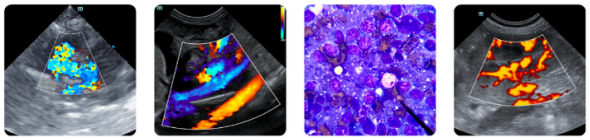

PATIENT

Snow Muresan

SPECIES

Feline

BREED

Siamese Mix

SEX

MN

AGE

4 years 5 months

WEIGHT

6.45 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Jill Rankin

HOSPITAL NAME

Bridgeland Vet Clinic

REFERRING VET

Dr. Flath

INVOICE

11463

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3/11/2026

PRESENTING CLINICAL SIGNS

- Snow is a four-year-old, male neutered Siamese cat with a history of chronic vomiting, which has improved but is still ongoing, and a recently treated fractured tooth.
- In January, Snow presented with concerns of vomiting undigested food three to four times per week, typically occurring a couple of hours after eating. On the days he vomited, he was also lethargic and had a decreased appetite, but would return to normal the following day. His diet consists of a mix of Hill's Science Diet Perfect Weight, and Royal Canin Urinary Health and Appetite Control, with the Royal Canin foods having been introduced two months prior to the onset of symptoms. Blood work performed at that time was unremarkable aside from a mild eosinophilia. A T4 level was normal. A fecal parasite screen was recommended due to the eosinophilia, but a sample was never provided by the owner. There has been no diarrhea.
- During the January examination, a fractured maxillary canine tooth (104) was incidentally discovered. The owner elected to address this issue first, and Snow subsequently underwent a successful root canal procedure with a specialist. The cat reportedly did well after the procedure.
- As of the current visit, the vomiting is still occurring, but it is less frequent and is no longer accompanied by lethargy or decreased appetite. The owner has now decided to proceed with an abdominal ultrasound to further investigate the persistent vomiting.

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 a large amount of echogenic non-shadowing debris, most consistent with exfoliated cells, crystals, mucous and/or small blood clots likely combined with incidental suspended lipid. Both sterile inflammation as well as urinary tract infection can 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 is size (4.3 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 (4.3 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.

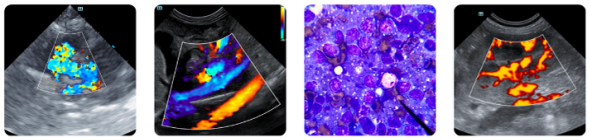
Adrenal Glands

The area of the right adrenal gland is visualized without evident adrenal gland pathology.

The left adrenal gland is unable to be well visualized.

Spleen

Spleen is subjectively large in size 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. The spleen measures just at the upper ends of normal limits in thickness, at 1.0 cm thick at the hilus.



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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 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.

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

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.

Cranial abdominal/suspect pancreaticoduodenal and 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

- 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.
- Mildly reactive cranial abdominal/suspect pancreaticoduodenal and mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Mild 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

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extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

- Moderate to large of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

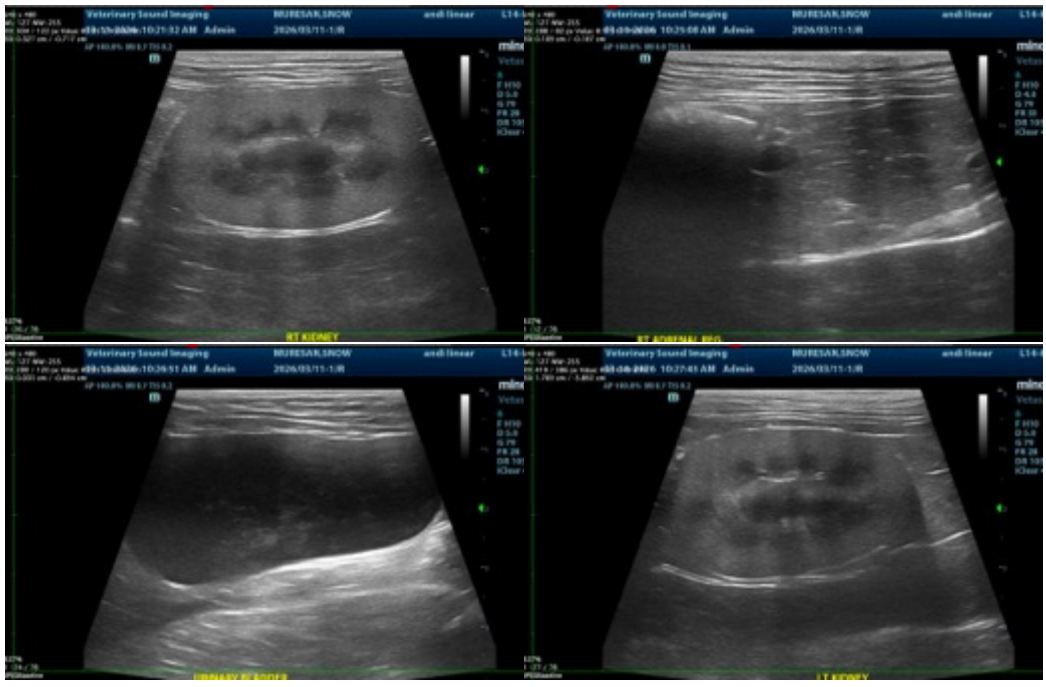
If not recently evaluated, a general metabolic health screen (CBC, chemistry panel with electrolytes and urinalysis) is recommended.

A routine fecal/giardia exam 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.

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.

Pending results of above, fine needle aspirates of the lymph nodes, if they can safely be reached, although they may be too small for sampling, and the spleen could be considered if patient's coagulation status is appropriate. Ultimately, however if clinical signs persist, biopsies of the GI tract, being sure to include ileum, if possible, may be necessary for ad definitive diagnosis and therefore to further guide medical management.



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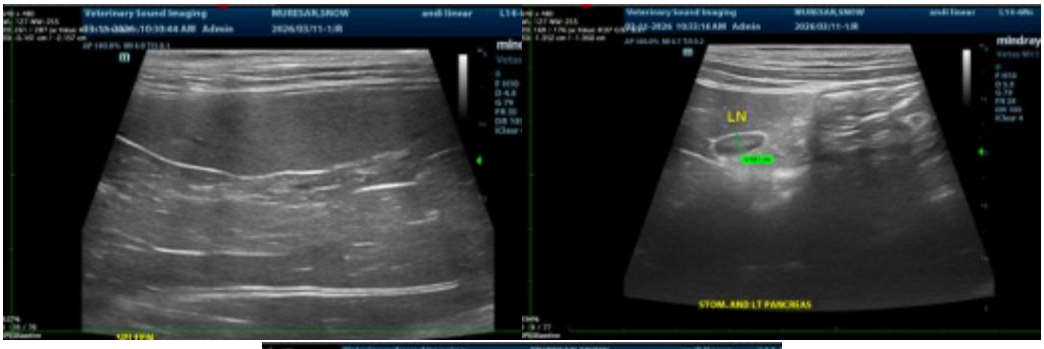

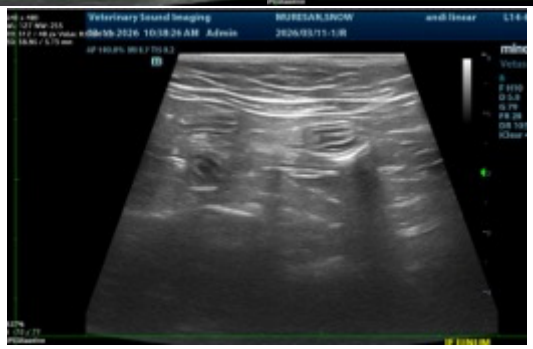

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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