



## PATIENT

Kiwi Hasan

## SPECIES

Feline

## BREED

Himalayan

## SEX

Spayed Female

## AGE

14

## WEIGHT

10.78 Pounds

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Meghan Myers, VMD

## HOSPITAL NAME

Hershire AH

## REFERRING VET

Lindsay Bohling, DVM

## INVOICE

35399

## DATE

11/4/25

## PRESENTING CLINICAL SIGNS

History: Patient is undergoing adequate injections every 2 weeks for arthritis. On physical exam - patient has a gallop rhythm, multiple dermal masses and mild ocular discharge. Client noted progressive weight loss - in April patient weighed 13.56 lbs, in September weighed 12.28 lbs. Bloodwork revealed - Creatinine 1.7, BUN 32. Urinalysis showed SG 1.014, trace protein, and evidence of UTI -- treated with Clavamox for 1 week. Recheck urinalysis showed rods- client declined culture. Convenia administered 10/23. Patient's thyroid was rechecked - T4 is 2.3. Tried to transition patient to a kidney diet- but does not love it. Client gives mirataz - helps sometimes. Patient is down to 10.86 lbs. Patient now is vomiting and showing little interest in food -- client has tried variety of options. BW on 11/3 showed Quant Panc- WNL. CBC- mild lymphopenia. Chem - amylase increased, Creat 1.8. Patient is vomiting through cerenia.

## 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. No mineral is observed. Moderate pyelectasia is present in the left kidney, measuring 0.46 cm in the transverse view. The left kidney is small/normal, measuring 3.7 cm. The right kidney is small/normal, measuring 3.6 cm.

### Adrenal Glands

Left adrenal gland is normal in size (0.49 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.39 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

### Spleen

Spleen is subjectively large in size with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a mildly coarse/heterogeneous echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal. The spleen measures 1.3 cm thick at the hilus.

### 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 homogeneous 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 of the gallbladder appears as a thin hyperechoic/calcified rim casting a distinct distal acoustic shadow. 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 mildly distended with primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal chyme. 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 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.

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**

- Moderate inflammatory bowel disease 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.
- Mildly reactive mesenteric lymphadenopathy- infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Scalloped spleen- can be associated with benign or malignant infiltrative disease. Common causes include a reactive spleen secondary to immune stimulus or early infiltrative round cell neoplasia such as lymphoma or mast cell tumor.
- Porcelain gallbladder wall- Porcelain (calcified) gallbladder is an uncommon finding in companion animals and has been observed as both an incidental finding and associated with biliary neoplasia. In humans, porcelain gallbladder can be a manifestation of chronic gallbladder disease, chronic cholecystitis, intramural hemorrhage with subsequent calcification, imbalances in calcium metabolism, and even giardiasis. This finding should be interpreted in combination with any clinical signs and/or laboratory changes suggestive of biliary disease and/or calcium dysregulation, etc.



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- Mild to moderate chronic kidney disease changes with moderate pyelectasia in the left kidney.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

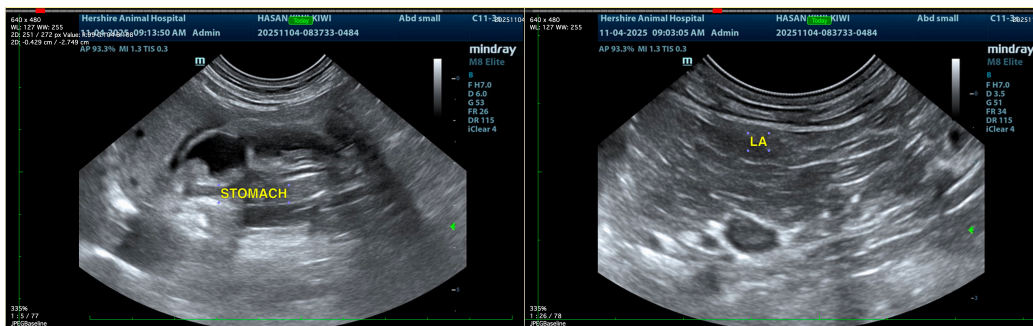
Further recommendations for patient's reported weight loss depend in part on daily caloric intake, as given the transition in diet and patient's less than normal desire for the diet, some of the weight loss may be decreased intake. Therefore, if not already evaluated, a thorough evaluation of daily caloric intake is recommended to assure an adequate daily caloric intake is occurring vs an inadvertent reduction in calories due to change in diet and/or feeding schedule, competitive eating environment, etc.

Having said that, there is some visible evidence of possible concurrent bowel disease that could be resulting in malabsorption or maldigestion. Therefore, especially if patient's daily caloric intake is normal, 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 may be necessary for a definitive diagnosis. Fine needle aspirates of the spleen could be considered if patient's coagulation status is appropriate or if a cytologic diagnosis is unable to be obtained, biopsies of the GI tract, being sure to include ileum, if possible, may be necessary for a definitive diagnosis, and therefore, to further guide medical management.

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 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.).





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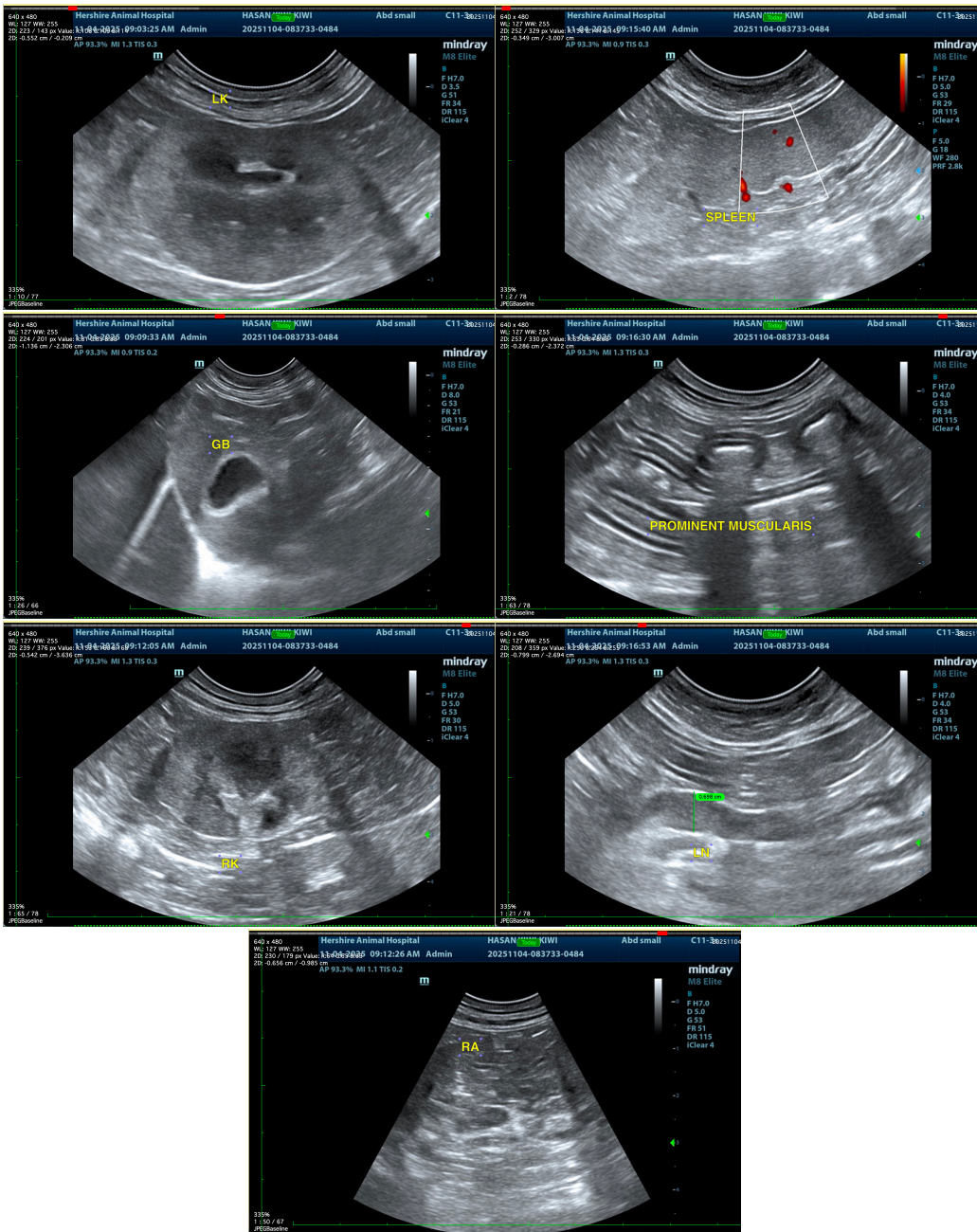
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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info@sonopath.com

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