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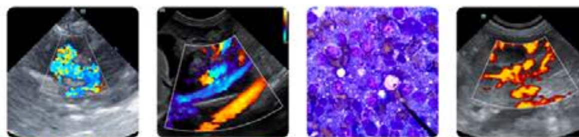


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Oliver Wiswesser

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

11 Years

WEIGHT

7.2 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

Larkin Veterinary Center

INVOICE

73052

DATE

2/18/26

PRESENTING CLINICAL SIGNS

AUS to further evaluate hyporexia x 1 week, weight loss and chronic intermittent vomiting. Mild ALT elevation and monocytosis on BW. Supportive care on 2/9/26: SQF, Cerenia, Buprenorphine OTM, Mirtaz.

Abnormal PE/Chem/CBC/UA Results: CBC: Hct 40.5%, WBC 12.67-n, Bands suspected, Mono 1.88 H, Eos 0.16 H, Plts 85 L, Plt Crit 0.15 L, Neut 7.81-n. Immature/Toxic neut present Chem: Cr 1.2, BUN 28, Alb 2.7, ALT 144 H, remainder NSF

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 normal in size but bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. Left kidney measures 4.12 cm. Right kidney measures 3.94 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.47 cm at cranial pole and 0.36 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

Spleen is subjectively large in size (1.2 cm thick at the hilus) with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a mildly coarse/heterogenous echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

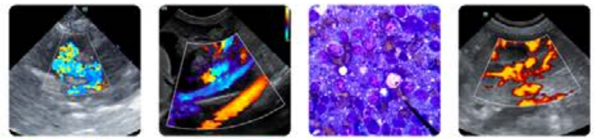
Liver is subjectively enlarged (swollen contour). Mild parenchymal remodeling with diffusely mildly coarse architecture and increased portal markings is present. No focal nodules or masses are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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,



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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. *See other.

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.

At the level of the Ileocecocolic junction there is a very subtle, ill-defined, approximately 1.2 cm x 0.70 cm heterogeneous density that appears to be in part anechoic and could represent a mildly fluid distended cecum, with some very subtly enhanced hyperechoic fat and mesentery adjacent to it. Having said that, upon closer examination of the Ileocecocolic junction with the linear probe at the end of the study, this change is less visible/less defined, and the earlier description could just be some subtly enhanced fat and mild lymphadenopathy adjacent to the Ileocecocolic junction, which is not uncommon with inflammatory bowel disease.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC 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.

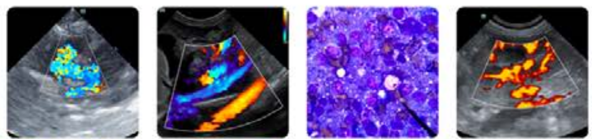
- Hypoechoic hepatomegaly – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.

- 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.

- Mild/subtle chronic kidney disease changes – This finding could be in part normal age related change and should be interpreted in combination with laboratory changes, etc.

- As described above, mild reactive mesenteric lymphadenopathy versus mild typhlitis can't be ruled out.

- 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,



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inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a T4 +/- free T4 is recommended.

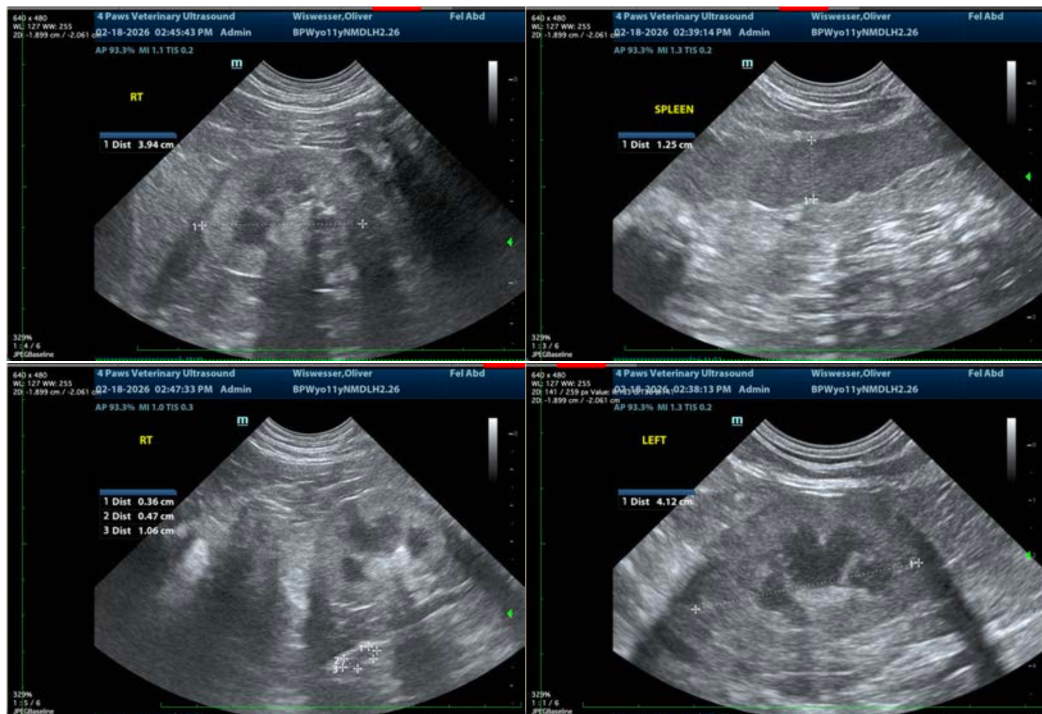
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

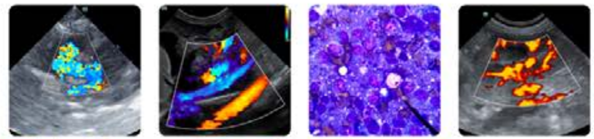
A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

Fine needle aspirates of the spleen and liver are recommended if patient's coagulation status is appropriate.

Ultimately, however, if a diagnosis is not obtained, biopsies of the GI tract, being sure to include ileum, if possible, may be necessary for 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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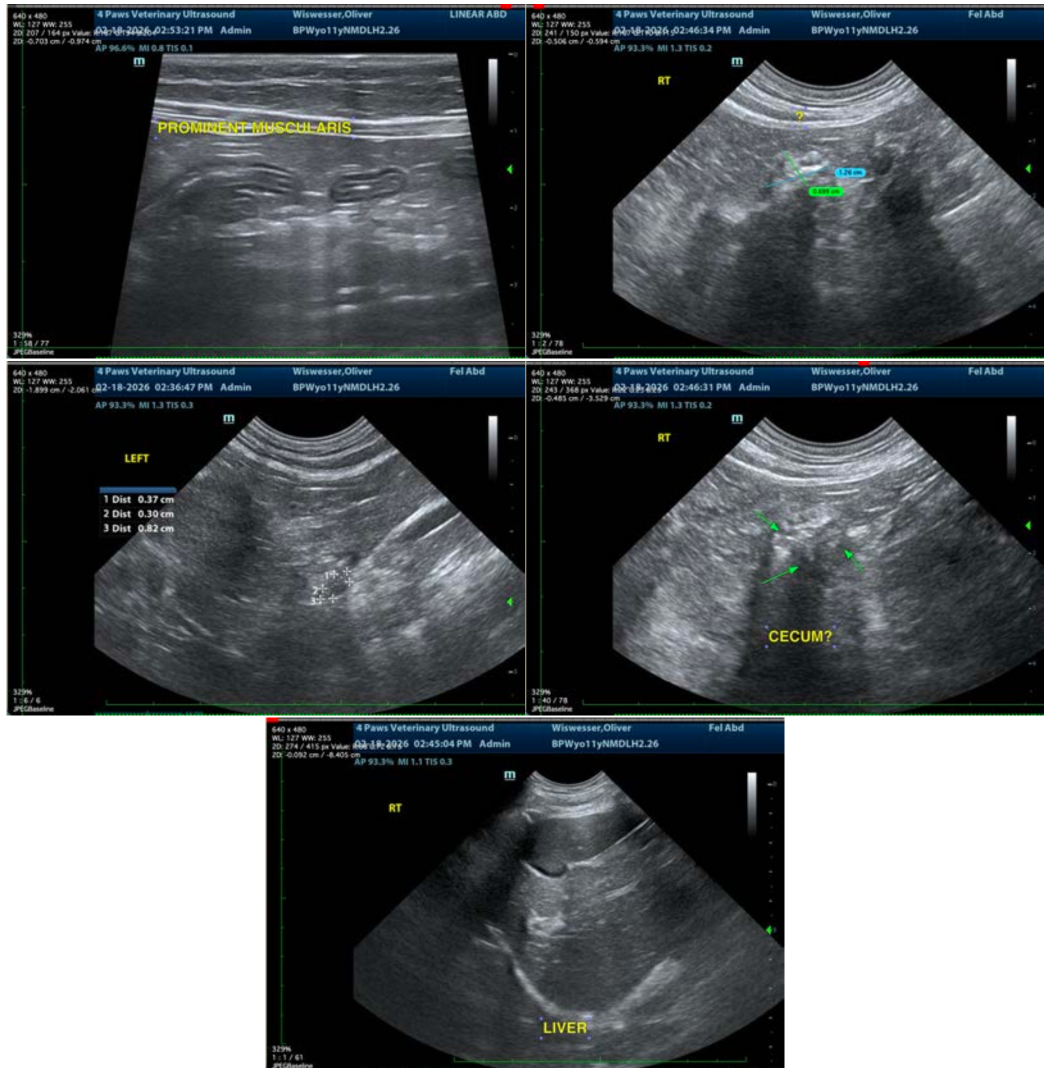

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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