



**PATIENT**

Luna Rogge

**SPECIES**

Feline

**BREED**

Oriental

**SEX**

Spayed Female

**AGE**

6 Years

**WEIGHT**

~4.7 kg

**INTERPRETED BY**

Beth Johnson, DVM  
 DACVIM

**IMAGING PERFORMED BY**

Amanda Stewart

**HOSPITAL NAME**

Headon Forest Animal  
 Hospital

**REFERRING VET**

Dr. Guagliano

**INVOICE**

71890

**DATE**

11/18/25

**PRESENTING CLINICAL SIGNS**

P presented Nov 11/25 with history of chronic vomiting. O has done multiple diet trials on her own, has found a diet to help reduce vomiting significantly. However patient still vomits once daily between 4:30am-6:30am (very consistent). Vomit is usually clear/foam, sometimes contains small amount of digested food. Physical exam was WNL.

Abnormal PE/Chem/CBC/UA Results: Bloodwork - mild eosinophilia, mild basophilia, mild hyperglycemia (suspect stress hyperglycemia); elevated ALT 245 (27 - 158), elevated ALP 96 (12 - 59). fPL 29.2 (0.0 - 4.4). Radiographic Findings n/a Primary Question to Be Answered in This Exam to evaluate the structure of the abdomen

**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.

The right kidney is normal is size (4.42 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.

The left kidney is normal is size (4.11 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 right adrenal gland is normal in size (0.48 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.33 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.

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.



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***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 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***

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.

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**

- 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.
- Moderately reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

If not recently evaluated, a T4 +/- free T4 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.

Fine needle aspirates of the enlarged lymph nodes +/- the liver could be considered if patient's coagulation status is appropriate, but ultimately if a diagnosis is unable to be obtained, biopsies of the GI tract, being sure to include ileum, if possible, may be necessary for definitive diagnosis and therefore to further guide medical management.

In the meantime, in addition to supportive/symptomatic medical management of clinical signs, additional diet trials could be considered, as could empirical deworming with a 5-day course of Panacur, especially given the reported eosinophilia.



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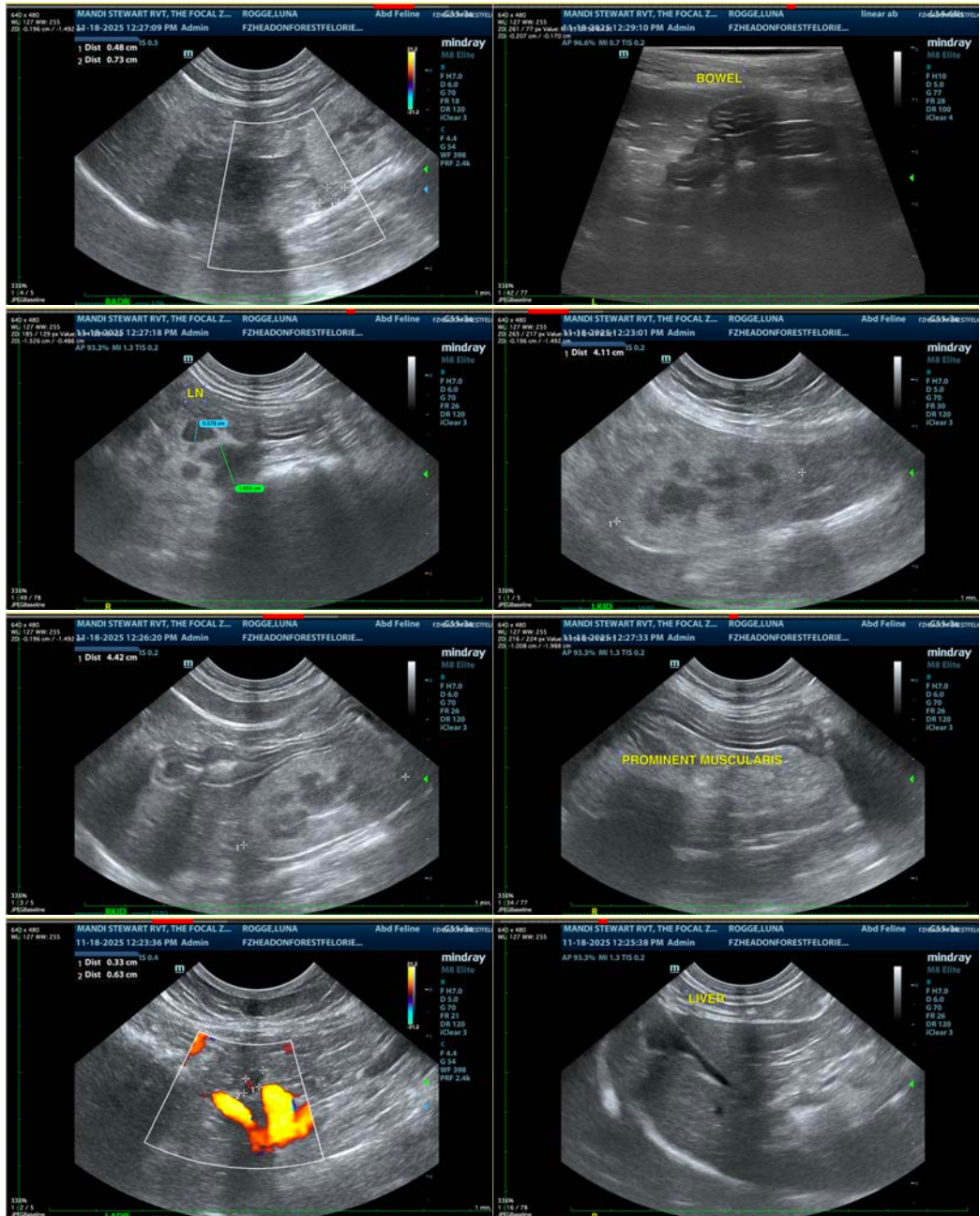
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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