



PATIENT

Ben Dickinson

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

11 Years

WEIGHT

10.5 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Erin Wicks

HOSPITAL NAME

Shores Veterinary
Emergency Center

REFERRING VET

Dr. Law

INVOICE

73374

DATE

3/4/26

PRESENTING CLINICAL SIGNS

Diarrhea and stool with blood noted (chronic). Has been seen at Shores and rdvm multiple times. 2/20/26 was seen and rads performed: gas and dense stool in colon, swelling at distal colon. Follow up at rdvm on 3/1 for continued diarrhea with blood and vomiting. decreased appetite for 7-10 days. Rdvm called owner today and discussed concern for pancreatitis; recommended 24 hour hospital care with abdominal ultrasound.

Abnormal PE/Chem/CBC/UA Results: Shores 2/20 rads: gas and some dense stool in colon; swelling at distal colon rdvm 3/2 cbc: hct 29.7%, Hgb 10.4 L, reticulocytes 103 H, retic Hgb 14.0 L rdvm 3/2 chem: WNL rdvm 3/2 spec fPL: 10.1 abnormal rdvm 3/2: fecal PCR-results pending rdvm 3/2: fecal O & P (zinc): negative 3/4/26 fpl today is 21.1

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 (4.98 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 (4.81 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 adrenal glands are unable to be well visualized in these images.

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 mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestine demonstrates areas of mildly to 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 is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is no evidence of obstruction, foreign material or infiltrative disease.

The colon beginning in what appears to be the mid descending colon is markedly thick with loss of layering, measuring 1.2 cm in thickest areas. The ileocecolic junction is difficult to definitively isolate, but the transverse colon and early descending colon have a more normal thickness and appearance. Cranial to the thick wall the colon appears mildly distended with what appears to be visibly normal stool.

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.

PRIMARY FINDINGS

- The thick colon wall is concerning, especially given the loss of layering, for infiltrative neoplasia such as round cell neoplasia i.e., lymphoma versus other. A benign inflammatory process, however, cannot be ruled out without tissue sampling.
- Concurrent mild to 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.

SECONDARY FINDINGS

- Mild to moderate amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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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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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Fine needle aspirates of the colon wall could be considered if patient's coagulation status is appropriate, but if a cytologic diagnosis is unable to be obtained, ultimately biopsies of the colon may be necessary for a definitive diagnosis and therefore to further guide medical management.

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If colonoscopy is pursued, biopsies of the ileum, if possible, would be recommended at the same time.

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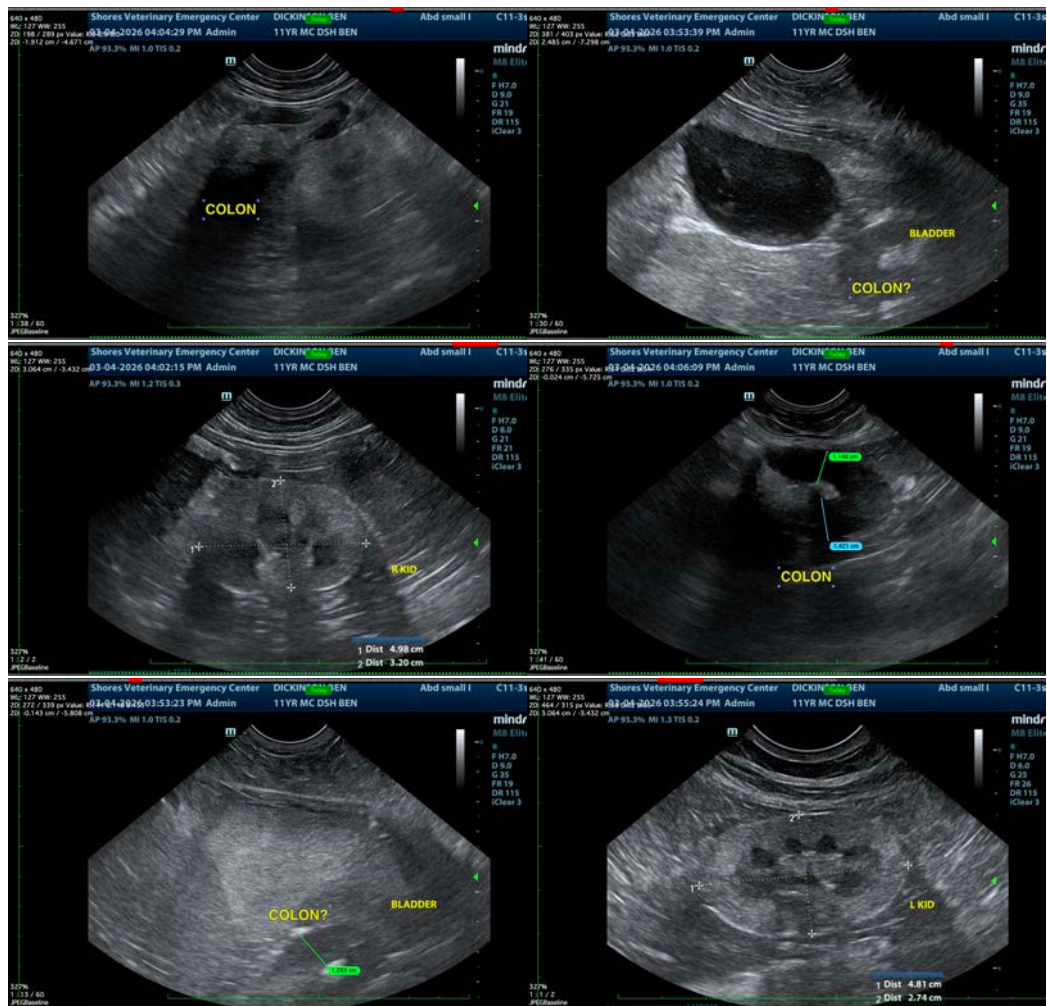
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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