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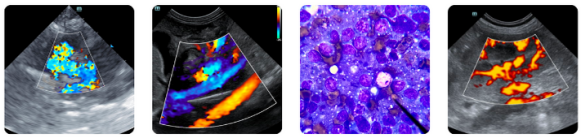

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath
FOSTERING THE ART OF VETERINARY MEDICINE™
SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT

SmokeySocks Root

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

8 years

WEIGHT

3.5 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Brighton Greens Veterinary Hospital

REFERRING VET

Dr. Janeway

INVOICE

11235

DATE

2/2/2026

PRESENTING CLINICAL SIGNS

- Prev I131 treatment for hyperthyroidism. O states pt vomits especially when he eats dry food. possible IBD.
- Working diagnosis: IBD

Abnormal PE/Chem/CBC/UA Results: NSF in 2025. LABS attached from `1/27/2026.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. The wall is normal in thickness with a smooth mucosal surface, except for several irregular, echogenic, pedunculated densities extending from the ventral wall. One measuring approximately 0.4 cm in diameter. The other measuring approximately 0.6 cm. No mineral is observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal is size (3.5 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.

The left kidney is normal is size (3.8 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.

Adrenal Glands

The areas of the right adrenal gland is examined without evident adrenal gland pathology.

The left adrenal gland is normal in size (0.43 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

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. 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 mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted. 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 mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted.

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

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.

Sub lumbar, mesenteric and cranial abdominal/portal 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.

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.
- Significantly reactive diffuse lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Concurrent chronic low grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- The liver changes are non-specific and could represent a benign process such as bacterial or lymphoplasmacytic, cholangiohepatitis, hepatic lipidosis, other infectious or inflammatory reactive hepatopathy or infiltrative neoplasia such as round cell neoplasia can't be ruled out without tissue sampling.
- The urinary bladder wall changes could similarly represent a benign process such as polypoid cystitis, although infiltrative uroepithelial neoplasia can't be ruled out without tissue sampling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, 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.

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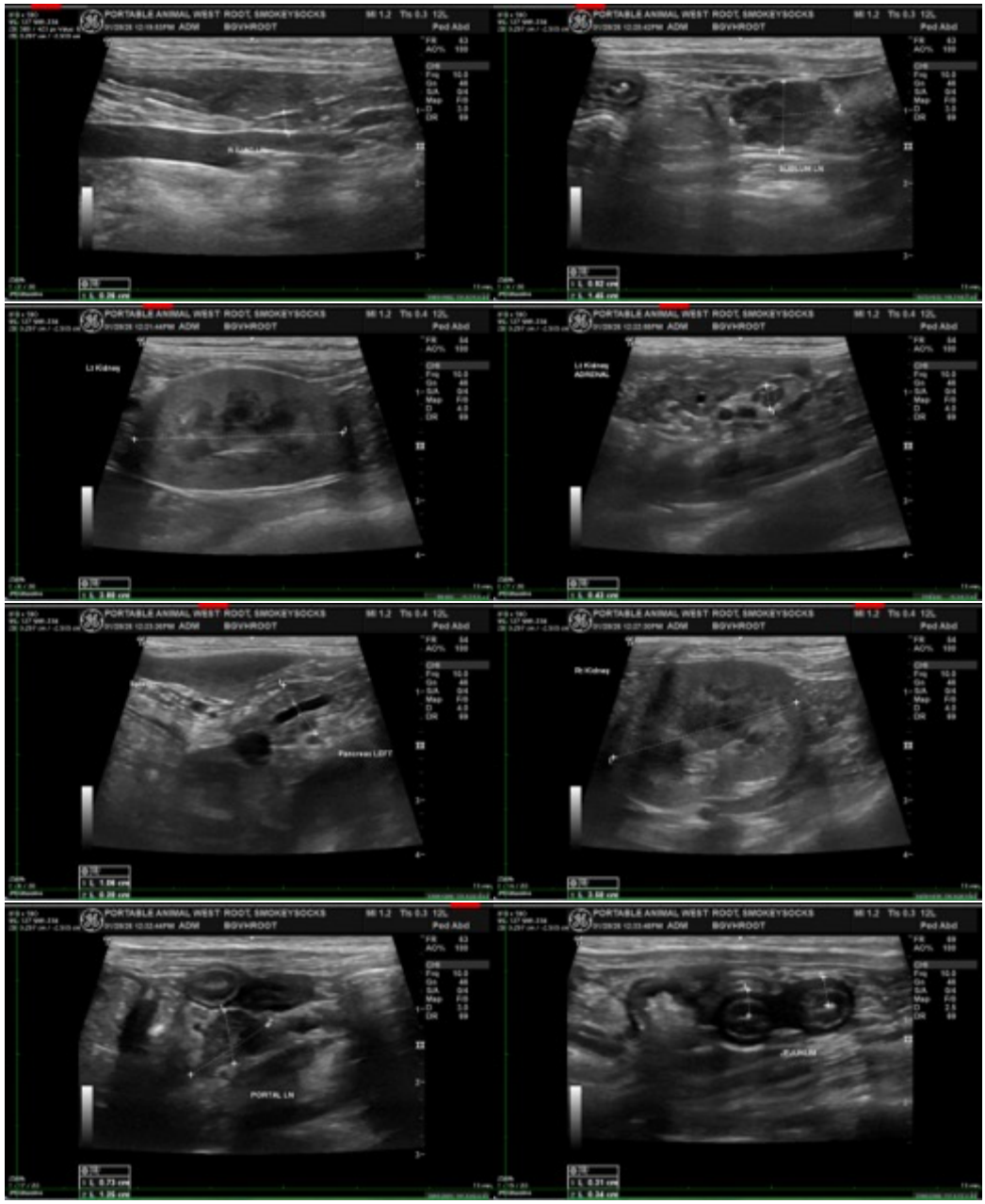
Tissue sampling could be considered. Fine needle aspirates of the liver, the enlarged lymph nodes +/- the urinary bladder nodules (with some risk for tumor seeding/trailing) could all be considered if patient's coagulation status is appropriate.

Ultimately, however, biopsies of the GI tract may be necessary including ileum, if possible, for a definitive diagnosis and therefore to further guide medical management.

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



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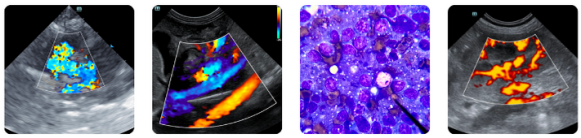

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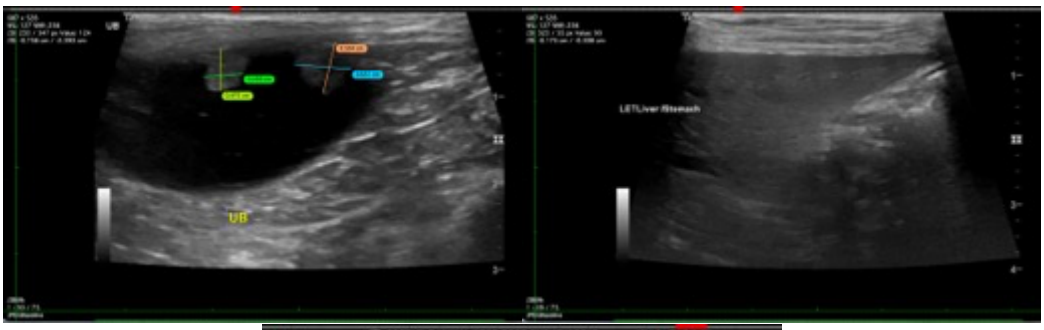

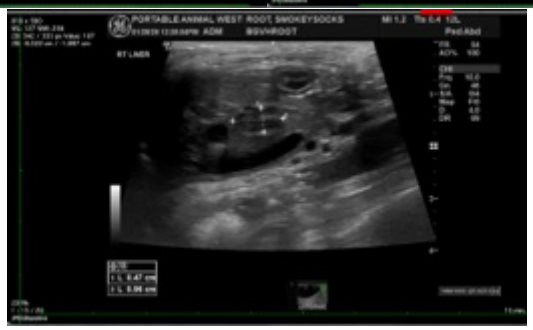

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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