



PATIENT

Mousey Johnston

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

8 Years

WEIGHT

8.8 lbs

INTERPRETED BY

Beth Johnson, DVM
 DACVIM

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Hillview Veterinary
 Clinic

REFERRING VET

Dr. Stevenson

INVOICE

71998

DATE

11/20/25

PRESENTING CLINICAL SIGNS

O reports more vomiting, switched food to higher grade wet food but still vomits food or dark liquid, sometimes daily, on average about 5X per week. Sometimes hairballs seen. 2 days ago lost interest in food and didn't want treats either. Hiding in closet and under couch, more sneezing lately, indoors only, normal stools. Not on any meds. Lives above business and there are mice in the building and racoons sit on the deck.

Abnormal PE/Chem/CBC/UA Results: Chem WNL T4 normal Eosinophils 0.08(0.21-1.21) Platelets 511(100-440)

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.

The right kidney is normal is size (3.84 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 (3.55 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 (0.45 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.50 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.

Diffusely, 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. Focally, however, in the mid to caudal abdomen there is an at least 1.6 cm long (although definitive length is difficult to determine in these images) loop of small bowel that still maintains layering but has a focally much more prominent/thick muscularis layer, resulting in an overall bowel thickness of 0.46 cm in that area. 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.

Lymph nodes adjacent to the bowel mass described 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

- Diffusely 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, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.
- The focally thicker muscularis layer is concerning for early or emerging neoplasia such as round cell neoplasia i.e., lymphoma, although layering remains intact, and a benign inflammatory process cannot be ruled out without tissue sampling.
- Reactive lymph nodes adjacent to bowel mass – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

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.

If it can safely be reached, fine needle aspirates of the focally thick muscularis +/- the mildly enlarged adjacent lymph nodes could be considered if patient's coagulation status is appropriate. If a cytologic diagnosis is unable to be obtained, however, an exploratory laparotomy for planned full thickness GI biopsies and resection and anastomosis of the area described above may be necessary for a definitive



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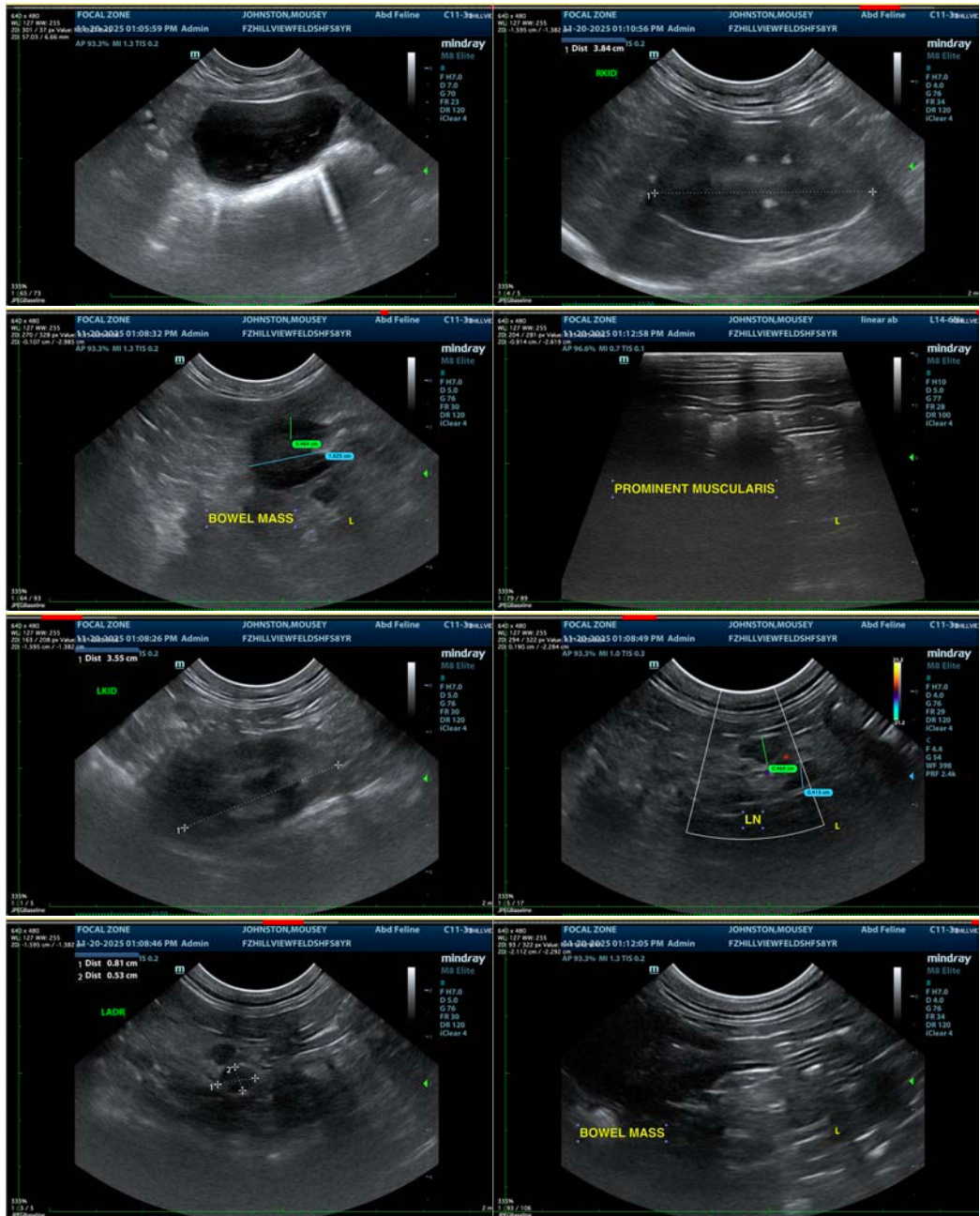
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diagnosis and therefore to further guide medical management. I don't believe that the area in question is the ileocecolic junction, but I cannot definitively rule it out.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.





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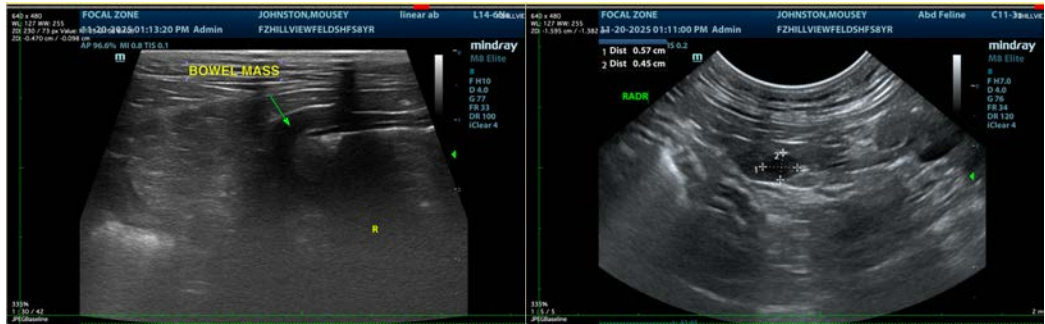
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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