



**PATIENT**

Midge Murphy

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Spayed Female

**AGE**

16 Years

**WEIGHT**

2.74 kg

**INTERPRETED BY**

Beth Johnson, DVM  
 DACVIM

**IMAGING PERFORMED BY**

Crystal Hill

**HOSPITAL NAME**

Snelgrove Veterinary  
 Services

**REFERRING VET**

Dr. Ioannou

**INVOICE**

72712

**DATE**

2/4/26

**PRESENTING CLINICAL SIGNS**

Passing normal BM in kennel. Has been possibly PU/PD. Weight loss since last January was 4.2kg. No meds. Rec Abdominal US.

Abnormal PE/Chem/CBC/UA Results: EOS 0.16, Glucose 9.9 otherwise WNL, no rads

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

Urinary bladder is only mildly distended. Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. In the face of urinary signs and/or suspected urinary bladder pathology, reassessment after complete filling is recommended.

The right kidney is normal is size (3.7 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. A cortical cyst is noted in the caudal pole of the right kidney measuring approximately 1.3 cm x 1.4 cm in size.

The left kidney is normal is size (3.26 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 right adrenal gland is uniformly plump egg-shaped (0.55 cm), hypoechoic in echogenicity with bilateral dystrophic mineralization noted. This is most likely a benign age-related change. This change can be caused by chronic stress/disease, so investigation for/management of other disease (chronic kidney disease, hyperthyroidism, etc.) is recommended.

The left adrenal gland is normal in size (0.33 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.



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**Gastrointestinal**

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestine demonstrates areas of mildly 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 is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is no evidence of obstruction, foreign material or infiltrative disease.

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 is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Pancreatic duct dilation is noted. Enhanced hyperechoic ill-defined surrounding fat is noted.

**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.

**PRIMARY FINDINGS**

- Suspect mild to moderate acute pancreatitis.
- Concurrent mild/emerging 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 change may be in part normal patient variant in a senior cat.*
- Very mild reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

**SECONDARY FINDINGS**

- Suspect incidental cortical cyst in the right kidney.
- Suspect mild age related or chronic disease related right adrenomegaly – Further evaluation of underlying adrenal disease should be considered if clinically indicated.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

For full use of provided lab work in making recommendations, due to geographic differences in reporting, please provide units, reference ranges, and/or at least high, normal, or low after each value.



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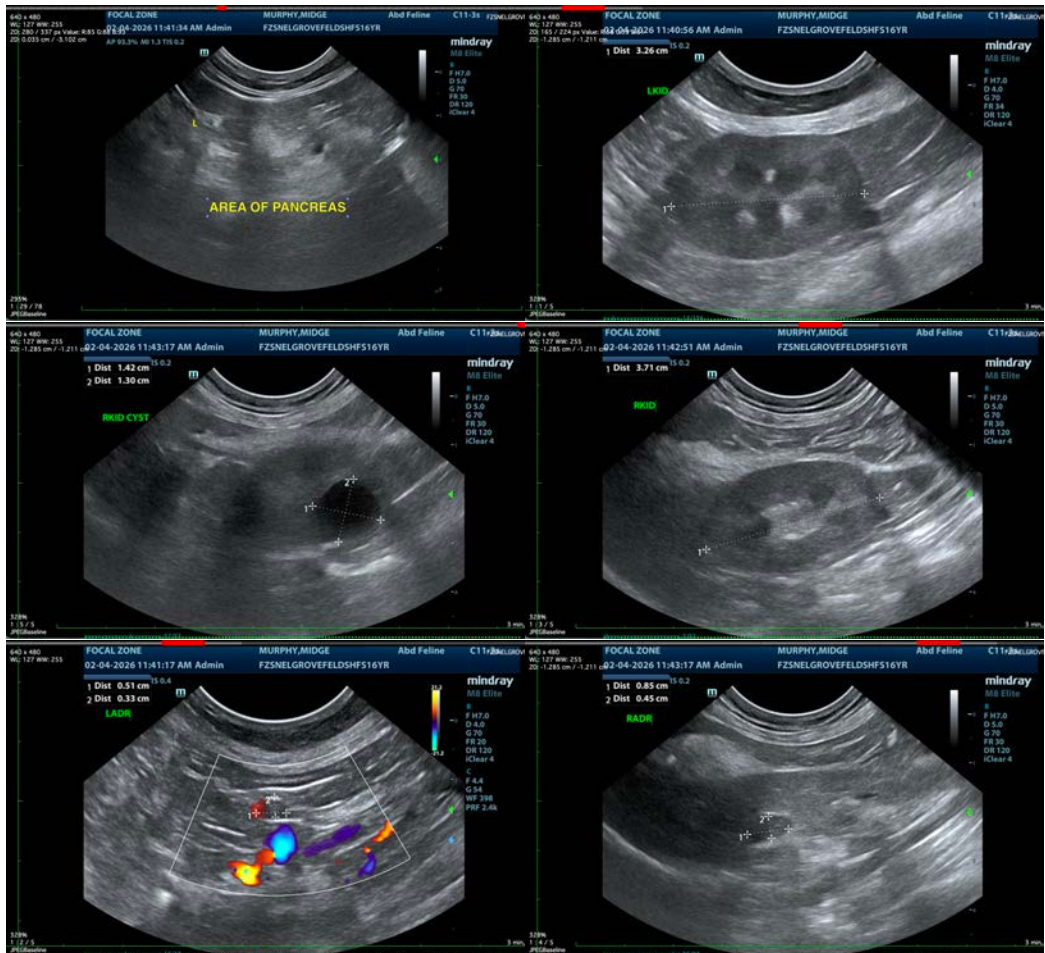
Having said that, if patient is hyperglycemic, further evaluation to rule out stress hyperglycemia versus persistent diabetes mellitus hyperglycemia is indicated, beginning with a urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended.

A Fructosamine could be considered.

In the meantime, additionally, given the changes noted above, 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.

Given the mild adrenomegaly, a blood pressure is also recommended if not recently evaluated.

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