



## PATIENT

Venus Miller

## SPECIES

Feline

## BREED

DSH

## SEX

Spayed Female

## AGE

3 Years

## WEIGHT

4.81 kg

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Melissa Randolph

## HOSPITAL NAME

Shores Veterinary  
Emergency Center

## REFERRING VET

Dr. Logan Law

## INVOICE

73804

## DATE

3/19/26

## PRESENTING CLINICAL SIGNS

P initially presented on 2/15. O noticed for 1-2 days diarrhea and progressed to blood noted in Dh. P then had vomited with pink color (blood). P had fever of 104.2. treated outpatient with sq fluids and ondansetron injection. P sent home with proviable paste and capsules. P returned on 3/17 for vomiting. P had been eating baby food before the vomiting. P given sq fluids and injection of cerenia. P rx'd ondansetron. P returned 3rd time 3/18 for anorexia, continued vomiting and diarrhea. owner was unable to fully medicate P do to vomiting. P admitted for supportive care: iv fluids, ondansetron.

Concern for primary GI (gastroenteritis, FB, parasitic, infiltrative disease) vs Secondary GI (pancreatitis, endocrine, metabolic, infectious, inflammatory); other

Abnormal PE/Chem/CBC/UA Results: PE: 3/17: CBC: HGB 16.9 (9.0-16.0), Plt 20 (140-595), PCT 0.025 (0.150-0.9) EPOC: cSO2 80.1 (50-80), BE -8.9 (-5.0-2.0), Sodium 147 (148-163), iCa 1.15 (1.21-1.51), Glu 139 (63-133) Chem Ca 8.4 (8.8-11.9), Glu 142 (70-130) platelet ct manual: marked amount of plt clumps rads: crisp edge to liver, bladder moderate in size, kidneys appropriate, colon appears to be fluid filled, stomach small with no overt foreign material or ingesta, SI no overt foreign body, uniform in nature with no obstructive pattern; left lateral does have areas of caudal bowels that have bubbles but not appreciate in other views 3/18 fpL: 1.5 normal

## 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 occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also 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 (3.97 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 (3.93 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 areas of the adrenal glands are examined without evident adrenal gland pathology.

### 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



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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 moderately 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 contains fluid.

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.

There is no apparent pathologic lymphadenopathy noted in these images.

## **ULTRASONOGRAPHIC FINDINGS**

- Moderate 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.
- Moderate amount of echogenic urinary bladder debris.

## **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.

Especially given patient's reported concurrent fever, 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.



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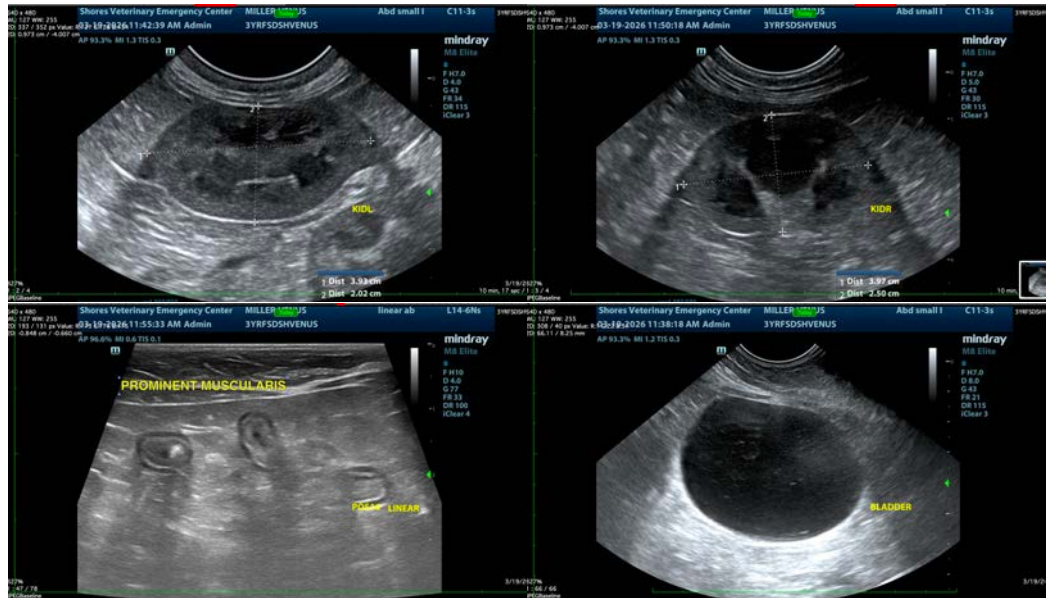
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Ultimately, if a diagnosis is not obtained and clinical signs persist, biopsies of the GI tract, being sure to include ileum, if possible, may be necessary for definitive diagnosis and therefore to further guide medical management.

In the meantime:

- If biopsies cannot be obtained, empirical therapies could include a probiotic (if diarrhea is present, such as visbiome or proviable), empirical deworming with a 5-day course of Panacur and, if tolerated, a transition in diet, based on trial-and-error response, beginning with a hydrolyzed protein diet. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several trials may be required.
- Additional considerations could include cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.).



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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