



PATIENT

Dan Muller

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

16 Years

WEIGHT

12.6

INTERPRETED BY

Beth Johnson, DVM,
DACVIM (SAIM)

IMAGING PERFORMED BY

Dr. Reyes

HOSPITAL NAME

Graceful Paws PC

REFERRING VET

Dr. Sanchez

INVOICE

35392

DATE

11/3/25

PRESENTING CLINICAL SIGNS

History of renal disease and diarrhea. Pet appears to also be uncomfortable
Abnormal PE/Chem/CBC/UA Results: CBC: WNL CHEM: CREA 2.2, ALB 2.5, ALT 21 Urinalysis: Sp Gr 1.019, RBC 3+ T4: WNL.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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.

Kidneys are irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. The left kidney measures small/normal, 3.5 cm. The right kidney measures small/normal, 3.6 cm.

Adrenal Glands

The adrenal glands are unable to be well visualized in these images.

Spleen

Spleen measures at the upper end of normal limits for thickness (1.0 cm thick at the hilus) 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 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.

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 mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestine demonstrates areas of moderate to severely 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 mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted.



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

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Pancreas

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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.

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Free Abdomen

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

SEX

The 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.

Neutered Male

ULTRASONOGRAPHIC FINDINGS

AGE

- 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.
- Concurrent chronic low grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- Mildly reactive mesenteric lymphadenopathy- infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Possible 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 as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- Mild to moderate chronic kidney disease changes

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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.
- Ultimately, tissue sampling is recommended. Fine needle aspirates of the enlarged spleen +/- the lymph nodes could be considered if they can safely be reached and if patient's coagulation status is appropriate. Having said that, the splenic changes are mild, and the lymph nodes are likely too small to sample at this time. Therefore, ultimately, 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



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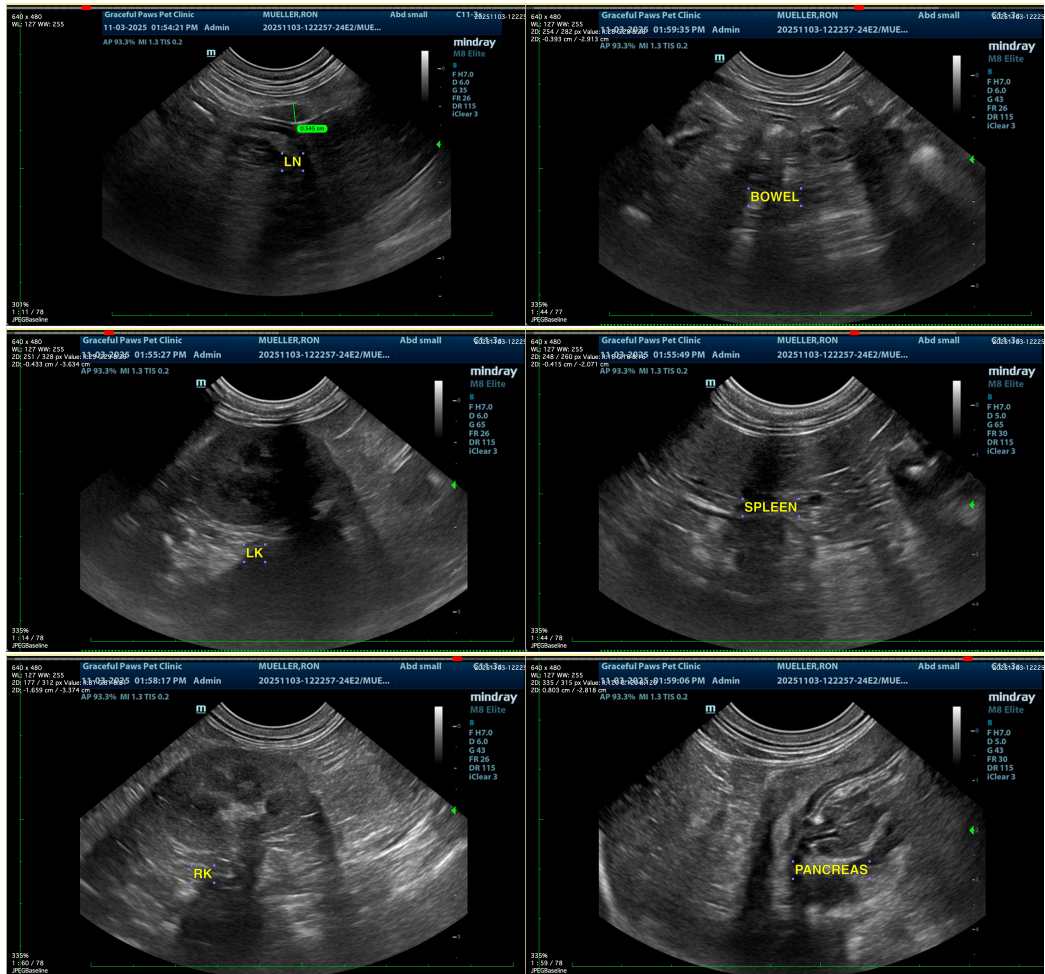
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and, if tolerated, a transition in diet, based on trial-and-error response, beginning with a hydrolyzed protein diet. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several trials may be required.

- 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.).



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



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