



PATIENT

Mothball McKeefry

SPECIES

Feline

BREED

Persian

SEX

Spayed Female

AGE

8 Years

WEIGHT

4 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Jessica Bailes

HOSPITAL NAME

All Creatures Great &
Small Veterinary Clinic

REFERRING VET

Dr. Beth Marszewski

INVOICE

74152

DATE

4/1/26

PRESENTING CLINICAL SIGNS

Chronic intermittent hx of vomiting and diarrhea as well as progressive weight loss. Marginal response to hydrolyzed diet. Vomiting/diarrhea worsened w/ flavored pred suspension trial. Lack of significant improvement despite cobalamin trial. Severe dental dz w/ recent hx of abscess

Abnormal PE/Chem/CBC/UA Results: Emaciated, 2/6 systolic murmur, ropey SI on palpation, feces on perineum; rectum scabby/erythematous on PE most recent labs: CBC: HCT (30%), neutrophilia (15,200), Lymphopenia (160) Chem: Alb (2.3), Glob (6.00< BUN (42), Amylase (1255), Lipase (94) T4: (0.5) U/A: USG (1.013), 2+ protein (UPC 3.0), wbc (4-10), Rods >100 fecal PCR: corona positive, otherwise all negative

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.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measured 3.76 cm. Right kidney measured 3.88 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.41 cm at cranial pole and 0.47 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.36 cm at cranial pole and 0.34 cm at caudal pole), 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 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 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

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. The pancreatic duct appears tortuous and dilated to the level of the duodenal papilla. It measures 0.39 cm dilated and appears to contain pinpoint mineral densities.

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

- 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.
- Chronic low-grade smoldering pancreatitis with mild duct dilation and mineral.

SECONDARY FINDINGS

- Mild age related kidney changes.
- Mild to moderate amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urine culture is recommended if not recently evaluated, followed by treatment of the suspected urinary tract infection based on culture and sensitivity results, if 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.

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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Ultimately, given the lack of improvement to some empirical managements, biopsies of the GI tract +/- pancreas, being sure to include ileum, if possible, may be necessary for definitive diagnosis and to further guide medical management.

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In the meantime, in addition to supportive/symptomatic medical management of clinical signs, if tolerated, a transition in diet is recommended, based on trial-and-error response.

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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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Additionally, fecal microbe transplant therapy could be considered.

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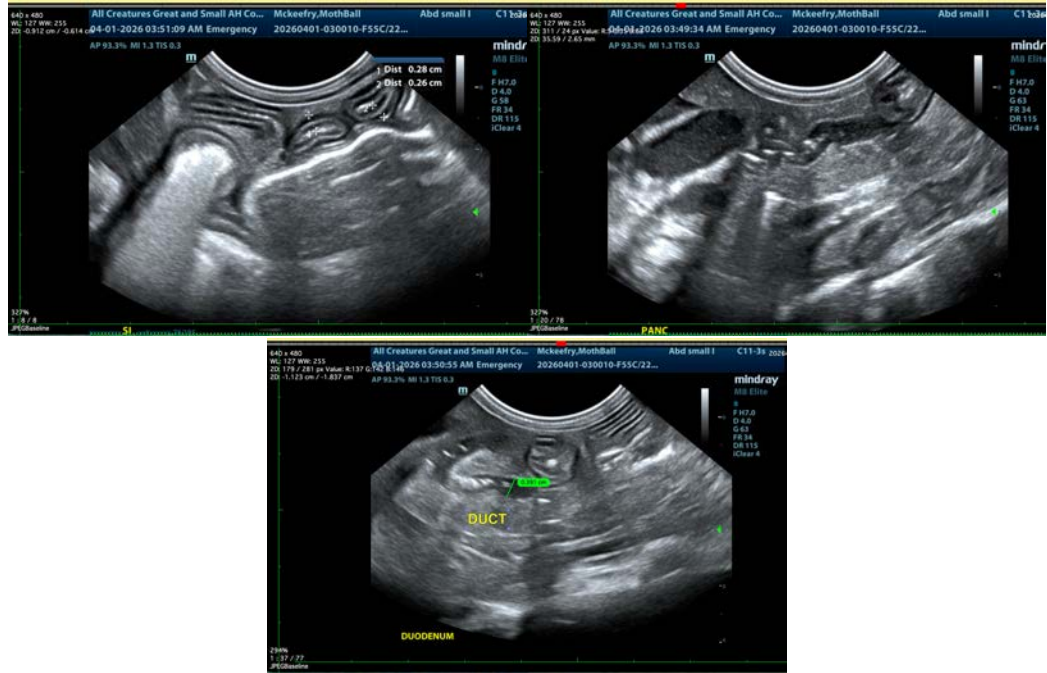
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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