

PATIENT

Ferguson Duffield

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

2 Years

WEIGHT

5.1 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Jill Rankin

HOSPITAL NAME

McKnight Veterinary
Hospital

REFERRING VET

Dr. Hannah

INVOICE

72760

DATE

2/5/26

PRESENTING CLINICAL SIGNS

Ferguson presents for an ultrasound to investigate a history of chronic, persistent hematochezia.

The patient has experienced intermittent hematochezia for approximately three to six months. Despite treatments including multiple dewormers, sucralfate, and a transition to a hypoallergenic diet, the bloody diarrhea has persisted. The patient has also been fecal tested. Additional clinical signs include occasional vomiting, though his weight has remained stable.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal in size (4.4 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 in size (3.6 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 not well visualized fully sagittal, so the measurement is of a partially obliqued transverse view.*

Adrenal Glands

The right adrenal gland is normal in size (0.35 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.35 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size 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) with a diffusely mildly coarse architecture and subtly increased portal markings. Mildly mixed echogenic changes are noted diffusely. 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 very mildly subjectively thick and hyperechoic. Luminal contents are primarily anechoic. The cystic and common bile ducts, while not pathologically distended, are diffusely tortuous in appearance.



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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 intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with 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

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.

Mesenteric and cranial abdominal 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

- Very mildly/subtly 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.
- Similarly, the liver changes are very mild/subtle and non-specific, with differentials including both benign microscopic hepatopathy such as bacterial or lymphoplasmacytic hepatitis, other infectious or inflammatory reactive hepatopathy, as well as infiltrative round cell neoplasia such as lymphoma unable to be ruled out without tissue sampling. Chronic low-grade smoldering pancreatitis and cholangitis/“triaditis” can’t be ruled out and should be suspected in the face of appropriate clinical signs and/or laboratory changes.
- Mildly to moderately reactive mesenteric and cranial abdominal lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Moderate amount of echogenic urinary bladder debris.

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.



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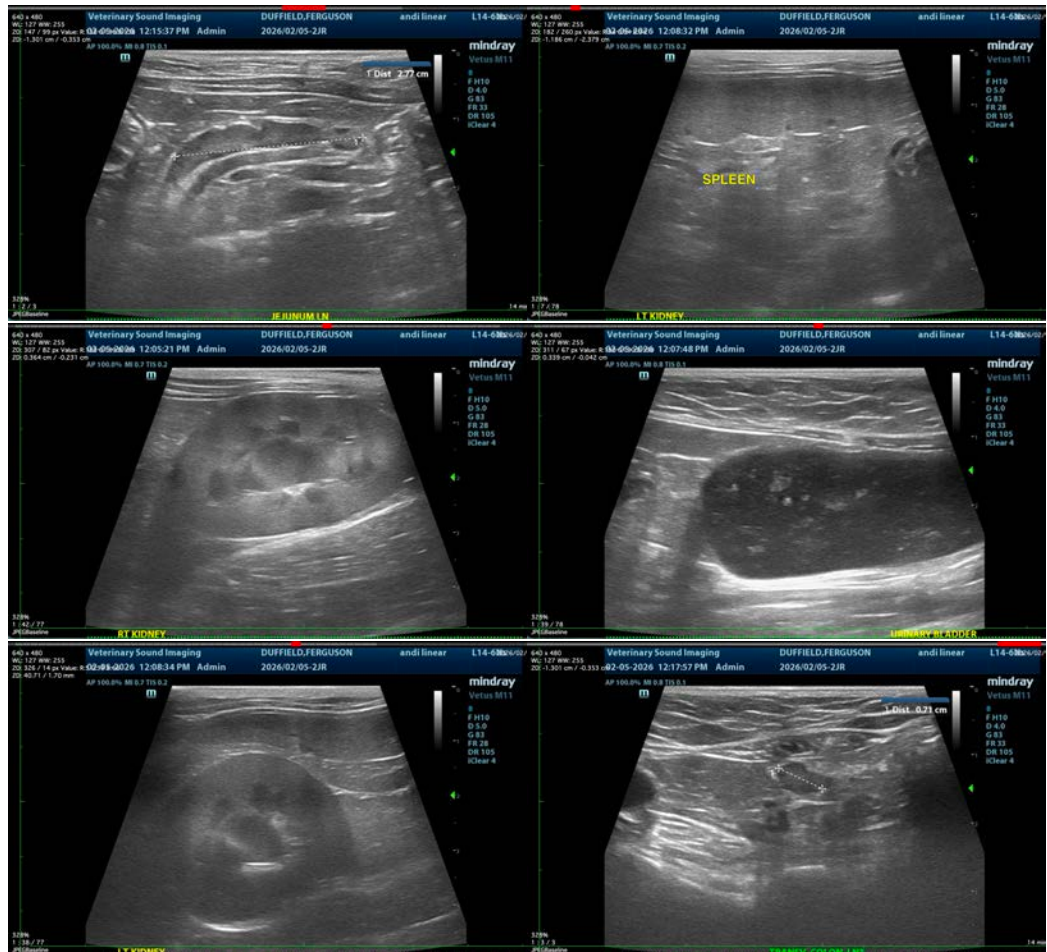
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A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool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

Tissue sampling could be considered, beginning with fine needle aspirates of the liver and spleen +/- the enlarged lymph nodes if they can safely be reached and if patient's coagulation status is appropriate.

Ultimately, however, if a diagnosis is not obtained and clinical signs persist, colonoscopy +/- concurrent upper GI endoscopy may be warranted for further visual evaluation and biopsies.

In the meantime, supportive/symptomatic medical management of clinical signs is recommended, including a probiotic (such as visbiome or proviable), empirical deworming with a 5-day course of Panacur and, if tolerated, a transition in diet, based on trial-and-error response, beginning possibly with a gastrointestinal biome diet vs a hydrolyzed protein diet vs other. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several brand attempts may be required.





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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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