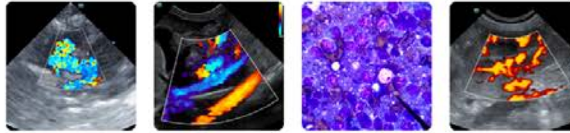


DATE
3/25/26

PATIENT
Bean Brockman

SPECIES
Feline

BREED
DSH

SEX
Spayed Female

AGE
4/1/25

WEIGHT
3.4 kg

INTERPRETED BY
Beth Johnson, DVM
DACVIM

HOSPITAL NAME
Mason Dixon Animal
Emergency Hospital

REFERRING VET
Dr. McCafferty

INVOICE
73978

PRESENTING CLINICAL SIGNS

Patient History: Owner rescued from petsmart. was at a rescue. Vomiting and lethargic for 3 days, not eating came to owner like this, blood in vomit

Current Medications: None listed.
Labwork Results: Labwork attached, reported as: alt 185 high, bun 42 high
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Requested.
Imaging Performed by: Andi Parkinson RDMS

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 (3.95 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, mineral or infarcts observed.

The left kidney is normal is size (3.57 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 (0.57 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.50 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 biliary tree appears normal without distension or

congestion. In the cranial abdomen there is an approximately 0.50 cm x 1.5 cm tortuous vessel that at first glance appeared concerning for a portosystemic shunt, but upon further evaluation appears to be an abnormal variant/tortuosity of the gastroduodenal and portal vein junction, as the portal vein demonstrates normal branching, which is inconsistent with portosystemic shunting.

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

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.

Free Abdomen

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

Cranial abdominal/portal 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

- 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.

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

- Concurrent chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.

- Further investigation is warranted to further and more definitively rule out portosystemic shunting. However, the vessel described above appears more consistent with an abnormal variant of a normal portal vein versus true shunting.

SECONDARY FINDINGS

- Mild to moderate amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Bile acids are recommended if not already evaluated. If bile acids are abnormal, additional imaging of the portal hilus with color flow doppler and/or advanced imaging such as an abdominal contrast CT scan may be warranted to more definitively ruled out extrahepatic portosystemic shunting, which again is not suspected based on these images but should be further pursued if bile acids are concerning.

In the meantime, further gastrointestinal workup is warranted, as bowel disease is a higher differential. Therefore, 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.

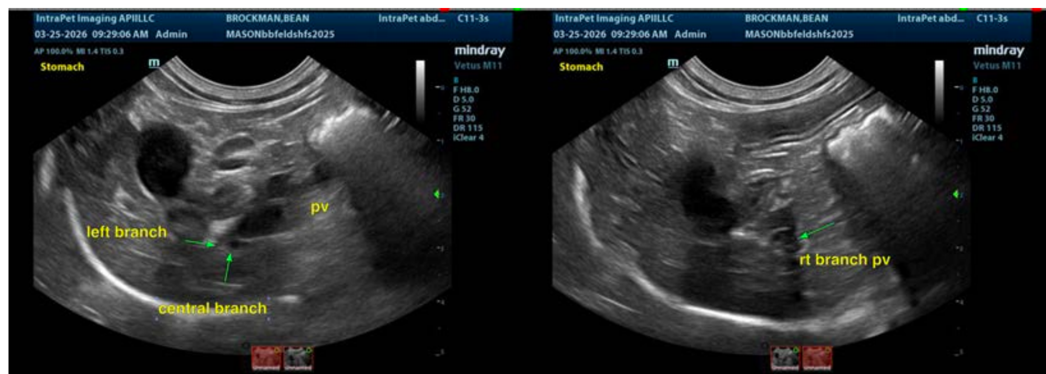
A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

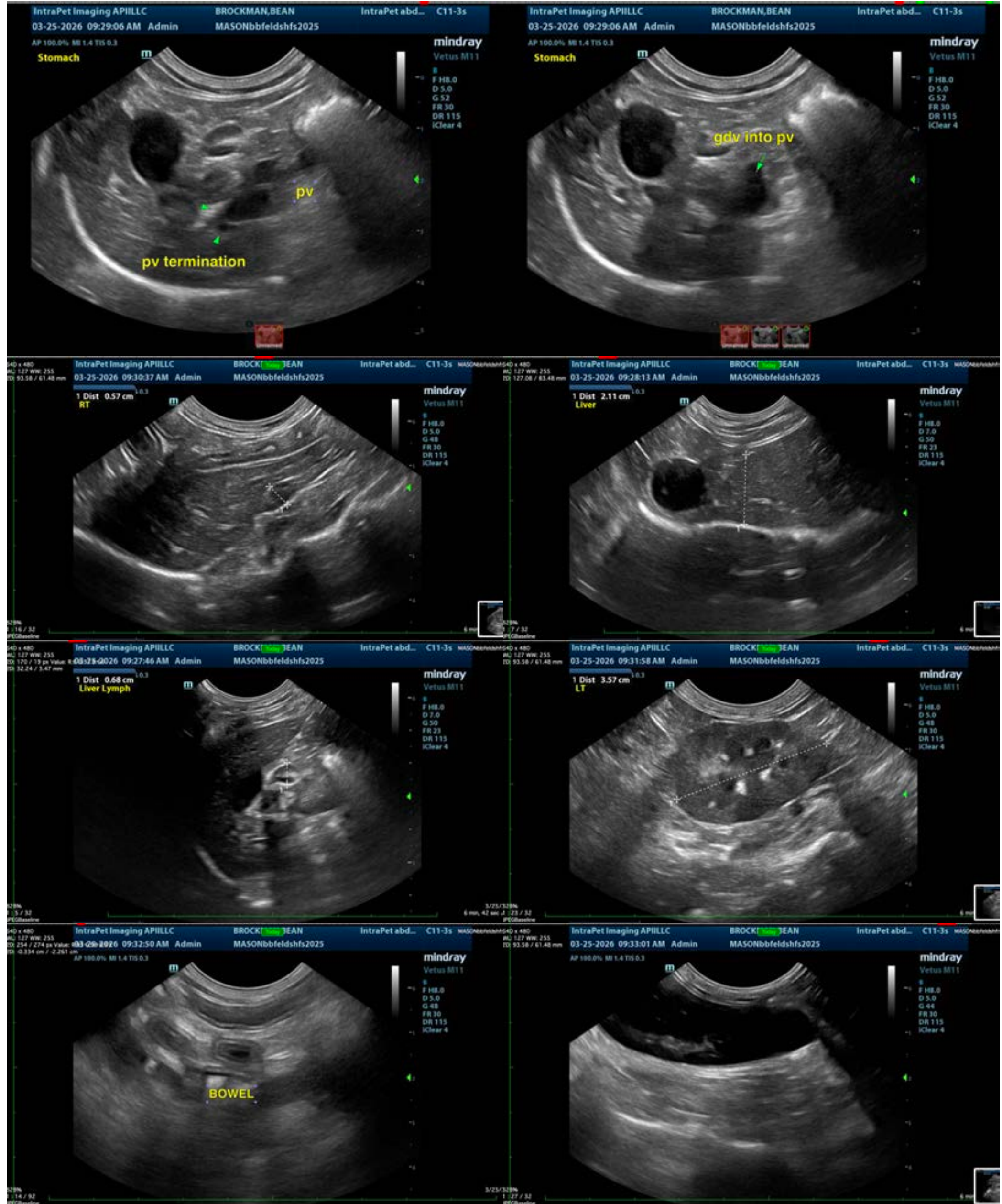
Fine needle aspirates of the enlarged lymph nodes could also be considered if patient's coagulation status is appropriate.

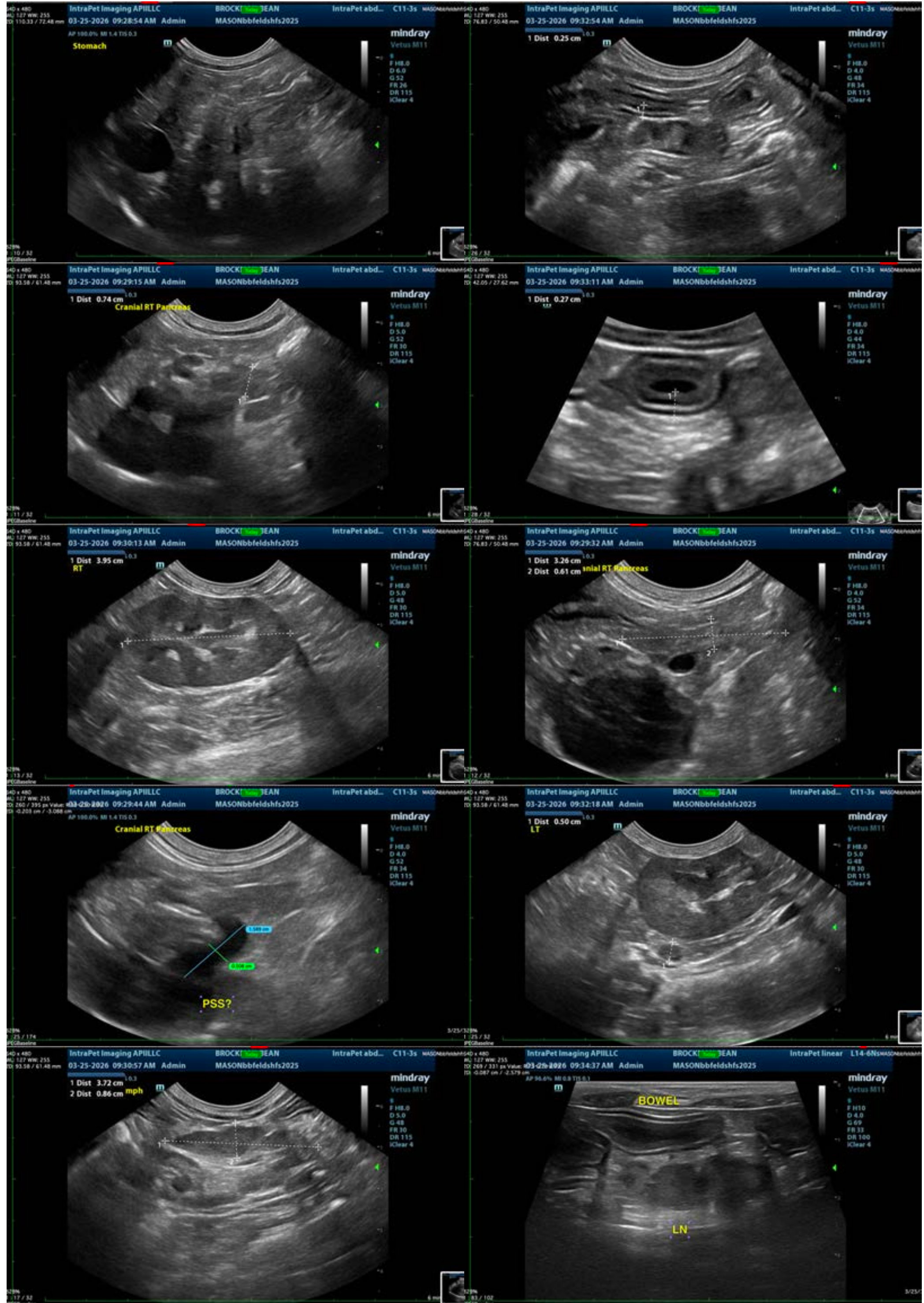
While continuing workup, in addition to supportive/symptomatic medical management of clinical signs, empirical deworming with a 5-day course of Panacur could be considered.

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.

Note that some images of the tortuous vessel are labeled "PSS?", but again upon further investigation portosystemic shunting is considered less likely. See images of branching for confirmation.




IntraPet Imaging APIILLC
BROCKMAN,BEAN
IntraPet abd...
C11-3s
03-25-2026 09:29:06 AM Admin
MASONbbfeldshfs2025
Stomach
mindray
Vetus M11
pv
pv termination
gdv into pv
03-25-2026 09:30:37 AM Admin
1 Dist 0.57 cm
RT
03-25-2026 09:28:13 AM Admin
1 Dist 2.11 cm
Liver
1 Dist 0.68 cm
Liver Lymph
03-25-2026 09:31:58 AM Admin
1 Dist 3.57 cm
LT
BOWEL
03-25-2026 09:33:01 AM Admin



IntraPet Imaging APIILLC
mindray
Vetus M11
Stomach
1 Dist 0.25 cm
1 Dist 0.74 cm
Cranial RT Pancreas
1 Dist 0.27 cm
1 Dist 3.95 cm
RT
1 Dist 3.26 cm
2 Dist 0.61 cm
Cranial RT Pancreas
PSS?
1 Dist 0.50 cm
LT
1 Dist 3.72 cm
2 Dist 0.86 cm
BOWEL
LN

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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