



## PATIENT

Saffron Flowers

## SPECIES

Feline

## BREED

Domestic Shorthair

## SEX

Spayed Female

## AGE

13 Years

## WEIGHT

5.9 lbs

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Kaitlyn Rudie, DVM

## HOSPITAL NAME

Sherwood Family Pet  
Care

## REFERRING VET

Michelle Janik, DVM

## INVOICE

73966

## DATE

3/24/26

## PRESENTING CLINICAL SIGNS

Presented for vomiting on 3/16. Hx of vomiting after eating but has recently gotten worse (2x daily). No diarrhea, stable appetite. Difficulty keeping down anything aside from slurry.

Abnormal PE/Chem/CBC/UA Results: LN cytology of mesenteric LN pending Intestines are thickened on palpation, P is sensitive with abdominal palpation.

## 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 in size (3.7 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 in size (3.4 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 (0.52 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.42 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.



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

## *Pancreas*

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. 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.

Medial iliac and 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.

## 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.
- Age related pancreatic remodeling.
- Markedly reactive mesenteric lymph nodes and less significantly/moderately reactive medial iliac lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

## SECONDARY FINDINGS

- Mild amount of echogenic urinary bladder debris.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

As is reportedly already pending, fine needle aspirates of the enlarged mesenteric lymph nodes are recommended if patient's coagulation status is appropriate.

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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Pending results of above, if a cytologic diagnosis is unable to be obtained, ultimately biopsies of the GI tract, being sure to include ileum, if possible, may be necessary for a definitive diagnosis and therefore to further guide medical management.

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Concurrently, based on the provided lab work results, patient may have early hyperthyroidism that could be contributing to vomiting.

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If treatment is not believed to be indicated and/or is not pursued, close monitoring of T4 and free T4 is recommended to help catch a developing problem if not already present.

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

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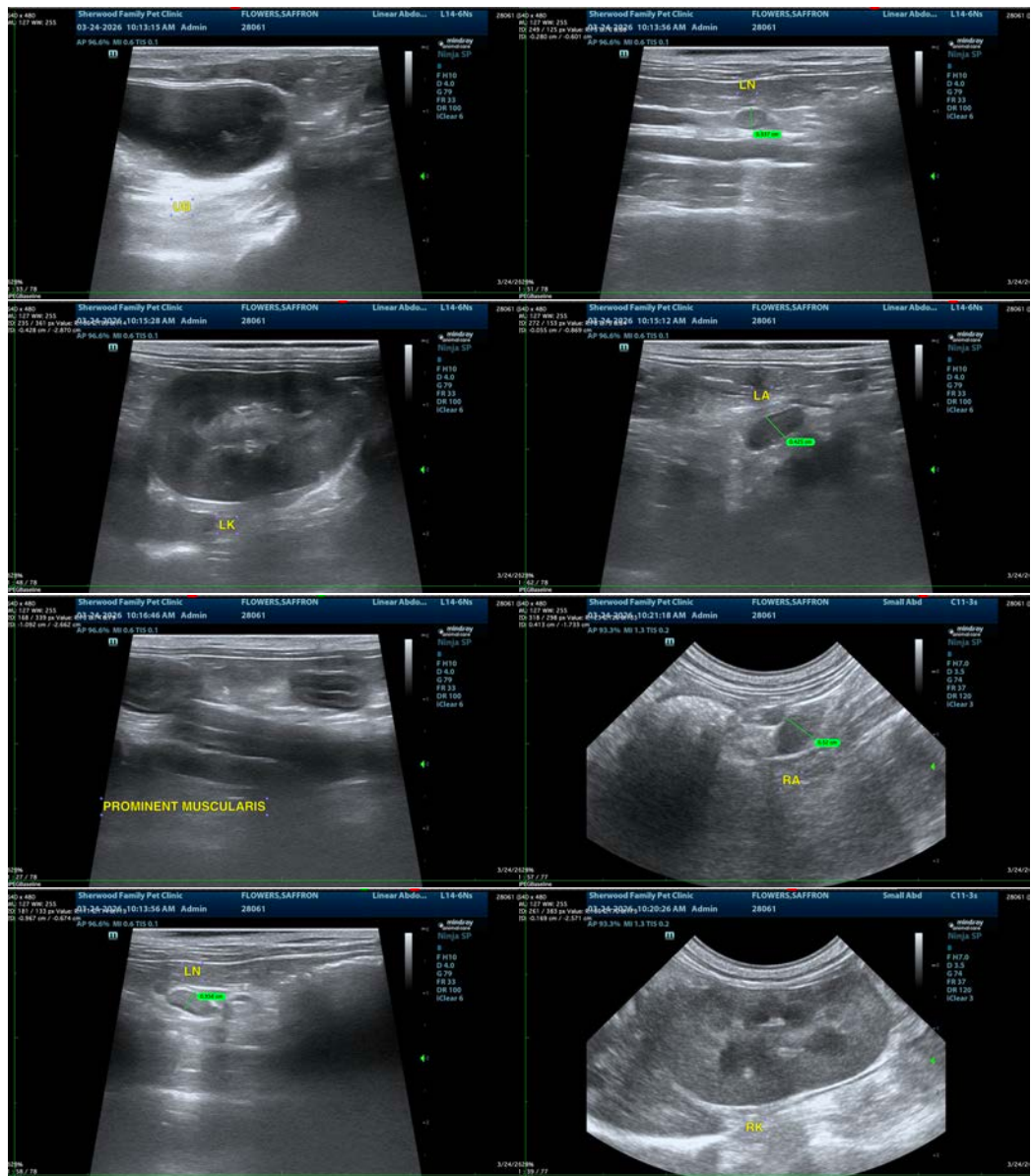
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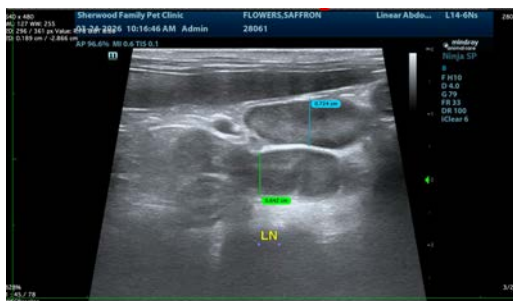
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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