



DATE PRESENTING CLINICAL SIGNS

11/17/25

Patient History: P presented on 10/16 for wellness. P noted some weight loss, but recently got 3 new kittens so unsure if stress was the cause (though normal appetite). CBC/Ch/T4 unremarkable/WNL. P also presented on 11/4 for raspy cough/hacking. P had lost 2lb since 10/16 visit despite still good appetite. No diarrhea, but p will vomit if he eats his food too fast. Chest rads on 11/4 show 2-3 "doughnuts", so poss. asthma. Started on Theophylline and abx. Did not start steroids, rec. cardiac work-up prior to starting steroids. Abdominal rads on 11/4 showed large amount of gas in stomach and SI, but otherwise unremarkable. Murmur grade: __none__

PATIENT

Jonesy Johnston

SPECIES

Feline

BREED

Maine Coon

SEX

Neutered Male

Current Medications: DOXYCYCLINE LIQUID 100MG/ML: 5mg/kg BID 11/4/2025, THEOPHYLLINE ELIXIR 50MG/ML 2 OZ: 4.25mg/kg BID 11/4/2025
Labwork Results: Labwork attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Torbugesic.
Stat Report: Not requested.
Imaging Performed by: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

AGE

10/4/12

WEIGHT

18.8 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

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 exfoliated cells, mucous and/or small blood clots, as well as dependent mineral "sand" (crystals) debris. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or discrete definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal in size (4.48 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.

HOSPITAL NAME

Everhart VH

Right kidney is normal in size (4.57 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.

REFERRING VET

Dr. DelFavero

Adrenal Glands

Left adrenal gland is normal in size (0.43 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

INVOICE

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Right adrenal gland is uniformly plump egg-shaped (0.56 cm), and hypoechoic in echogenicity, with bilateral dystrophic mineralization noted. This is most likely a benign age-related change. This change can be caused by chronic stress/disease, so investigation for/management of other disease (chronic kidney disease, hyperthyroidism, etc.) is recommended.

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 mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. 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 of the small intestine is diffusely similarly mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no definitively visible evidence of obstruction or foreign material. However, in several images, there is some slightly stronger acoustic shadow that when not associated with other changes, is most consistent with gas, and I believe may be in part colon, however, non-fully-obstructive foreign material, while thought much less likely, can't be definitively ruled out.

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

Pancreas

The pancreas that is observed 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.

Free Abdomen

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

The mesenteric 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.

ULTRASONOGRAPHIC Findings

Primary Findings

- Mild/emerging inflammatory bowel disease 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, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.
- Mildly reactive mesenteric lymphadenopathy- infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- While as described above, nonobstructive foreign material can't be definitively ruled out given the shadowing, which is believed to be primarily within the colon and attributed to gas within the small bowel, foreign material is considered unlikely.

Secondary Findings

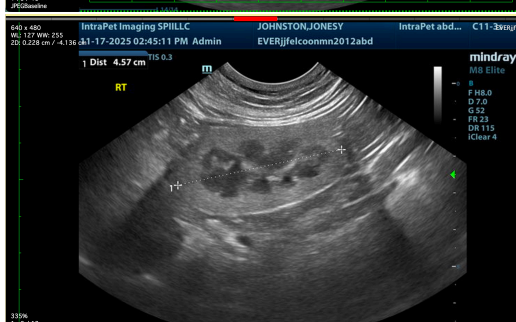
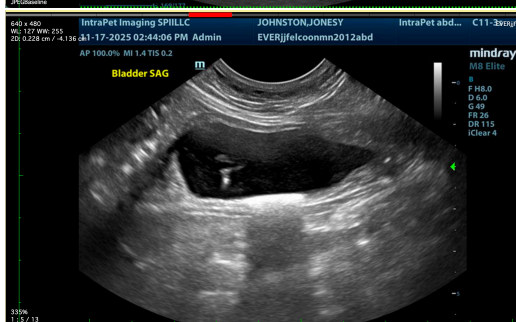
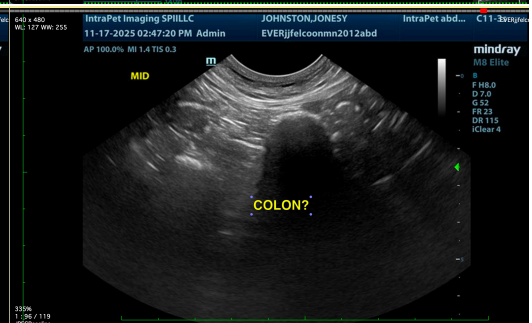
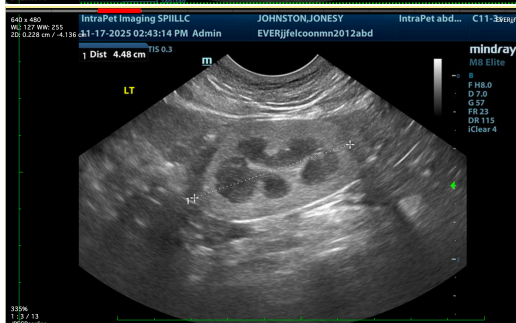
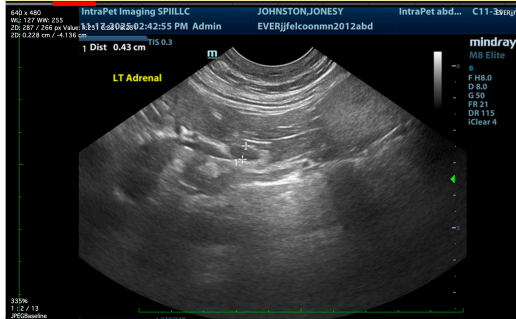
- Suspect mild age-related right adrenomegaly.
- A moderate amount of echogenic urinary bladder mineral/sand debris.

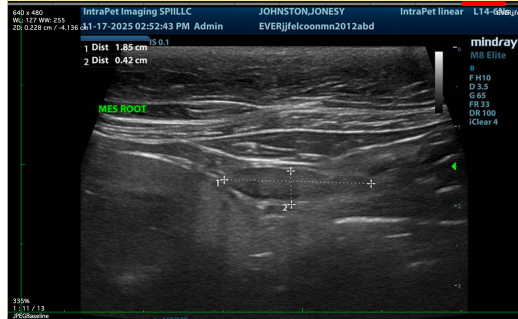
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The bowel changes described above are very mild/subtle but could indicate early or emerging infiltrative bowel disease contributing to patient's clinical signs. Having said that, continued work up and medical management of the suspected underlying respiratory disease, including potentially an upper respiratory infection that could be contributing to mildly decreased appetite and weight loss, etc., is recommended.

If improvement is not noted:

- 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.
- Ideally, biopsies of the GI tract, being sure to include ileum if possible, are recommended to definitively diagnose and therefore manage the infiltrative bowel disease.
- If biopsies cannot be obtained, empirical therapies could include a probiotic (if diarrhea is present, 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 with a hydrolyzed protein diet. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several trials may be required.
- Additional considerations could include cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.).





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.

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