



**DATE PRESENTING CLINICAL SIGNS**

12/4/25

**Patient History:** Pt presented on 12/2 for a few day duration of anorexia and diarrhea. Labs/xrays taken then - nsf. Pt represented on 12/4 for continue inappetence. Hx of bloody diarrhea in Spring 2024

**PATIENT**

Charlie Christ

**Current Medications:** Provable, Mirtazapine.

**Labwork Results:** Labwork attached, reported as chem17/cbc - nsf

**Date of Previous IntraPet Ultrasound:** No previous.

**Sedation:** Not required to complete full diagnostic ultrasound.

**Stat Report:** Not requested.

**Imaging Performed by:** Stephanie Warga RDCS, RVT.

**SPECIES**

Feline

**BREED**

DLH

**SEX**

Neutered Male

**AGE**

11/22/09

**WEIGHT**

6.6 lbs

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**HOSPITAL NAME**

Everhart Veterinary  
Hospital

**REFERRING VET**

Dr. Menefee

**INVOICE**

72362

**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.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measured 3.01 cm. Right kidney measured 3.3 cm.

**Adrenal Glands**

The right adrenal gland is normal in size (0.44 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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

**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). No focal nodules or masses are observed. 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.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. The cystic and common bile duct are not pathologically distended in these images but are diffusely tortuous in appearance.

### ***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 markedly/significantly 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 colon beginning at the ileocecolic junction and extending briefly from there is thick, measuring 0.42-0.49 cm thick with no loss of layering appreciated. The colon returns to more normal appearance approximately in the proximal descending area. The lumen is empty.

### ***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.

There is no apparent pathologic lymphadenopathy noted in these images.

### **PRIMARY FINDINGS**

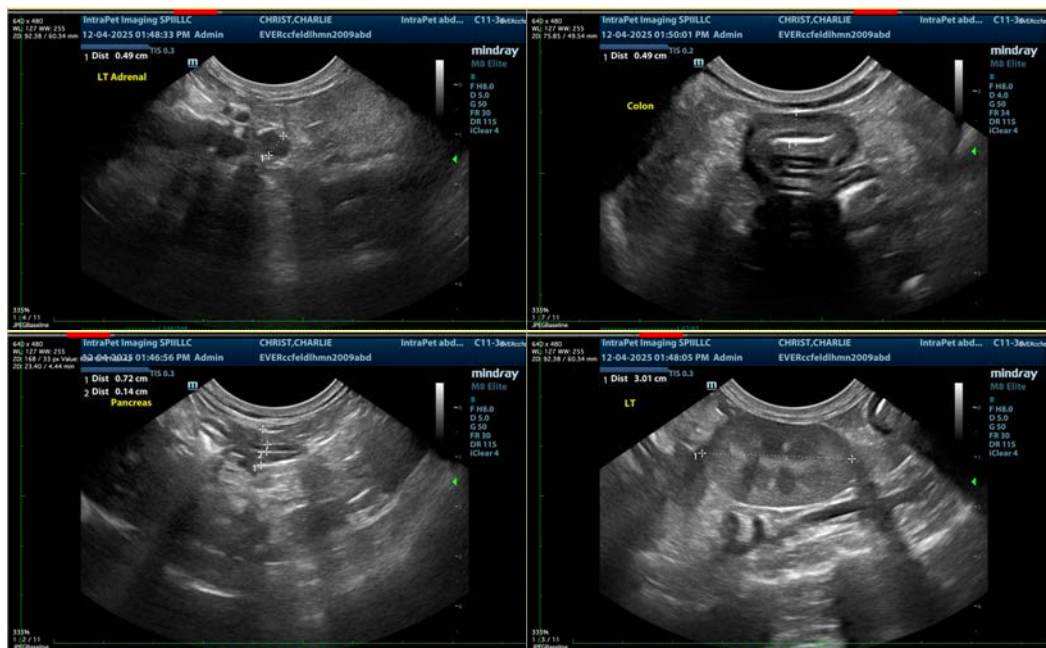
- Marked/significant inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.
- The colonic wall thickening similarly could represent a benign inflammatory process, or infiltrative neoplasia can't be 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.

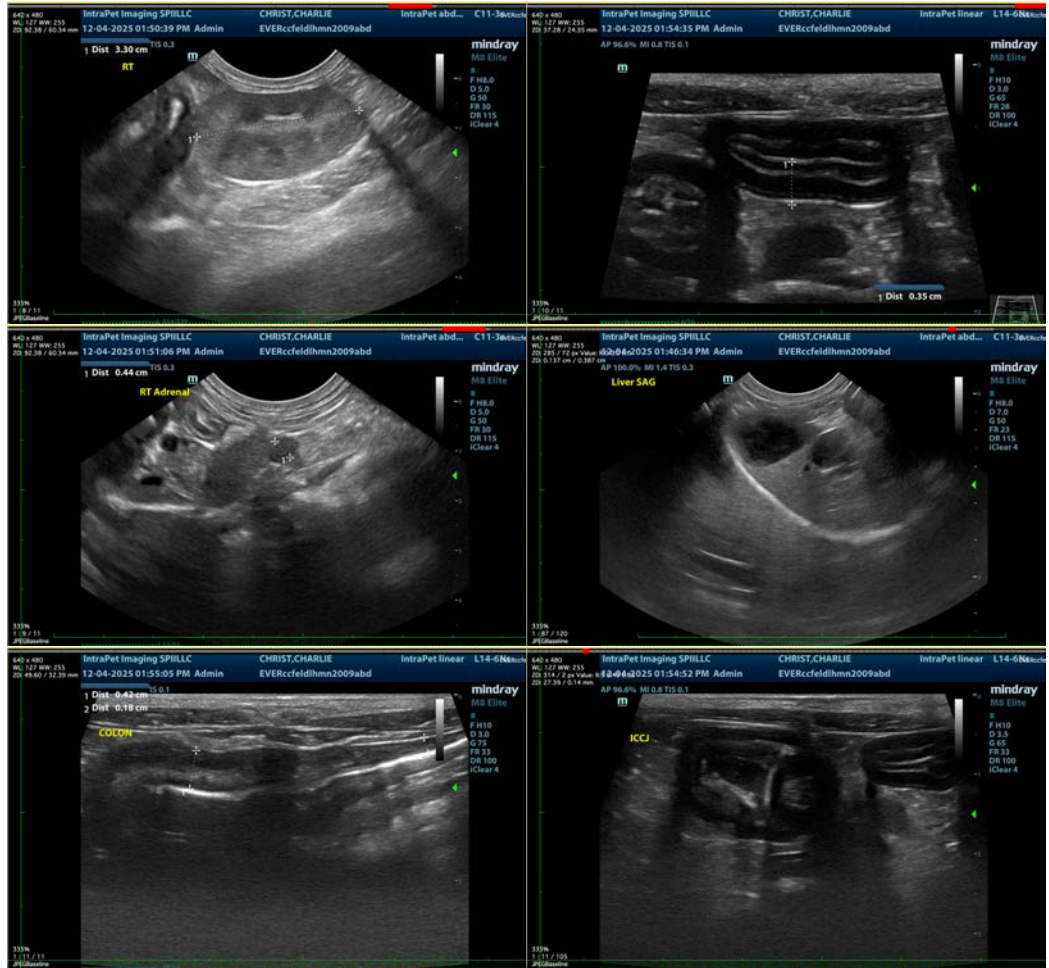
### **SECONDARY FINDINGS**

- Mild gallbladder debris – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness, however, it can also be associated with hepatobiliary disease in cats and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.
- Age related kidney changes.

## 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.
- 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.
- Ideally, biopsies of the GI tract, being sure to include ileum and proximal colon, 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 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.

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