



PATIENT

Bosya Peremyslova

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered Male

AGE

11 Years

WEIGHT

13.5

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Gary Jimmerson, DVM

HOSPITAL NAME

Willamette Veterinary
Hospital

REFERRING VET

Gary Jimmerson, DVM

INVOICE

72102

DATE

11/26/25

PRESENTING CLINICAL SIGNS

11y NM DSH, indoor/outdoor cat. Presented to rDVM for hyporexia on 11/23. Labs showed mild ALT elevation and dehydration, otherwise unremarkable (fecal not submitted). Pt received basic supportive care and did better for about 1 day, then pt's appetite started to decrease again. Pt presented to WilVet on 11/25 PM for hyporexia to anorexia and lethargy. No vomiting, normal stools. Normal vitals. Ultrasound to investigate possible causes for hyporexia and elevated ALT.

Abnormal PE/Chem/CBC/UA Results: butorphanol 0.3 mg/kg IM (0.18mL) EPOC = Gluc 141 (H), iCa 1.2 (L), lytes and lactate wnl vcheck fPL = <50 (N) ALT = 184 (H) UA (cysto) = USG >1.050, pH 6.0, WBCS 1/hpf, suspect cocci, no crystals, no casts. bacterial confirmation kit = no bacteria seen 11/23 Labs ALT 216 (H, range 143), TP 8.3 (H), AST 107 (H, range 54), ALP 7 (L), GGT <3 (N), t-bili 0.2 (N), Crea 1.7 (N), BUN 17 (N) T4 wnl CBC wnl

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 (4.03 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 (3.86 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 areas of the adrenal glands were examined without evident adrenal gland pathology, but they are difficult to fully visualize/isolate for measurement.

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), except for an approximately 0.40 cm x 0.70 cm hypo- to anechoic nodule/density near the cranial aspect of the spleen resulting in a mild capsular bulge. 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 suspected 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. Bowel wall layering is difficult to fully assess in these images, and recommendations include increasing depth or using a linear probe for more detail. 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.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Suspect 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.
- Hypo to anechoic splenic nodule – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions, and cannot be ruled out.

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.

Fine needle aspirates of the splenic nodule and liver are recommended if patient's coagulation status is appropriate.

If a cytologic diagnosis is unable to be obtained and clinical signs persist, ultimately further evaluation and potential 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, treatment recommendations include fluid therapy, anti-emetics, gastroprotectants, hepatic nutraceuticals such as ursodiol and/or Denamarin, and broad-spectrum antibiotics. Nutritional



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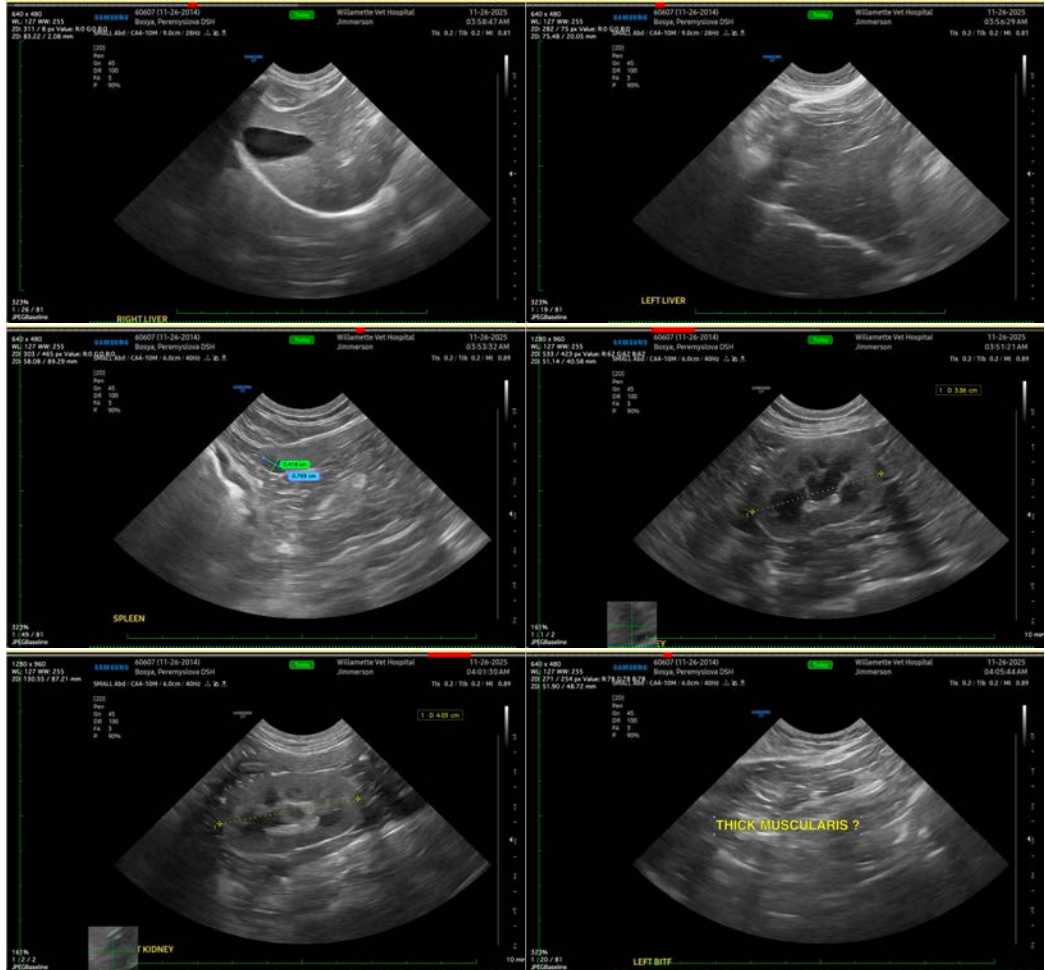
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support is critical to prevent/manage concurrent hepatic lipidosis, so appetite stimulants and/or, if indicated, feeding tube placement is also recommended.



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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