



**PATIENT**

Tiberius Lobach

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

7

**WEIGHT**

12.58

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Dr. Danielle Lanz

**HOSPITAL NAME**

New Holland VH

**REFERRING VET**

Dr. Danielle Lanz

**INVOICE**

45922

**DATE**

3/15/23

**PRESENTING CLINICAL SIGNS**

Presenting for hyporexia, hard food falls out of mouth when chewing. Can eat soft food. 2lb weight loss since December. Presented in December for diarrhea, vomiting but has since resolved. No diarrhea or vomiting since December.

Abnormal PE/Chem/CBC/UA Results: CBC/Chem: WNL Possible abdominal mass palpated mid abdomen

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is moderately 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 right kidney is normal in size (4.01 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 or infarcts observed. Non-obstructive areas of mineralization/nephroliths are noted.

The left kidney is normal in size (3.95 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 or infarcts observed. Non-obstructive areas of mineralization/nephroliths are noted.

**Adrenal Glands**

The right adrenal gland is normal in size (0.57 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.49 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

**Spleen**

The 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). No focal nodules or masses are observed. Splenic vasculature appears normal.

**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 stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) 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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Diffusely, the visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). 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. However, in one video, there is a focal bowel loop with a curvilinear echogenic luminal interface and strong acoustic shadow that could represent a foreign body. It is unclear what part of the gastrointestinal tract the bowel is, and there is no plication or obstructive pattern to suggest obstruction. Therefore, normal gas and chyme can't be definitively ruled out.

Near or in the area of the lleocecolic junction, there is bowel at the upper end of normal thickness (0.3-0.4 cm) with some subtle loss of mural detail. The area around the lleocecolic junction additionally exhibits mild lymphadenopathy and enhanced hyperechoic mesenteric fat.

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

**Pancreas**

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

**Free Abdomen**

There is no evidence of 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.

Mildly enhanced hyperechoic mesenteric fat is noted in the area of the lleocecolic junction.

**PRIMARY FINDINGS**

- The possible palpated mid abdominal mass is not distinctly visible in these images. Having said that, there is some concern for a possible foreign body within a bowel loop of unknown origin. Again, no obstructive pattern, plication, etc. are noted to support an obstruction, and normal gas and chyme could be causing the appearance, but foreign body can't be ruled out.
- There is some mild change in the area of the lleocecolic junction that may represent some infiltrative or inflammatory bowel disease. Infiltrative neoplasia is considered less likely.
- **Reactive mesenteric lymph nodes** – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

**SECONDARY FINDINGS**

- Non-obstructive nephroliths bilaterally

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

If not recently evaluated, given the nephrolithiasis, a urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

Given the history of vomiting and diarrhea, although reportedly resolved, some of the change in appetite could still be infiltrative bowel disease and/or other underlying causes of nausea, and further recommendations include a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory as well as T4 +/- free T4.



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Having said that, this patient's particular clinical signs of dropped hard food but managing soft food suggests some sort of dental or oral pain or problem chewing and/or swallowing. Therefore, recommendations include a thorough dental/oral exam, as well as potentially advanced imaging of the head and neck, such as a CT scan or potentially a swallow study.

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If vomiting returns and/or clinical signs persist without another underlying cause, recheck imaging of the two questionable abnormalities described today (both the possible foreign body as well as the mildly thick small bowel) is recommended.

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*Note: The images provided are very dark, which partially limits evaluation and could falsely suggest loss of layering in the bowel as described above. Additionally, subtle pathology could be missed. This may be a machine problem, but if possible to change settings to alter images, doing so is recommended.*

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**AGE**

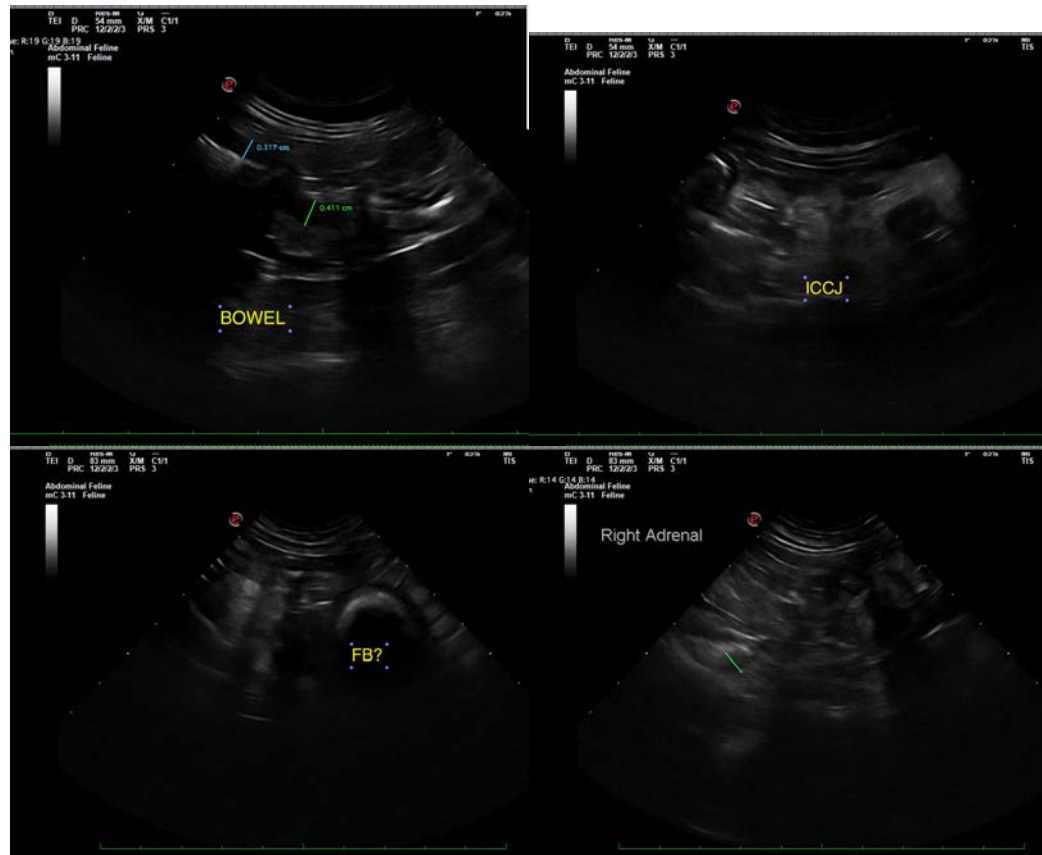
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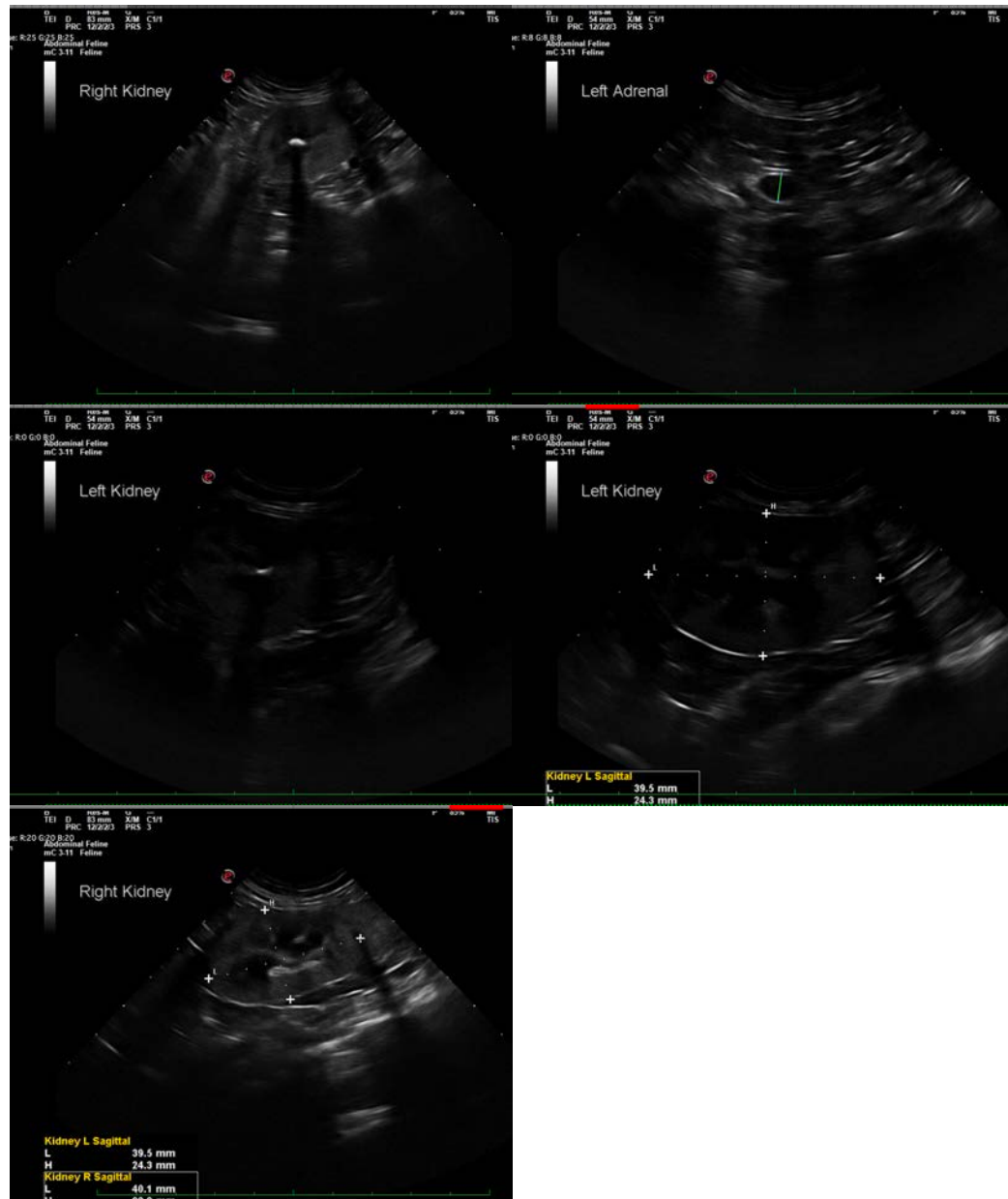
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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**  
Beth.Johnson@sonopath.com