



PATIENT	PRESENTING CLINICAL SIGNS
Gibbs Holz	Patient with previous history of foreign body presents for vomiting; unusual gas pattern seen on abdominal radiographs.
SPECIES	
Feline	Abnormal PE/Chem/CBC/UA Results: Chem/T4 - WNL (1/31/23). CBC -PLTs 29 (clump with adequate estimate).
BREED	ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN
DSH	Urinary System
SEX	The urinary bladder is moderately 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.
Neutered Male	
AGE	The right kidney is normal in size (3.73 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.
9 Years	
WEIGHT	The left kidney is normal in size (3.89 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.
13.8 Pounds	
INTERPRETED BY	Adrenal Glands
Beth Johnson, DVM DACVIM	The right adrenal gland is unable to be well visualized in these images, but the area is examined without evident adrenal gland pathology.
	The left adrenal gland is normal in size (0.23 cm at the cranial pole and 0.31 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.
IMAGING PERFORMED BY	Spleen
Kelly Vazquez	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.
HOSPITAL NAME	Liver
Ramapo Valley AH	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.
REFERRING VET	
Dr. Katara	
INVOICE	
44698	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.
DATE	Gastrointestinal
2/1/23	Fundic mucosal hypertrophy with hyperechoic mucosa and some mucosal remodeling is noted. There is no loss of mural detail. Layering is normal. There is mild luminal fluid accumulation. No evidence of masses/nodules or foreign material present.
	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,



PATIENT

Gibbs Holz

thick and hyperechoic, without evident loss of layering appreciated. The lumen 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.

SPECIES

Feline

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

Pancreas

BREED

DSH

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

SEX

Neutered Male

Free Abdomen

There is no evidence of free peritoneal effusion noted in these images.

AGE

9 Years

There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

WEIGHT

13.8 Pounds

- **Gastritis** – Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other. Microulceration cannot be ruled out.
- **Mild 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 aggressive lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.

INTERPRETED BY

Beth Johnson, DVM
DACVIM

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

IMAGING PERFORMED BY

Kelly Vazquez

There is no visible ultrasonographic evidence of a foreign body in these images. Therefore, recommendations include supportive/symptomatic medical management of possible gastritis/gastroenteritis, dietary indiscretion, etc. with antiemetics, gastroprotectants, and an appetite stimulant if needed, and empirical deworming with a 5-day course of Panacur is also recommended. However, given the mild bowel changes present, further evaluation (if this has been a chronic problem) could include a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory.

HOSPITAL NAME

Ramapo Valley AH

REFERRING VET

Dr. Katara

Given the mild gastric wall thickening, if clinical signs persist beyond supportive management, recheck imaging is recommended, or alternatively upper GI gastroscopy/endoscopy for further visualization of both the stomach and duodenum as well as biopsies of stomach and small bowel could be considered.

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SPECIES

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IMAGING PERFORMED BY

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HOSPITAL NAME

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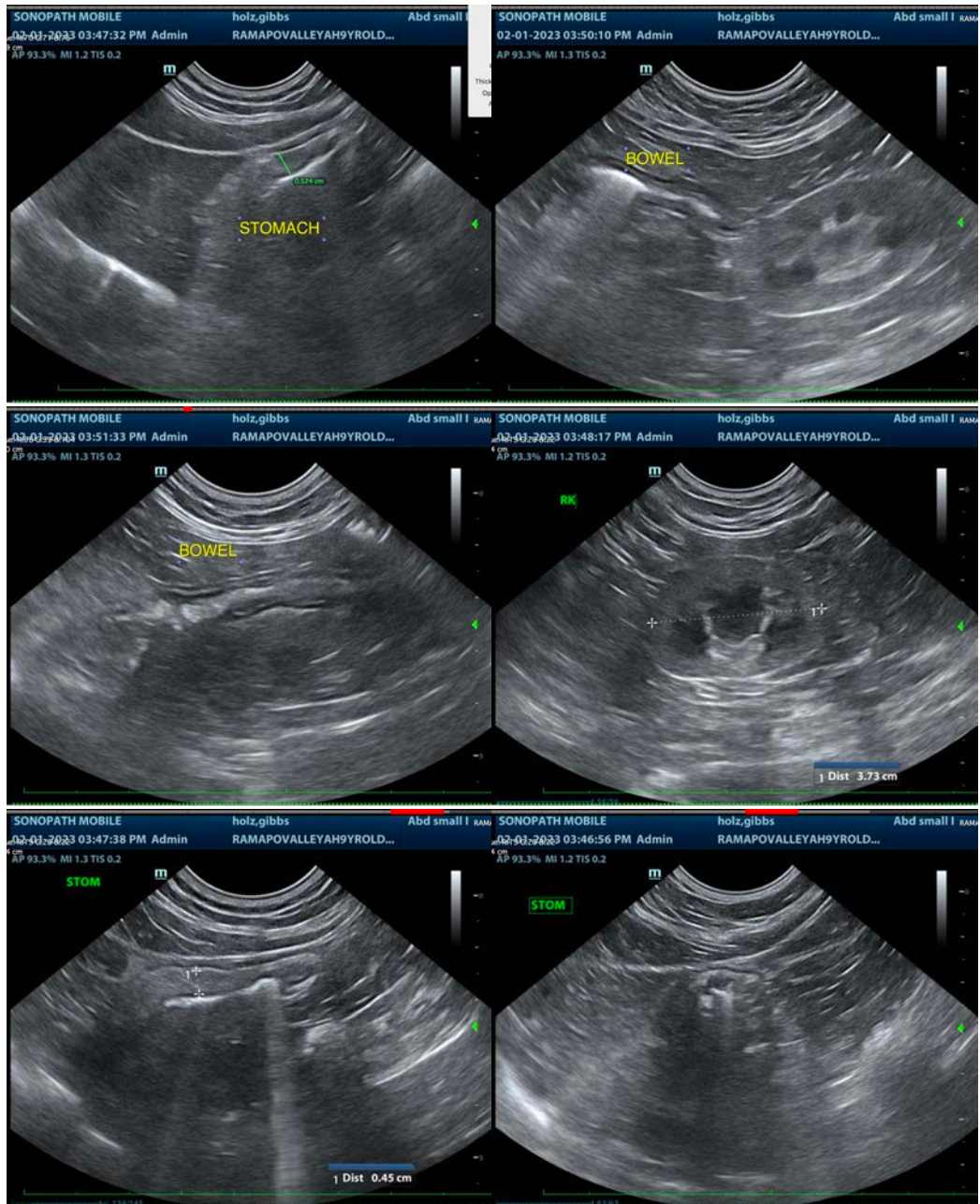
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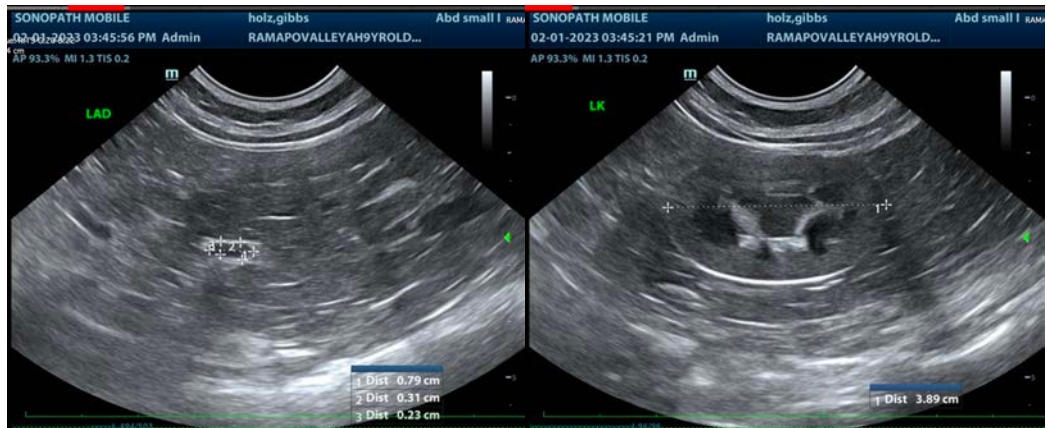
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DATE

2/1/23



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
Beth.Johnson@sonopath.com