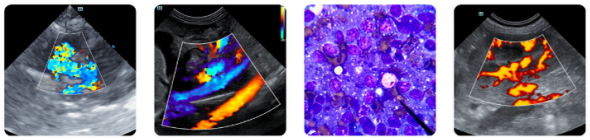




**PATIENT**

Peter Harris

**SPECIES**

Feline

**BREED**

Maine Coon mix

**SEX**

MN

**AGE**

9 years 11 months

**WEIGHT**

5.53 kg

**INTERPRETED BY**

Beth Johnson, DVM DACVIM

**IMAGING PERFORMED BY**

Dr. Mariusz Chmielinski

**HOSPITAL NAME**

Apex Veterinary Services Ltd.

**REFERRING VET**

Alpine 24/7 – ER Dr

**INVOICE**

11479

**DATE**

3/12/2026

## PRESENTING CLINICAL SIGNS

- Peter presented for abdominal ultrasound due to recurrent intermittent vomiting and diarrhea. Current episode includes vomiting after meals and recent stool containing mucus and small amounts of fresh blood. Appetite generally maintained. No current diarrhea today.
- Peter has a history of hairballs and occasional pica/chewing behavior, including chewing on plants or possible fabric strings under furniture. He is an indoor cat living with another cat and a dog, and occasionally grooms the dog. Possible exposure to mice in the house was also mentioned.
- Diet consists of urinary kibble and Almo wet food, though recently he has been eating primarily GI pâté diet.

Abnormal PE/Chem/CBC/UA Results: Vital Signs: Temperature [Celsius]:38.1, Heart Rate/min (HR):182, HR: Pulse Ratio: 1:1, Respiratory Rate/ min: 26, Respiratory Effort: 0, Mucus Membranes/ CRT: pink, moist/ CRT< 2 sec ,Mentation: BAR ,Hydration: Adequate CBC largely within normal limits Kidney parameters (SDMA, creatinine) within reference range indicating normal renal function Total T4 normal, suggesting euthyroid status Urinalysis showed hematuria (30–50 RBC/HPF) and struvite crystals, but no bacteria seen.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is adequately distended with anechoic contents as well as a mild amount of echogenic suspended and settled debris. No definitive masses, inflammatory changes, or cystoliths are observed but along the ventral apex is an approximately 0.5 cm long echogenic density that could represent some settled mineral debris/sand, although tissue pathology can't be ruled out. Otherwise the urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measures 4.28 cm and the right kidney measures 4.9 cm.

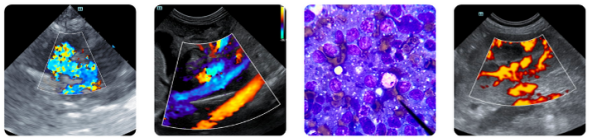
### *Adrenal Glands*

The right adrenal gland is normal in size (0.32 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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

### *Spleen*

Spleen is subjectively large in size (1.3 cm thick at the hilus) 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.





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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.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

### *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 very prominently 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 colon is diffusely mildly thick measuring 0.31 cm thick with normal intact layering. The lumen is empty with no evidence of obstruction or foreign material.

### *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.

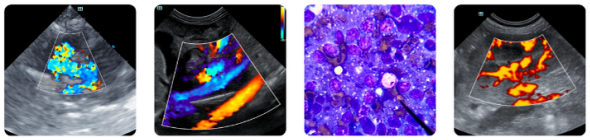
Mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

Additionally, enhanced hyperechoic mesenteric fat and omentum are noted primarily around the thickened ileum and ileocecal colic junction.

### PRIMARY FINDINGS

- Marked/significant 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.

- Moderately reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.





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- The mildly thick colon represents the same differentials as the small bowel most likely. With both benign and/pr infiltrative neoplastic being disease being possible, but unable to be differentiated without tissue sampling.

- 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.

- Mild gallbladder debris – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness, however, it can also be associated with hepatobiliary disease in cats and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

## SECONDARY FINDINGS

- Age related kidney changes.

- Suspect mineral/sand urinary bladder debris Although, as described above, mild tissue pathology can't be ruled out.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

Tissue sampling may ultimately be indicated. Fine needle aspirates of the enlarged spleen +/- the enlarged lymph nodes could be considered if patient's coagulation status is appropriate. Or, if a cytologic diagnosis is unable to be obtained, ultimately, biopsies of the GI tract (both upper and lower bowel) including colon, and if possible, ileum, may be necessary for a definitive diagnosis and therefore to further guide medical management.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.

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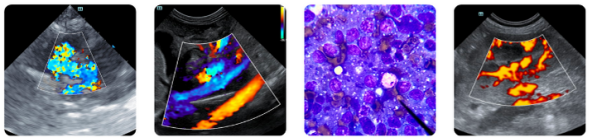

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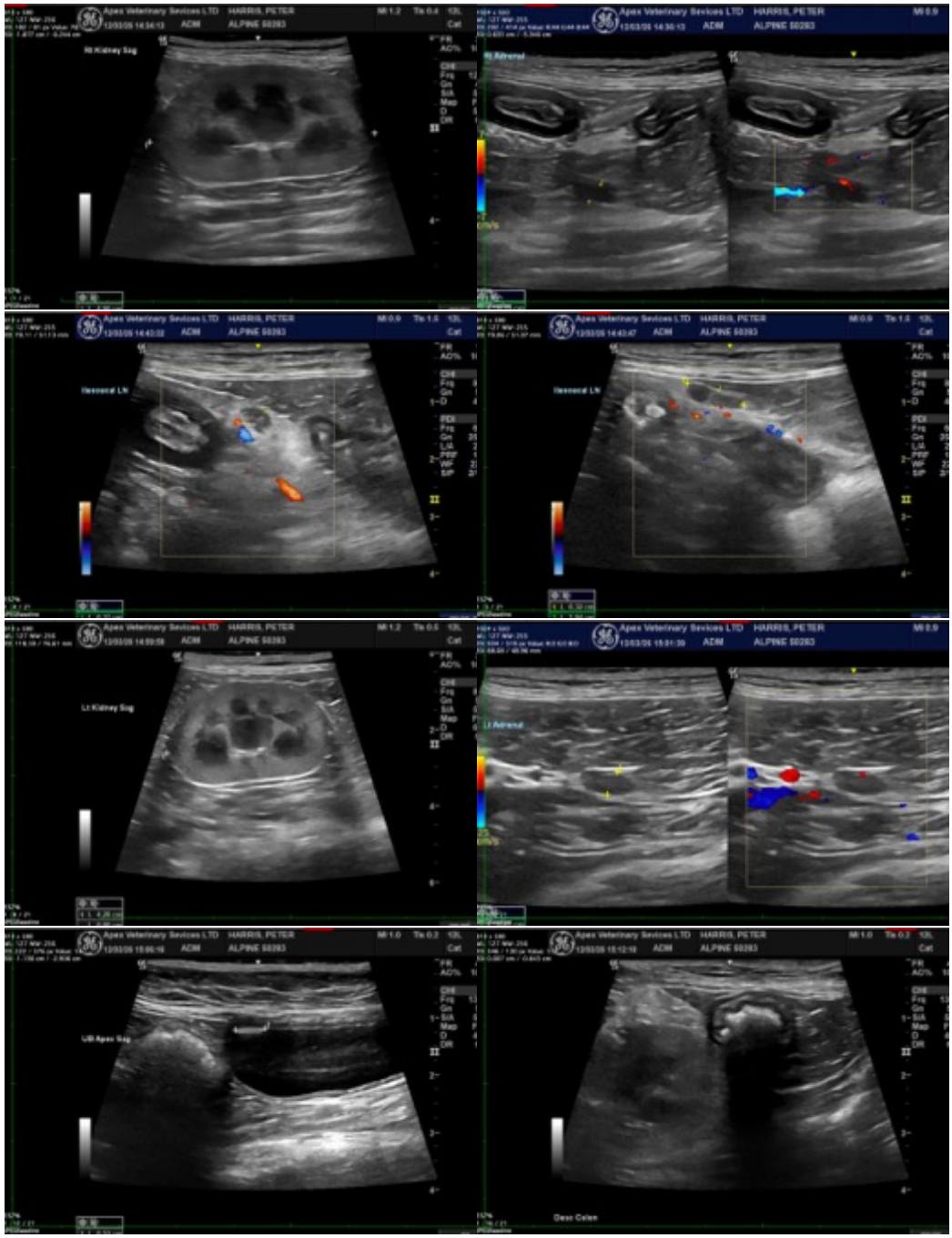

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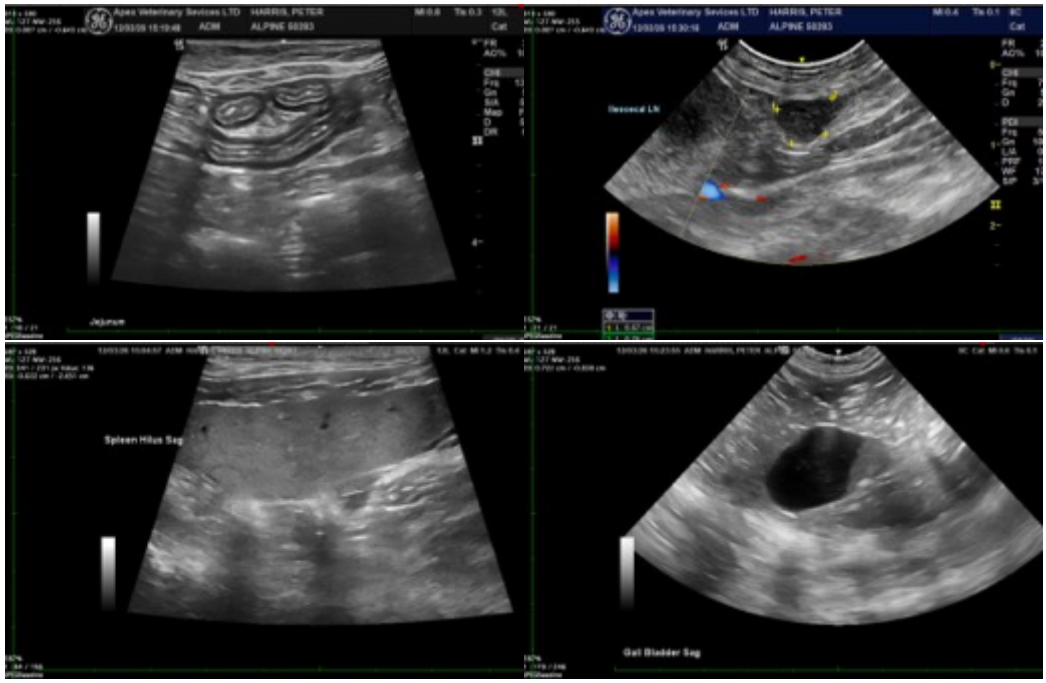

**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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