



PATIENT

Tinker Cornelius

SPECIES

Feline

BREED

DLH

SEX

FS

AGE

10 years 10 months

WEIGHT

17 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

**IMAGING
PERFORMED BY**

Loetitia Saint-Jacques,
LVT

HOSPITAL NAME

VCA Feline Animal
Hospital

REFERRING VET

Dr.

INVOICE

11306

DATE

2/12/2026

PRESENTING CLINICAL SIGNS

- Acute on chronic intermittent vomiting (03-Feb-2026), Hyporexia - improving (09-Feb-2026), Soft stool (09-Feb-2026.)
- History - Pt presents for wellness exam and vaccines. Pt has been doing well at home. Chronic intermittent vomiting - single liquid vomit from 6-8AM prior to breakfast once a week, usually prior to defecation. Evening meal is usually around 4:30PM. No hx of adverse vaccine reactions with rabies vaccine. No other concerns. No C/S - chronic intermittent vomiting. No PU/PD/PP.
- Diet: Hills Metabolic dry and WeRuva wet
- Environment: Indoor only with outdoor supervised time; 1 household cat (gets along well)
- No current medications, supplements, or preventatives

Abnormal PE/Chem/CBC/UA Results: No arrhythmia/No murmur- Owner requested ECHO LABS WNL.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or definitive cystoliths are observed. The 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 measures 4.3 cm, and the right kidney measures 4.29 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.31 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

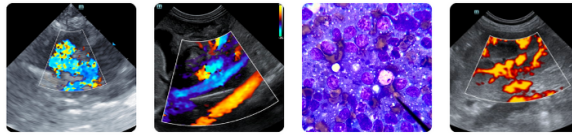
The left adrenal gland is normal in size (0.6 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size (1.3 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

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



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homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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.

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 moderately 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 cecum appears mildly fluid distended in some views. The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The area of the pancreas contains irregular hyperechoic pancreatic remodeling.

Free Abdomen

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

Mesenteric and medial iliac 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.

PRIMARY FINDINGS

- 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.
- 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 or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.
- Hyperechoic pancreas - This finding is suggestive of pancreatic fibrosis, possibly secondary to chronic pancreatitis. A TLI is recommended to rule out exocrine pancreatic insufficiency (EPI), especially if clinical signs (weight loss, diarrhea, etc.) are present.
- Mildly to moderately reactive mesenteric and medial iliac lymph nodes - infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Mildly fluid dilated cecum.



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SECONDARY FINDINGS

- Age related kidney changes.
- A mild to moderate amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

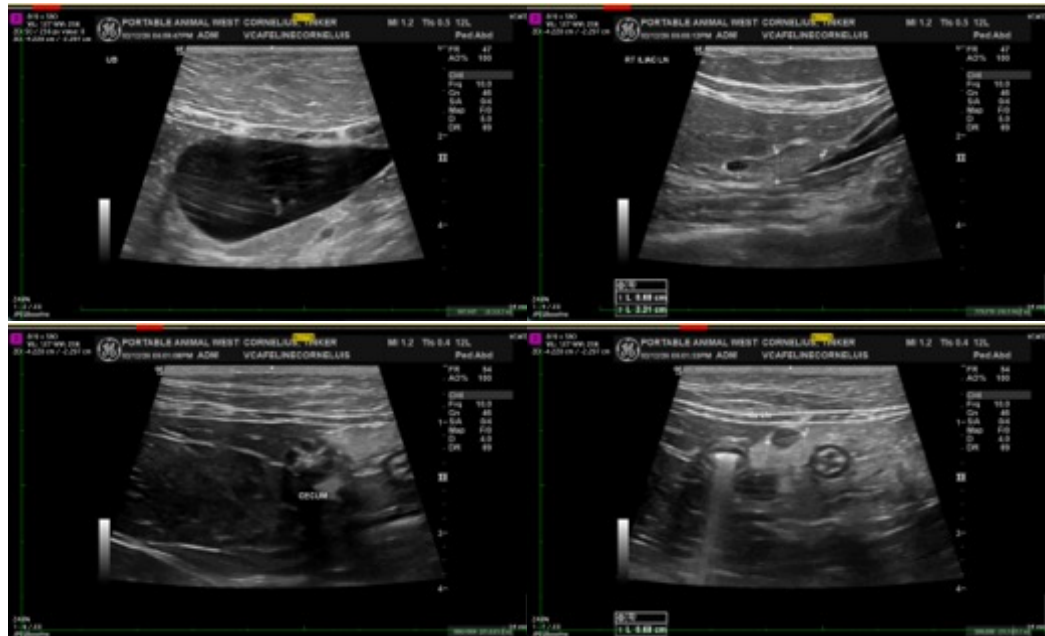
A routine fecal/giardia exam is recommended if not recently evaluated.

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.

Pending results of above, ultimately, tissue sampling may be indicated and if pursued, fine needle aspirates of the spleen +/- the enlarged lymph nodes could be considered if lymph nodes can safely be reached and if patient's coagulation status is appropriate. Ultimately, 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.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.



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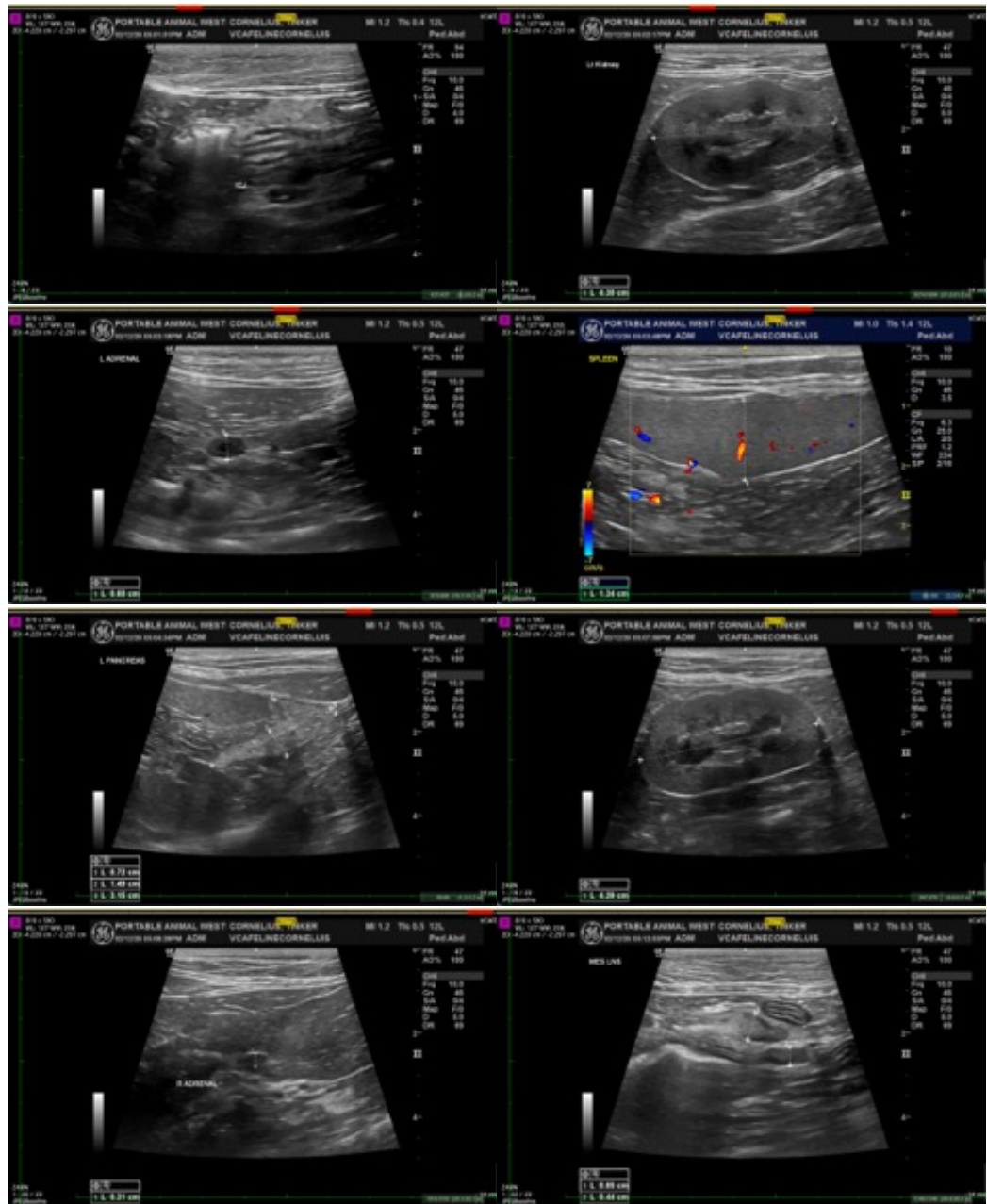
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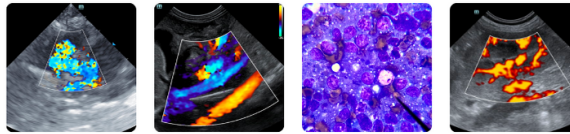
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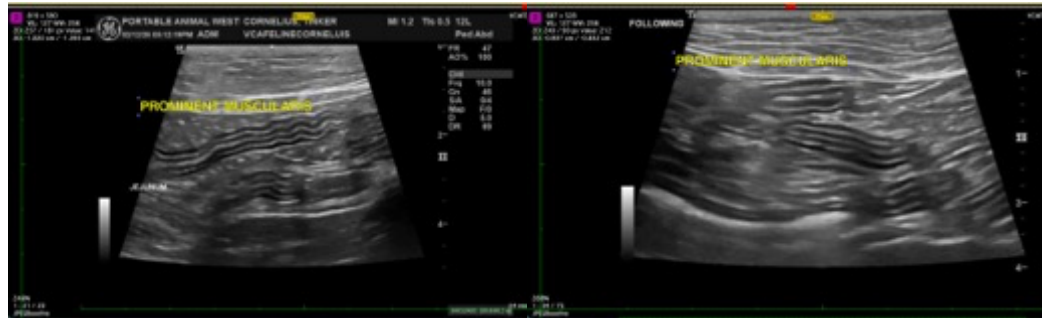
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@sonopath.com