



PATIENT

Murphy Stamatien

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

3 Years

WEIGHT

12.9

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Pamela Harrigan,
RDCS, Certified Vet
Sonographer

HOSPITAL NAME

All Friends Animal
Hospital

REFERRING VET

Michael Solomon, DVM

INVOICE

71981

DATE

11/20/25

PRESENTING CLINICAL SIGNS

Increased vomiting (liquid). Weight gain, was 11.6 lb in September, not 12.9 lb. No change in food consumption. Cat used to free feed, but not 4 small meals a day. Indoor only cat. Currently on forti flora.

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 (5.0 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 (4.9 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 (0.44 cm at cranial pole and 0.38 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.56 cm at cranial pole and 0.48 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen measures at the upper ends of normal limits for thickness at 1.0 cm thick with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. 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.

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,



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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 and cranial abdominal/gastric 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

- Mild/emerging 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 mildly heterogeneous liver changes are non-specific but could indicate a microscopic hepatopathy such as bacterial or lymphoplasmacytic cholangiohepatitis, hepatic lipidosis, other infectious or inflammatory hepatopathy, or even infiltrative neoplasia such as round cell neoplasia can't be ruled out without tissue sampling.
- Mild 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 well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- Chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- Mildly to moderately reactive mesenteric and cranial abdominal/gastric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given patient's weight gain, if not already evaluated, a thorough evaluation of daily caloric intake is recommended to assure an appropriate daily caloric intake is occurring vs an inadvertent increase in calories due to change in diet and/or feeding schedule, etc.

Given the concurrent vomiting, however, further gastrointestinal workup considerations could include:



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

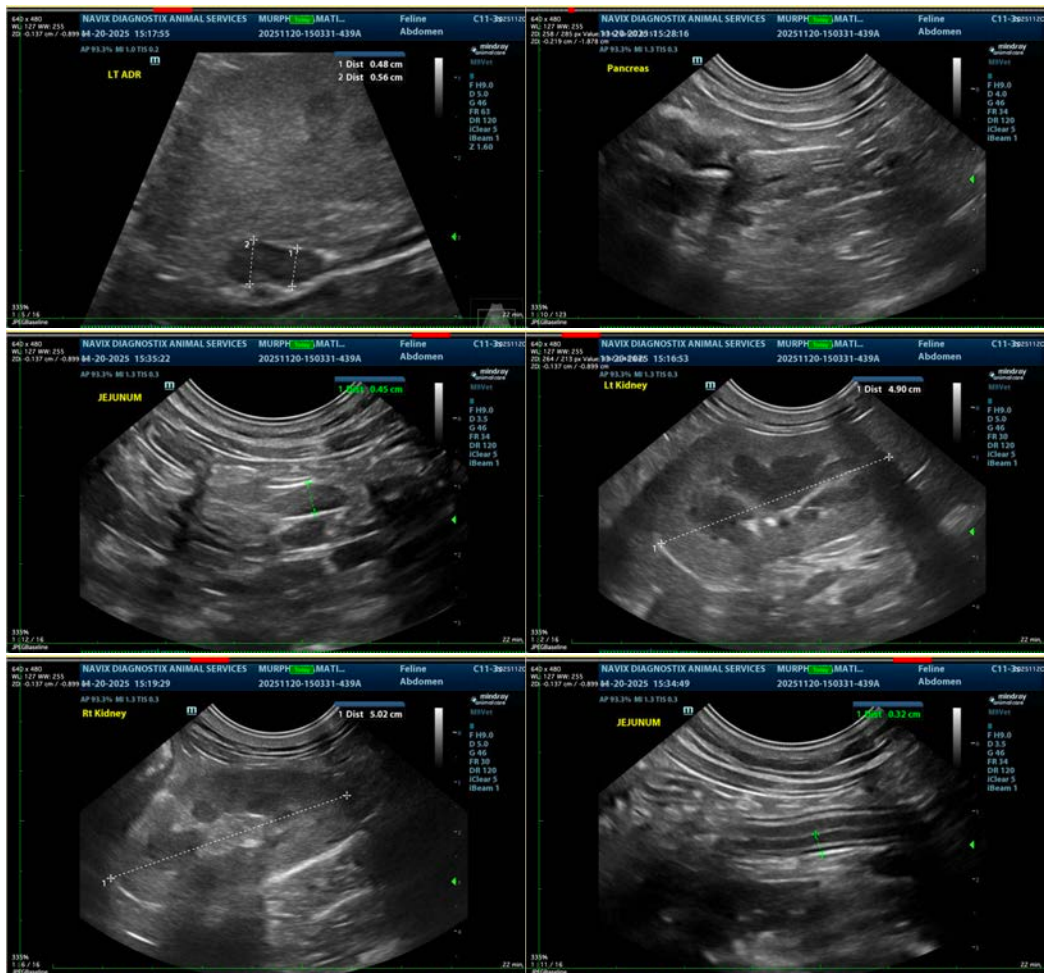
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

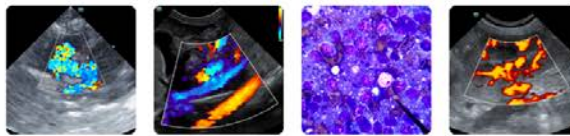
Fine needle aspirate of the spleen and liver +/- lymph nodes if they can safely be reached could be considered if patient's coagulation status is appropriate.

If tolerated, a transition in diet is recommended, based on trial-and-error response.

Some options to consider include a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs a fiber response/colitis diet vs a bland, easy to digest or low-fat diet vs other.

Further diagnostic and treatment recommendations are largely dependent on results of above.





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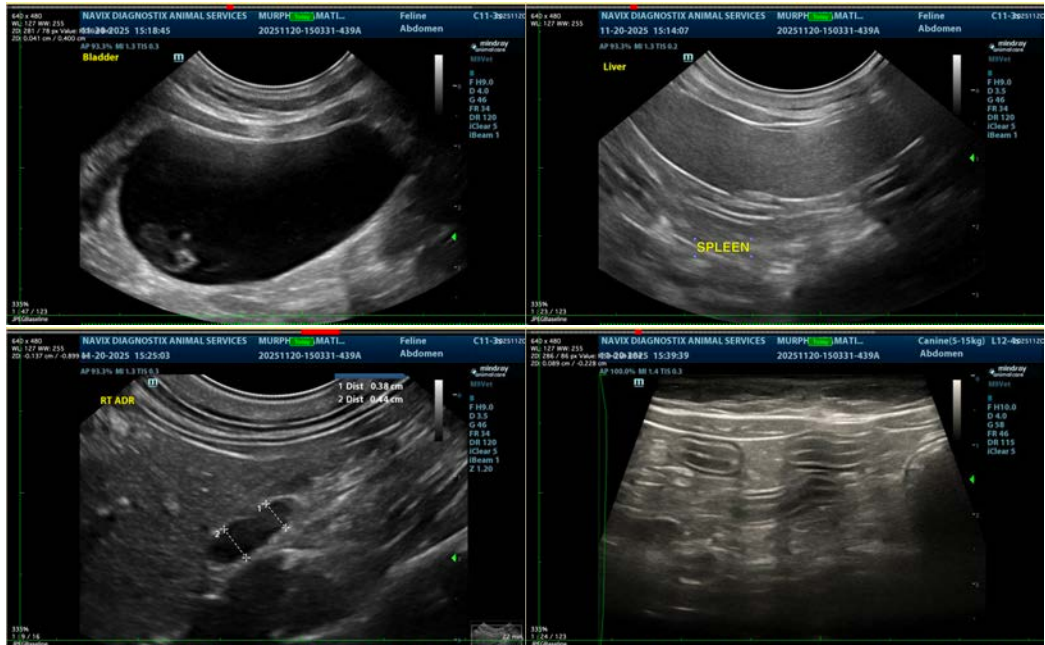
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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