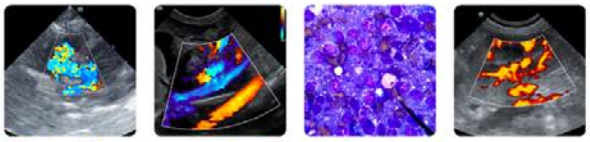


PATIENT

Hyrka Quesnel

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

14 Years 2 Months

WEIGHT

4.17 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Jill Rankin

HOSPITAL NAME

Bridgeland Vet Clinic

REFERRING VET

Dr. Rachel

INVOICE

71910

DATE

11/18/25

PRESENTING CLINICAL SIGNS

Hyrka is a 14-year-old male neutered domestic longhair cat with a primary history of intermittent, self-resolving gastrointestinal episodes that began in 2025, and a resolved history of idiopathic cystitis. Since January 2025, Hyrka has experienced four episodes of gastrointestinal upset, with the most recent occurring approximately two weeks prior to his 11/10/2025 visit. These episodes are characterized by three days of lethargy, decreased appetite, vomiting, and diarrhea, which reportedly resolve after he vomits a hairball. Prior to January 2025, there was no history of vomiting or diarrhea. An investigation on 11/10/2025 was initiated to explore potential underlying causes, with considerations including chronic pancreatitis, inflammatory bowel disease (IBD), or dietary indiscretion. Hyrka has a history of idiopathic cystitis from five years ago, which has been managed with a Hill's c/d stress diet, and he has had no subsequent urinary issues. Diagnostic testing performed on 11/10/2025 revealed a stress-induced hyperglycemia confirmed by a normal fructosamine, a mildly elevated precision PSL, a high normal T4 of 31, and a normal urine protein:creatinine (UPC) ratio of 0.2.

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 definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. Left kidney measures small-normal at 3.8 cm. Right kidney is normal size at 4.1 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.36 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

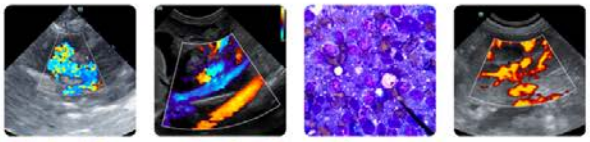
The left adrenal gland is normal in size (0.34 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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.



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Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen is mildly distended with primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal chyme. There is no evidence of obstruction, foreign material, or infiltrative disease. Pyloric outflow tract appears patent.

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

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.

Free Abdomen

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

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.

PRIMARY FINDINGS

- Marked/significant 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, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.
- Concurrent chronic low-grade smoldering pancreatitis is suspected.
- Moderately reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

SECONDARY FINDINGS

- Moderate gallbladder debris – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness, however, it can also be associated with hepatobiliary disease in cats and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

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- Mild/subtle chronic kidney disease changes.
- Mild amount of echogenic urinary bladder debris.

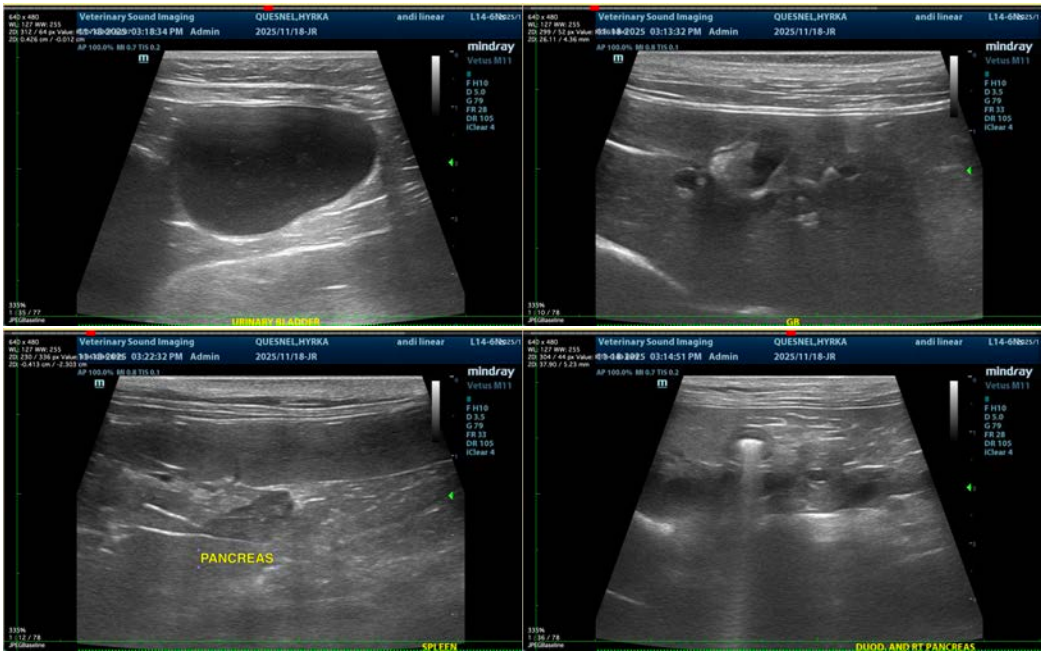
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- 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.

- 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.).



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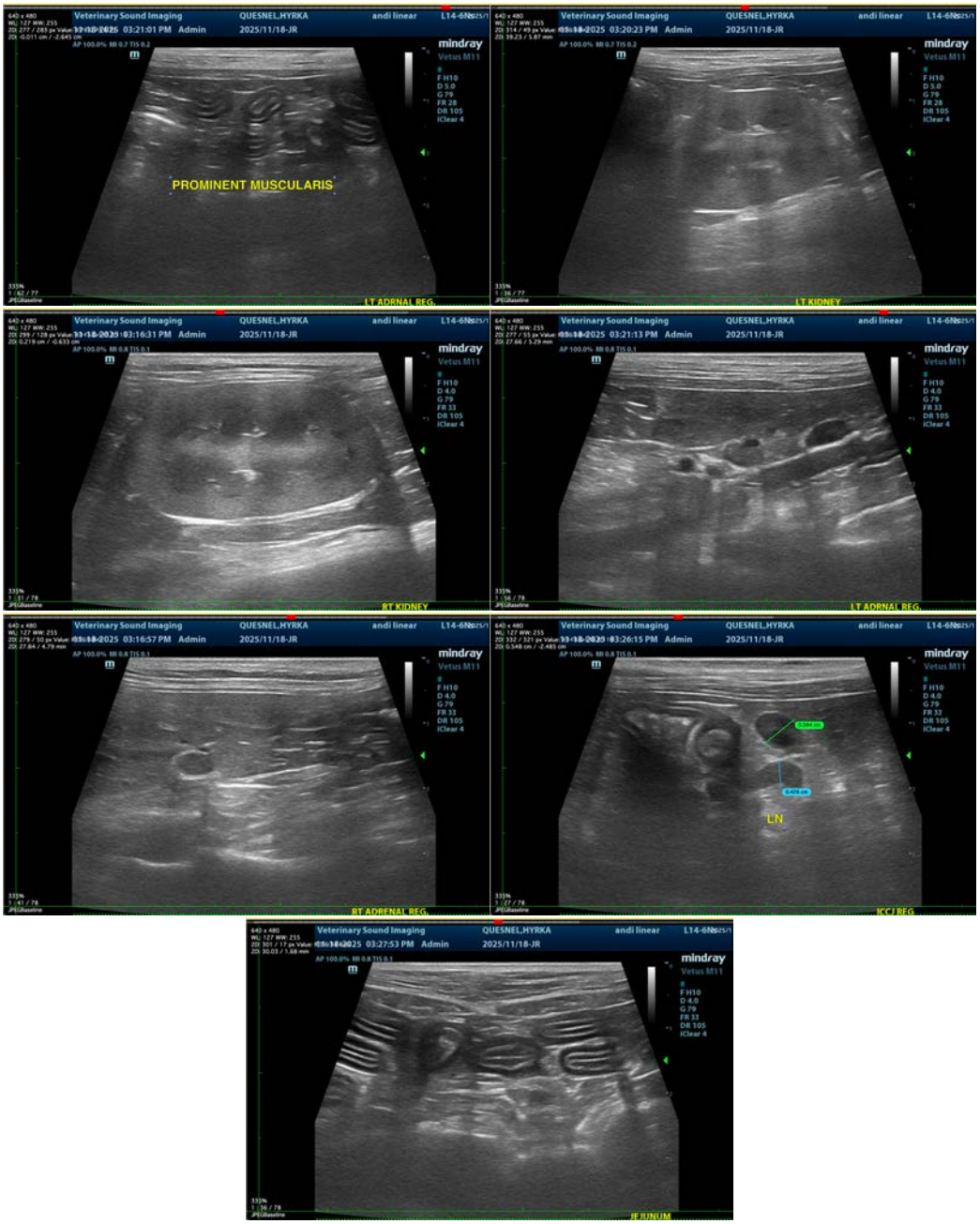

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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