



**PATIENT**

Melman Fetch

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

9 Years

**WEIGHT**

10 lbs

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Kerri Becker

**HOSPITAL NAME**

Bergen County VC

**REFERRING VET**

Dr. Moore

**INVOICE**

72717

**DATE**

2/4/26

**PRESENTING CLINICAL SIGNS**

Vomiting, decr. appetite.

**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 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. The left kidney is normal in size at 3.95 cm. A chronic infarct is noted in the caudal pole of the left kidney. The right kidney is normal in size at 4.29 cm.

**Adrenal Glands**

The right adrenal gland is normal in size (0.29 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.32 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**

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.

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 markedly/significantly 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.



**PATIENT**

Melman Fetch

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

9 Years

**WEIGHT**

10 lbs

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Kerri Becker

**HOSPITAL NAME**

Bergen County VC

**REFERRING VET**

Dr. Moore

**INVOICE**

72717

**DATE**

2/4/26

***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.

Mesenteric 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**

- Marked/significant 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.
- Markedly reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Very subtle/mild chronic kidney disease changes, primarily indicated by chronic infarct in the left kidney.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

If not recently evaluated, a general metabolic health screen (CBC, chemistry panel with electrolytes and urinalysis) 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.

Fine needle aspirates of the enlarged mesenteric lymph nodes could be considered if patient's coagulation status is appropriate, but if a cytologic diagnosis is unable to be obtained, 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 diagnostic and treatment recommendations are largely dependent on results of the above.



**PATIENT**

Melman Fetch

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

9 Years

**WEIGHT**

10 lbs

**INTERPRETED BY**

Beth Johnson, DVM  
 DACVIM

**IMAGING PERFORMED BY**

Kerri Becker

**HOSPITAL NAME**

Bergen County VC

**REFERRING VET**

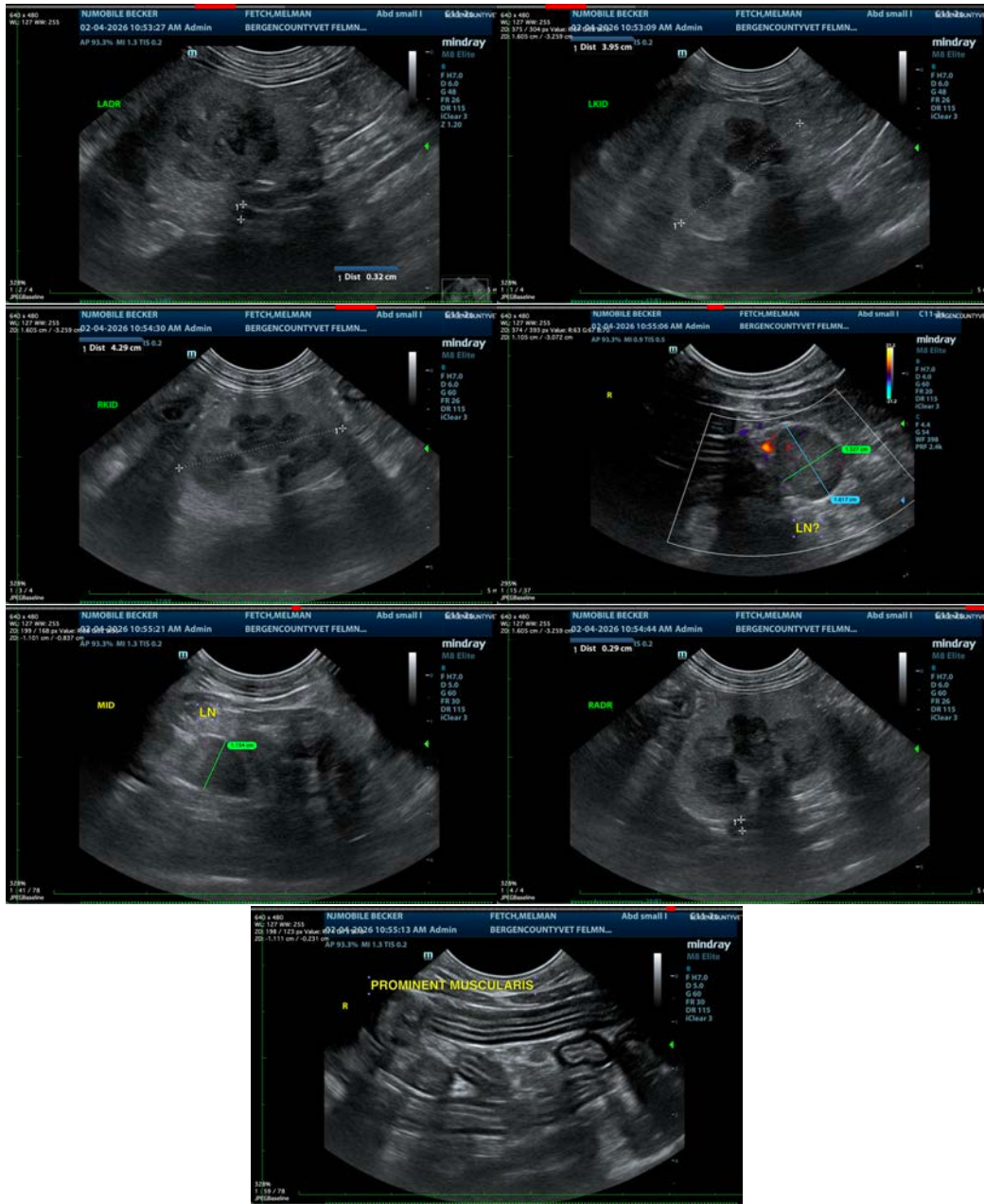
Dr. Moore

**INVOICE**

72717

**DATE**

2/4/26



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