



PATIENT

Bentley Julian

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

14 Years 11 Months

WEIGHT

6.14 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Brandywine Valley
Veterinary Hospital

REFERRING VET

Robert Cafaro, VMD

INVOICE

73013

DATE

2/17/26

PRESENTING CLINICAL SIGNS

AUS to further evaluate weight loss, (well managed) hyperthyroidism, nasal discharge and inflammation.

Meds: Felimazole 2.5 mg - 1 T PO BID

Abnormal PE/Chem/CBC/UA Results: CBC: Hct 34.6%, Plts 40 L - severe clumping. Remainder NSF
Chem: normal LES and renal values, NSF T4: 1.7 on felimazole

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 3.66 cm. Right kidney measured 4.21 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.30 cm at cranial pole and 0.30 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.30 cm at cranial pole and 0.30 cm at caudal pole), 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, except for in the cranial right liver where there is an approximately 1.6 cm x 2.7 cm anechoic density/cyst. 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.



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

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. 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.

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- 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. **This finding may be in part normal patient variant in a senior cat.*
- Pancreatic age-related remodeling/Chronic pancreatitis – Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.

SECONDARY FINDINGS

- Suspect incidental hepatic cyst or feline biliary cystadenoma, which trends in appearance toward benign. Other pathology, while thought less likely, can't be ruled out without tissue sampling.
- Age related kidney changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further evaluation of patient's weight loss is in large part dependent on appetite. Given the concurrent mild to moderate bowel changes, if weight loss is in the face of appropriate daily caloric intake or even increased caloric intake or appetite, then further evaluation of digestion and absorption is recommended, beginning with:

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.

Additionally, or especially if patient's weight loss is in the face of a decreased appetite, the contributing cause may be the reported nasal discharge, which may warrant further workup, including advanced imaging such as CT scan, rhinoscopy, etc.



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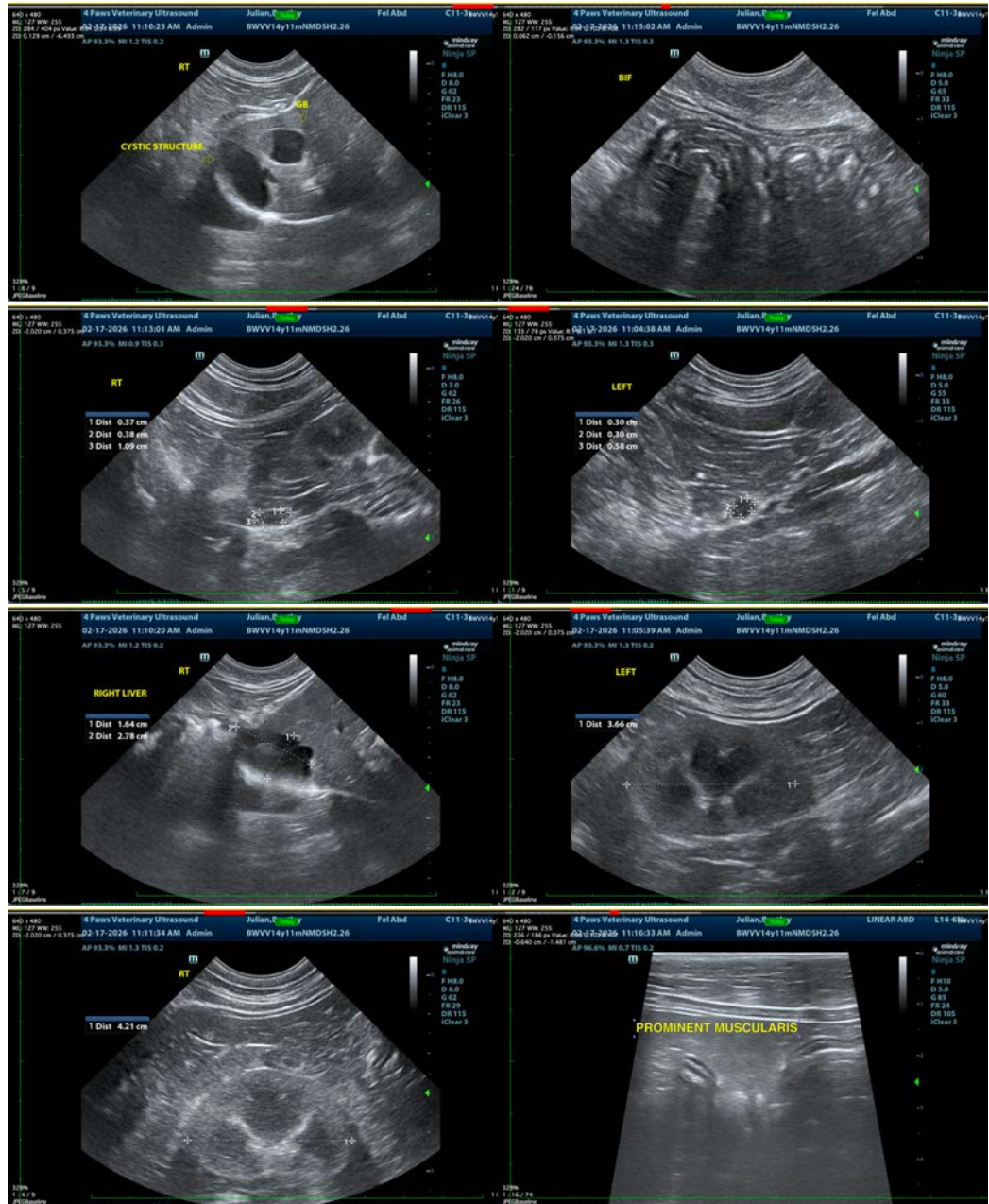
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Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.





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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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