

PATIENT

Zinnia Adcock

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

11 Years

WEIGHT

11.36 Pounds

INTERPRETED BY

Beth Johnson, DVM
 DACVIM

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Centreville AH

REFERRING VET

Dr. Sandhu JR

INVOICE

36781

DATE

2/9/26

PRESENTING CLINICAL SIGNS

- Presented for ongoing weight loss, previous concerns for some constipation which owner reports has resolved
- Eating and drinking normally, maybe drinking a bit more, no V/D/C/S
- Small lesion above right eyelid not bothering patient and no major growth or changes noted
- Weighed 14 lbs in Sept 2025
- Has been on Clavamox, Denamarin and Mirtaz
- Abnormal PE/Chem/CBC/UA Results: Elevated ALT 211, ALP 313, GGT 11, Bilirubin 15, Calcium 2.98 and Cholesterol 6.03 rest unremarkable. Sample appeared icteric ++, MM maybe a bit icteric in clinic.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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.

The kidneys are 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, measuring 3.51 cm. The right kidney is normal in size, measuring 3.69 cm.

Adrenal Glands

Left adrenal gland is normal in size (0.38 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

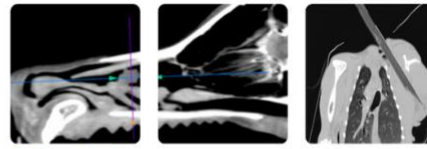
Right adrenal gland is normal in size (0.39 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen measures just at the upper ends of normal limits in thickness (1.0 cm thick) with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

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.



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Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. The cystic and common bile duct, while not visibly 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.

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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 of the small intestine is empty with no evidence of obstruction or foreign material.

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

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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.

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Free Abdomen

There is no visible free peritoneal effusion noted in these images.

The 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.

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ULTRASONOGRAPHIC FINDINGS

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- Mild/emerging inflammatory bowel disease 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.
- Very mildly reactive mesenteric lymphadenopathy- infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Splenomegaly- can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

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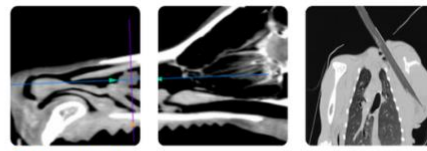
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- Mild chronic kidney disease changes
- Chronic low grade smoldering cholangitis/cholangiohepatitis, or even "triaditis", can't be ruled out.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

**Due to geographic differences in laboratory units, for labwork abnormalities to be included in interpretation and recommendations, please include either units, reference ranges, and/or at minimum, a high versus a low next to the provided value if actual lab work is not attached.

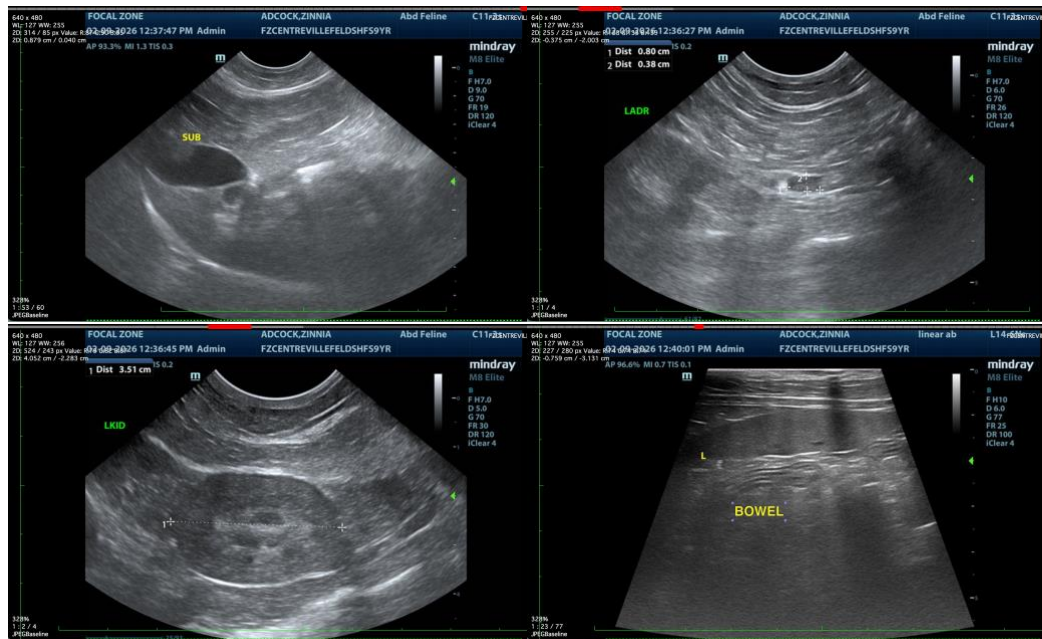
Having said that, if patient is hypercalcemic, a malignancy panel (PTH, PTHrP, iCa) to Michigan State College of Veterinary Medicine is recommended for further investigation of the reported hypercalcemia.

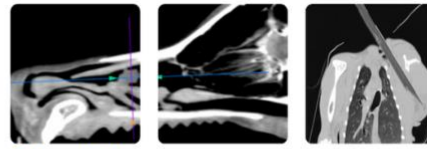
A T4 +/- free T4 is recommended if not recently evaluated.

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.

Pending results of above, fine needle aspirates of the spleen, as well as the liver, could be considered if patient's coagulation status is appropriate.

In the meantime, treatment recommendations include fluid therapy, anti-emetics, gastroprotectants, hepatic nutraceuticals such as ursodiol and/or Denamarin, and broad-spectrum antibiotics. Nutritional support is critical to prevent/manage concurrent hepatic lipidosis, so appetite stimulants and/or, if indicated, feeding tube placement is also recommended.





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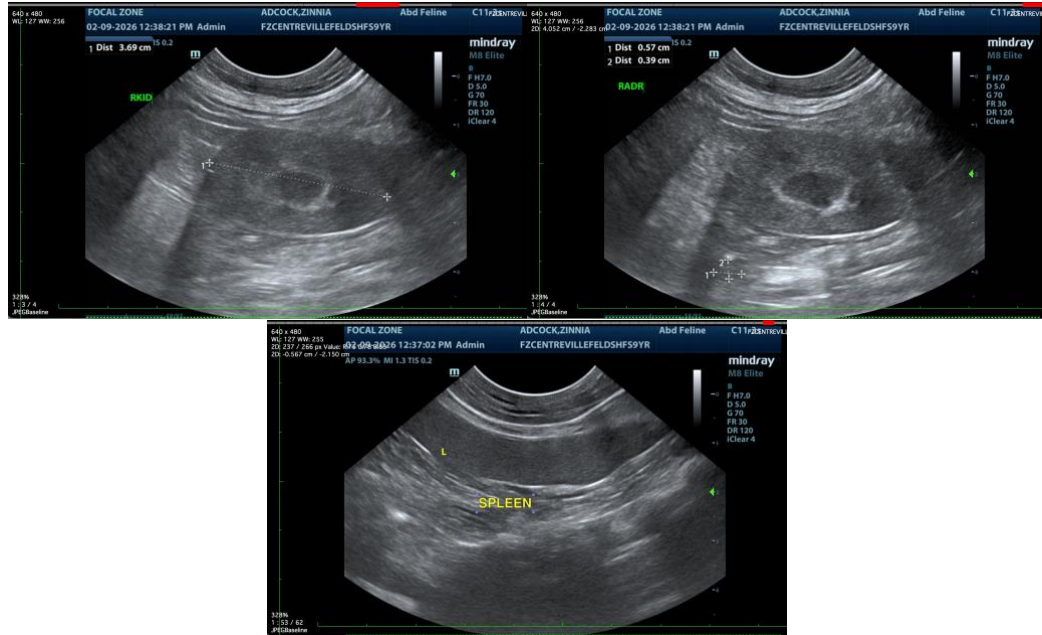
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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