

PATIENT

Wizard Hiebel Chand

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

10 Years 1 Month

WEIGHT

14.8 pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Lucas Budden

HOSPITAL NAME

Frontier Veterinary
Hospital

REFERRING VET

Dr. Lucas Budden

INVOICE

14260

DATE

03/11/26

PRESENTING CLINICAL SIGNS

- Clinical signs: Abdominal pain
- History: Presented on 3/9/2026 for showing signs of pain. Originally he seemed to be painful in the neck and shoulders but last night it seemed to change to the lower back and abdomen. He had a decreased appetite at the time but did eat well the night before presentation. Has a history of presumed inflammatory bowel disease. No vomiting or diarrhea noted. During exam was tense on abdominal palpation and comfortable on spinal palpation. At this time senior lab work was run and x-rays of the abdomen were performed. Subcutaneous fluids were administered and an enema was also performed. Represented on 3/11/2026 as patient had not defecated. He had been hiding in a closet at home which was abnormal for him and he still seemed to be seeming uncomfortable in the abdomen. Another enema was performed and he finally defecated. Another set of x-rays was taken and his colon appeared to be fully evacuated. Another round of subcutaneous fluids administered as well as Cerenia. An abdominal ultrasound was performed to reassess the GI tract to determine the underlying cause of the abdominal pain.
- Current medications:
- Diet:
- - Hill's z/d
- Parasiticide Medication:
- - Revolution plus
- Other Medications:
- - Provable capsule: one capsule daily.
- - Prednisolone 2.5 mg: discontinued after last lab panel, last dose was 3/9/26 (previously on EOD dosing)
- - Dasuquin: one chew daily.
- - Gabapentin: 100mg
- - Dexdomitor and Torb sedation to facilitate imaging

Physical exam: Normal TPR, stable weight, pain score 1 out of 4 due to being tense on abdominal palpation, normal exam otherwise Lab work: 3/9/2026 senior panel Glucose high 301 Triglyceride high 288 Remainder of CBC/CHEM normal Thyroid normal 1.5 USG 1.054 Protein 1+ Glucose 3+ Clear appearance Fructosamine high 388 3/9/2026 abdominal x-rays Radiographic

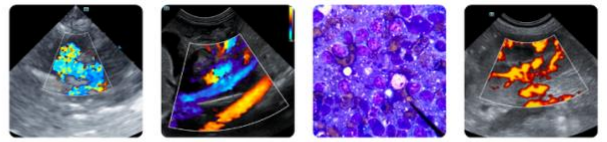
Conclusions/Recommendations: 1. No evidence of a mechanical obstruction. sonography would be recommended to further assess more sensitively. 2. The appearance of the cranioventral thorax is most likely associated with anesthesia-related atelectasis and summation of fat in the mediastinum. 3. Minimal splenomegaly.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

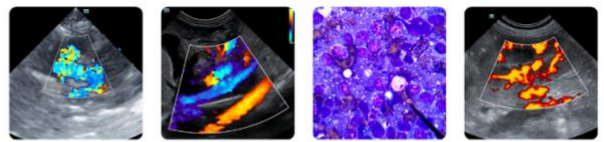
Urinary System

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.

Left kidney is normal in size (4.12 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.



PATIENT	Right kidney is normal in size (4.29 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.
Wizard Hiebel Chand	
SPECIES	Adrenal Glands
Feline	Left adrenal gland is normal in size (0.42 cm at cranial pole and 0.43 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.
BREED	Right adrenal gland is normal in size (0.36 cm at cranial pole and 0.30 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.
DLH	
SEX	Spleen
Neutered Male	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). An approximately 0.4 cm in diameter non-capsule disrupting discrete homogenous hyperechoic nodule near the cranial aspect of the spleen was present. Additionally, a 0.3 by 0.7 cm homogenous isoechoic extension of the mid medial spleen near the hilus most consistent with a benign accessory processor spleen.
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WEIGHT	Liver
14.8 pounds	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.
INTERPRETED BY	Gastrointestinal
Beth Johnson, DVM DACVIM	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.
IMAGING PERFORMED BY	
Dr. Lucas Budden	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.
HOSPITAL NAME	
Frontier Veterinary Hospital	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.
REFERRING VET	
Dr. Lucas Budden	The visible colon is normal in wall thickness (< 0.2 cm) and layering. The lumen is diffusely mildly fluid distended consistent with patient's reported recent enemas.
INVOICE	Pancreas
14260	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.
DATE	Free Abdomen
03/11/26	There is no visible free peritoneal effusion noted in these images.



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Mesenteric lymphadenopathy is prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

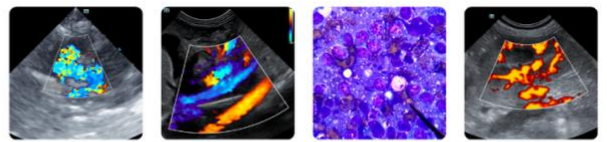
ULTRASONOGRAPHIC FINDINGS

- Mild 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.
- Moderately mesenteric lymphadenopathy- infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Concurrent chronic low-grade smoldering pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.
- Hyperechoic hepatomegaly- Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.
- Hyperechoic splenic nodule- most consistent with benign myelolipoma. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given patient's history, if the abdominal pain could have been related to constipation which has reportedly resolved, then monitoring may be appropriate. Otherwise, given the concern for possible emerging infiltrative bowel disease, additional gastrointestinal workup could be considered including 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.

In the meantime, continued monitoring/evaluation for concurrent orthopedic and/or neurologic/spinal pain is recommended.



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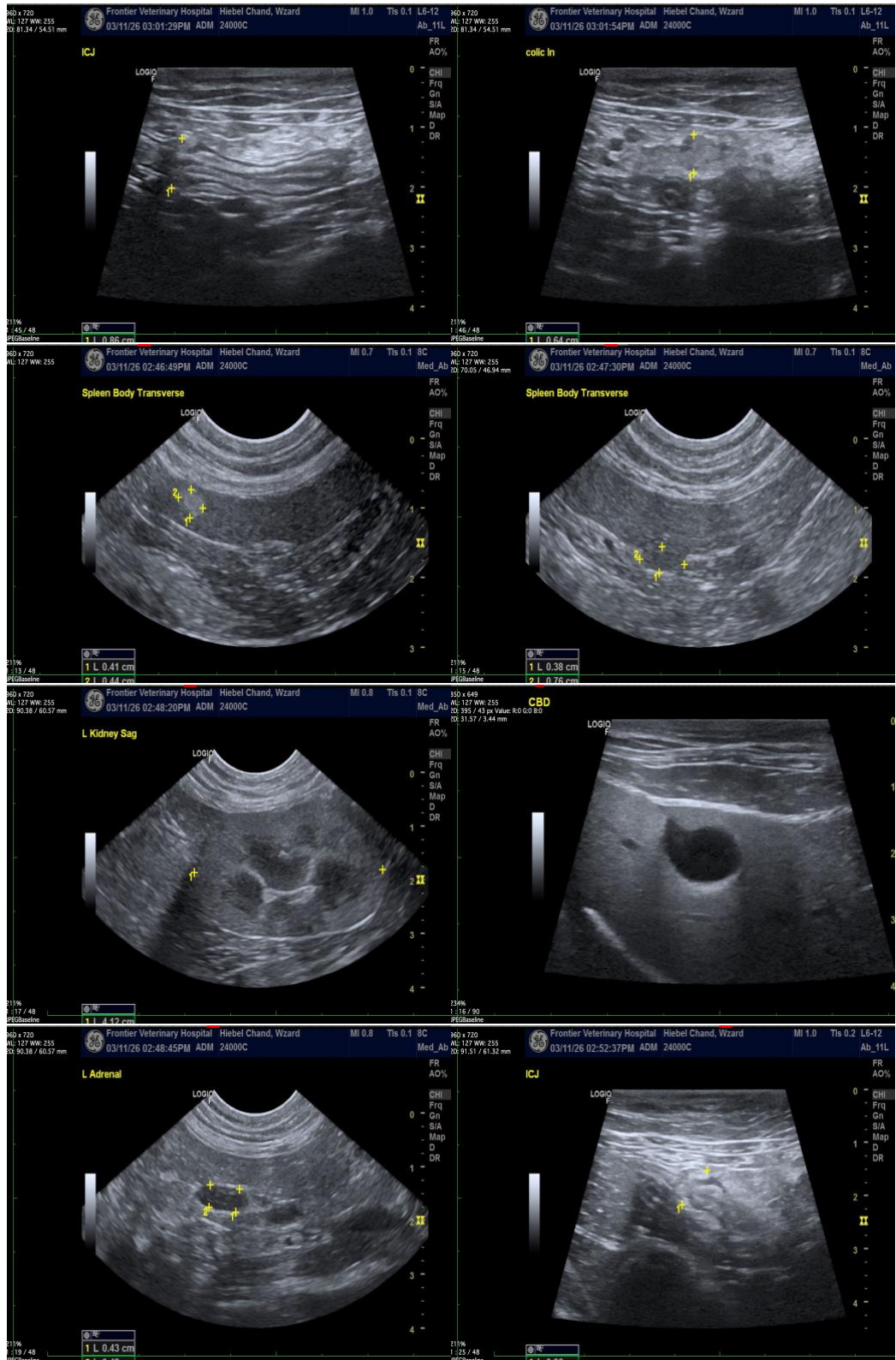
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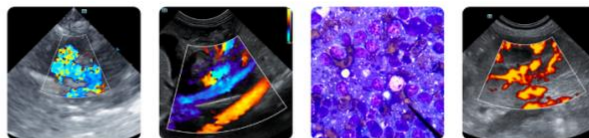
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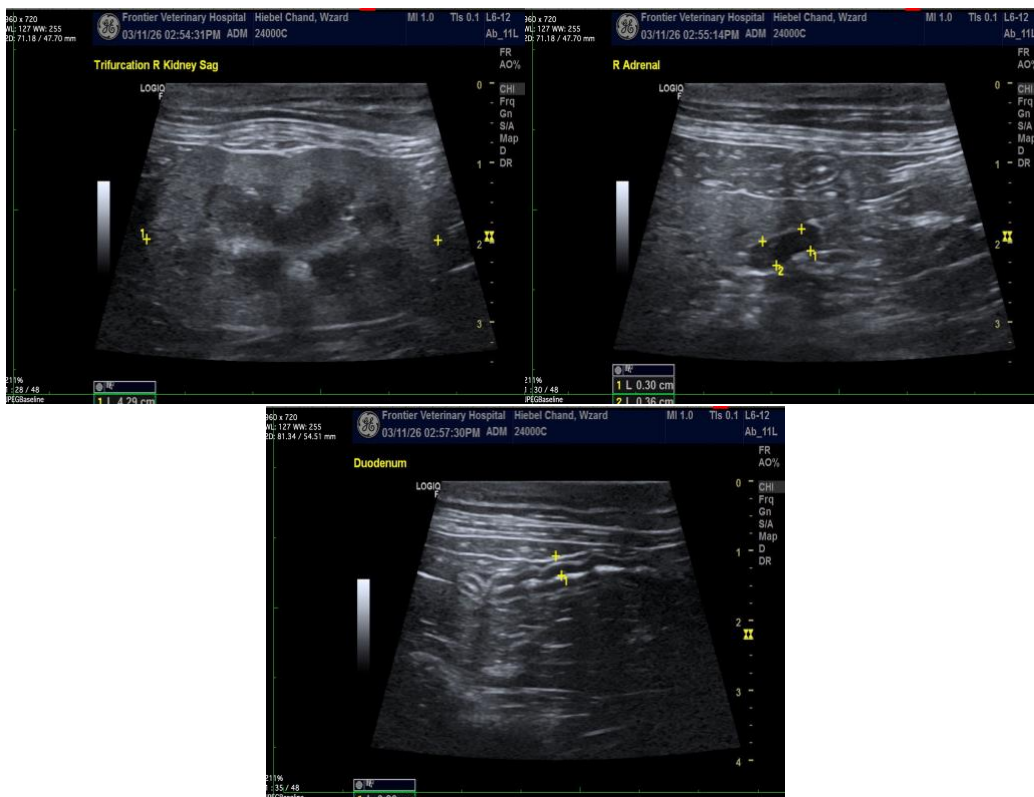
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

info@sonopath.com