

PATIENT

Trinity Nuhn

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

5 years

WEIGHT

4 kg

INTERPRETED BY

Beth Johnson, DVM
 DACVIM

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Galt AH

REFERRING VET

Dr. Teminski

INVOICE

11528

DATE

3/20/2026

PRESENTING CLINICAL SIGNS

- Ongoing regurgitation and vomiting, chronic vomiting and inappetence.
- Differentials include gastric FB, IBD.
- Current Medications: Mirtazapine SID.

Abnormal PE/Chem/CBC/UA Results: Bloodwork all WNL Primary Question to Be Answered in This Exam Rule out FB.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The 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.

The right kidney is normal is size (3.3 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 (3.75 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 right adrenal gland is normal in size (0.28 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.3 cm), shape and overall architecture, echogenicity and echotexture. 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 visible stomach wall is normal in thickness and layering. The lumen is mildly distended with primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with



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normal chyme. There is no evidence of obstruction, foreign material, or infiltrative disease. Pyloric outflow tract appears patent.

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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.

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

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Pancreas

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.

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Free Abdomen

There is no visible free peritoneal effusion noted in these images.

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Gastric 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

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- 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.
- Concurrent chronic low grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- Mild to moderately reactive gastric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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The changes noted above are subtle/mild but could indicate early or emerging gastric or gastrointestinal disease. A routine fecal/giardia exam is recommended if not recently evaluated.

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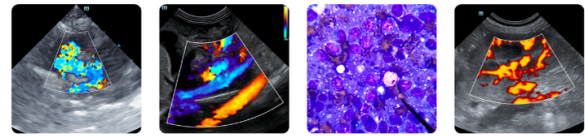
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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In the meantime, in addition to supportive/symptomatic medical management of clinical signs, empirical deworming with a 5-day course of Panacur is recommended, as is, if tolerated, a transition in diet is recommended, based on trial-and-error response.

Some options to consider include a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs a fiber response/colitis diet vs a bland, easy to digest or low-fat diet vs other.



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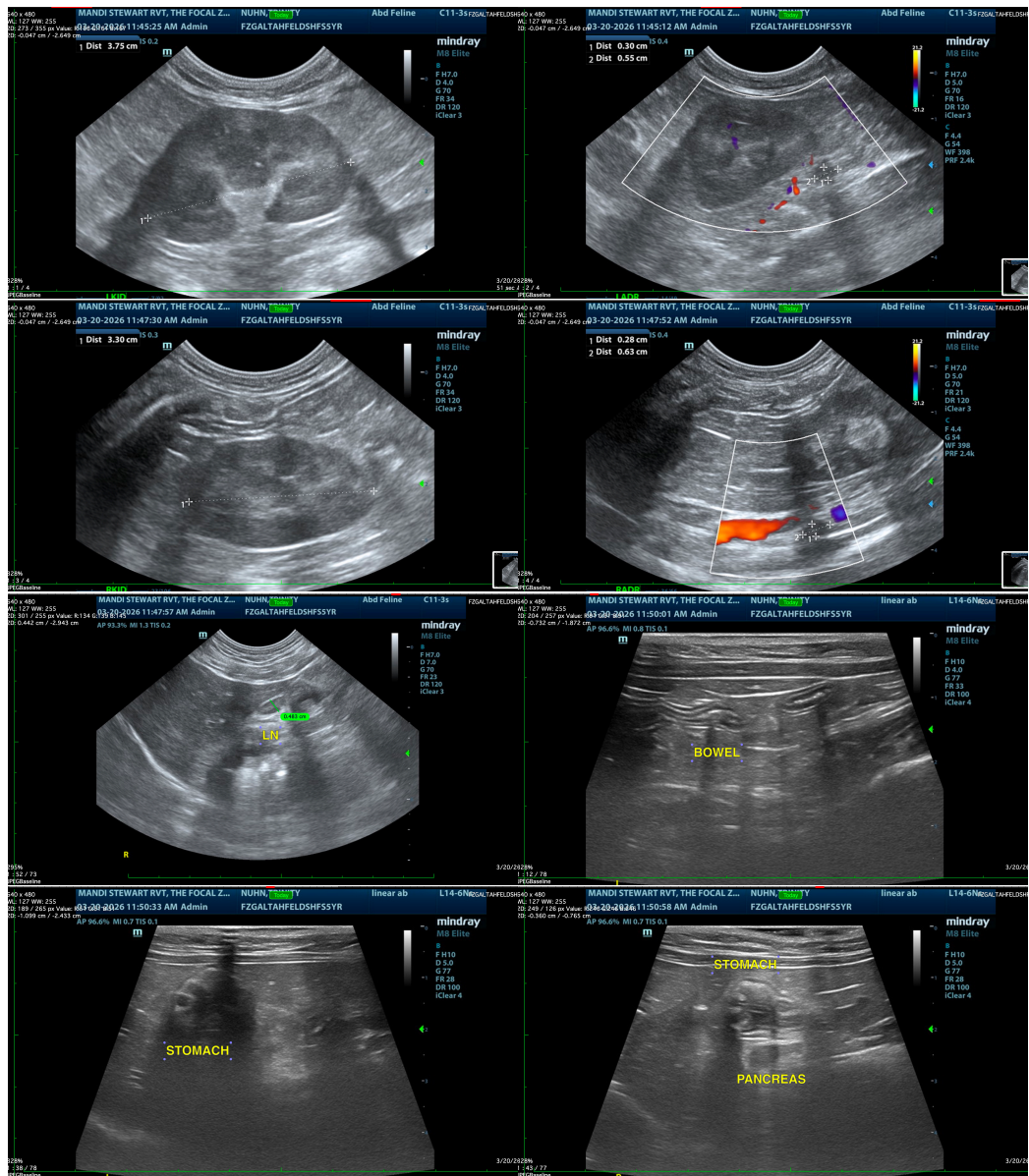
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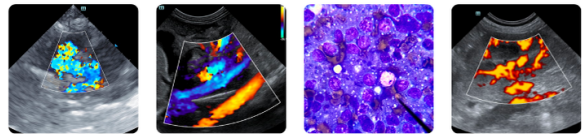
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Additionally, given that some of the vomiting appears to potentially be regurgitation, if not recently evaluated, thoracic radiographs are recommended. Ultimately, if a diagnosis is not obtained, and clinical signs persist, upper GI gastroscopy/endoscopy for further visual evaluation and biopsies of the stomach and proximal small bowel may be necessary for a definitive diagnosis and therefore to further guide medical management.



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.



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