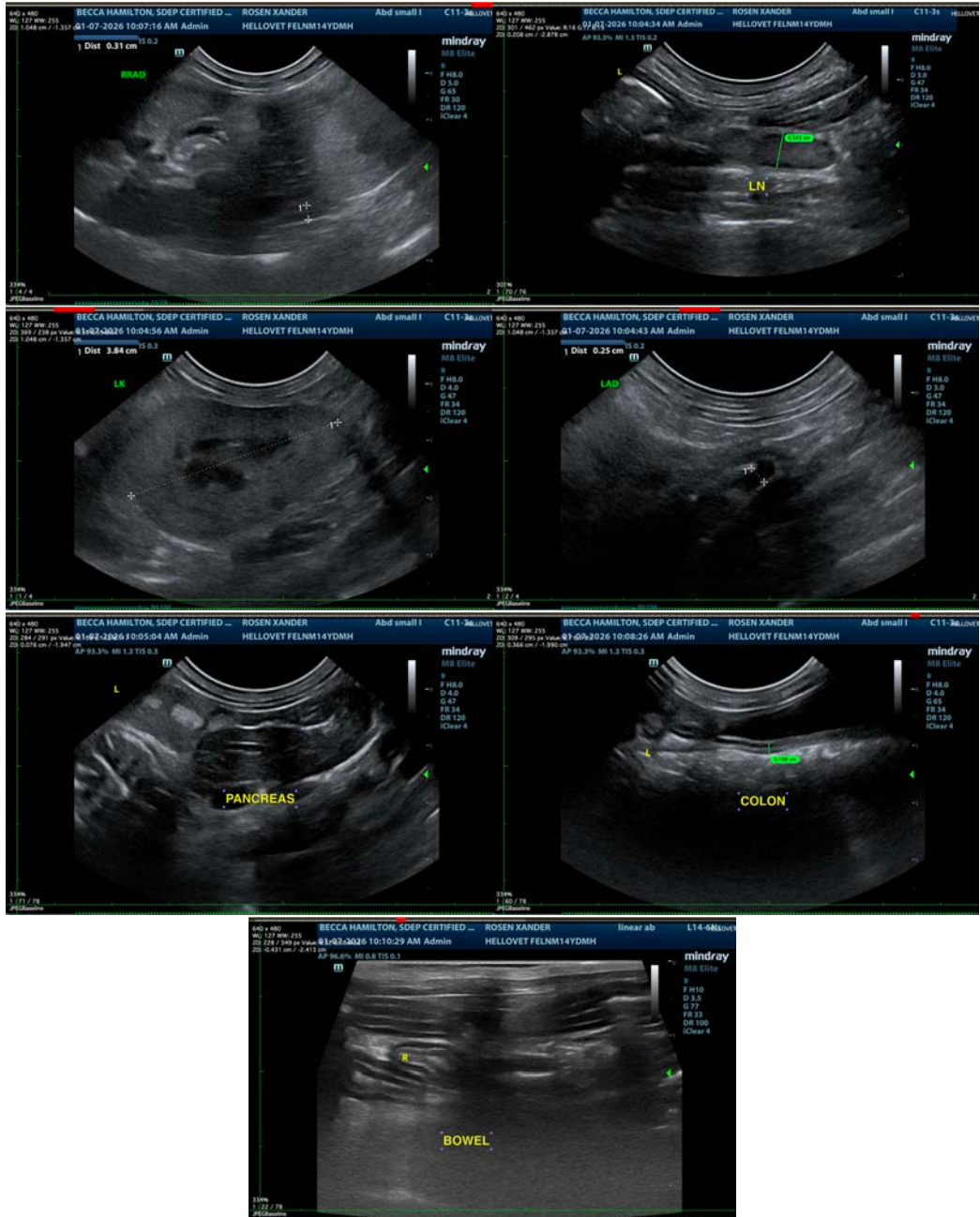
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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](mailto:info@sonopath.com)