PATIENT

Peaches Anderson

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

9 Years 2 Months

WEIGHT

14.66 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Lucas. Budden

HOSPITAL NAME

Frontier VH

REFERRING VET

Dr. Lucas. Budden

INVOICE

35393

DATE

11/3/25

PRESENTING CLINICAL SIGNS

History: Clinical signs: diarrhea and hematochezia History: Chronic diarrhea with intermittent hematochezia. First noted in December of 2024. Did not resolve with probiotic. Stable weight. Normal appetite. No vomiting. Current diet is Instinct Raw Boost chicken kibble and Fussie Cat Premium wet food. Medications: Gabapentin, butorphanol, Dexdomitor to facilitate ultrasound

Abnormal PE/Chem/CBC/UA Results: PE: BCS 8/9, mild dental tartar, no thyroid slip of note, no abnormalities on rectal exam, abdominal palpation normal Labs: Senior panel 1/6/25 Creatinine high 2.2 Cholesterol high 285 Albumin high 4.2 Remainder of CBC/CHEM normal Thyroid normal 2.1 FEL V/FIV negative/negative HWT negative Fecal negative USG 1.058 Protein 2+ RBC 0-1 Squamous epithelial 0-1 Quiet sediment otherwise FNA of LN pending

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 is normal in size, measuring 3.9 cm. The right kidney is small, measuring 3.2 cm. Chronic infarcts are noted bilaterally.

Adrenal Glands

Left adrenal gland is normal in size (0.3 cm at cranial pole and 0.3 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.3 cm at cranial pole and 0.3 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

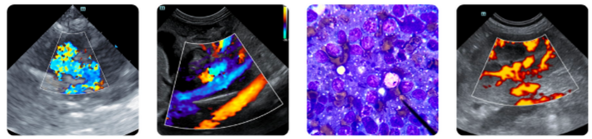
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

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



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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, 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. This change is primarily noted in the ileum.

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.

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.

ULTRASONOGRAPHIC FINDINGS

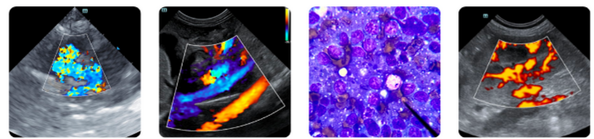
- Chronic low grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- Very mild/emerging, primarily involving the ileum, inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including 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.
- Chronic kidney disease changes, including bilateral chronic infarcts

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

As is reportedly already pending, fine needle aspirates of the enlarged lymph nodes are recommended if patient's coagulation status is appropriate.

Ultimately, however, if a cytologic diagnosis is unable to be obtained, biopsies of the GI tract, being sure to include upper and lower, as well as ileum, if possible, given patient's reported clinical history.

In the meantime, if not recently evaluated, a routine fecal/Giardia exam is recommended, as is a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI



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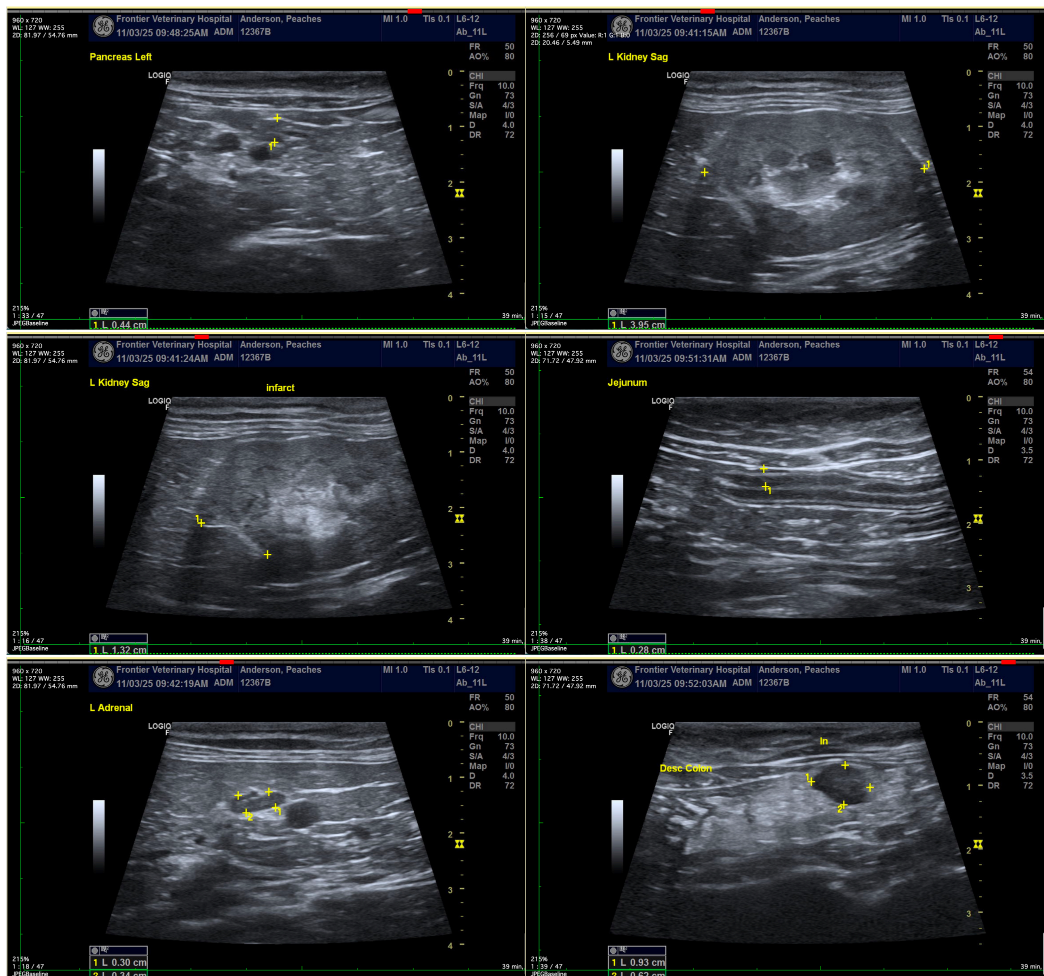
Laboratory is recommended for further evaluation of GI and pancreatic function.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

Supportive/symptomatic medical management of clinical signs is recommended, including a probiotic (such as visbiome or proviable), empirical deworming with a 5-day course of Panacur and, if tolerated, a transition in diet, based on trial-and-error response, beginning possibly with a gastrointestinal biome diet vs a hydrolyzed protein diet vs other. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several brand attempts may be required.



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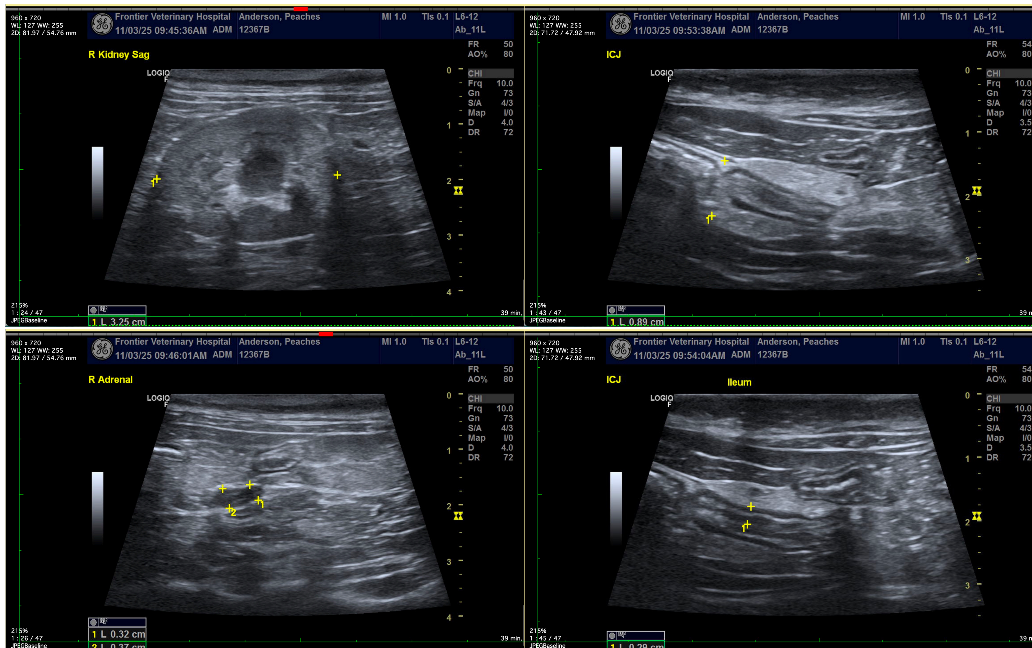

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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