

PATIENT

Grace Young

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

12 Years

WEIGHT

12.8 pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Jack Reese

HOSPITAL NAME

Willow Run Veterinary
Clinic

REFERRING VET

Dr. Anna Leppien

INVOICE

11761

DATE

04/22/26

PRESENTING CLINICAL SIGNS

2-day history of vomiting and diarrhea. Very loose stool, vomiting mucus, undigested food. P has a history of foreign body ingestion as a kitten, no known foreign material ingestion recently.

Abnormal PE/Chem/CBC/UA Results: Hemoconcentration HCT 56.5% Bloodwork otherwise WNL

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 (4.0 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. Trace pyelectasia is noted. There is no evidence of mineral or infarcts observed.

The left kidney is normal is size (3.98 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. Mild pyelectasia is present measuring 0.29 cm in transverse view. There is no evidence of mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (0.44 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.39 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.

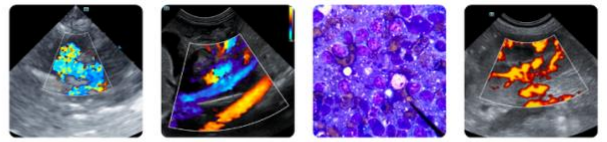
Liver

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 of the stomach is empty with 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

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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.

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Free Abdomen

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

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There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

INTERPRETED BY

Beth Johnson, DVM
DACVIM

- *Addendum after receiving additional images:*
- Mild bilateral pyelectasia.
- Moderate inflammatory bowel disease 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.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Report will be addended when additional GI images are received. However, at this time, based on the provided history, if not recently evaluated a routine fecal/giardia exam is recommended. As is 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.

REFERRING VET

Dr. Anna Leppien

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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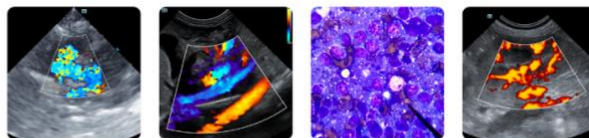
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Addendum after receiving additional images:

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The appearance of the bowel is consistent with a possible mild to moderate infiltrative bowel process as described above. Therefore, the above recommendations stand but in addition, pending results of above, 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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In the meantime, supportive/symptomatic medical management of clinical signs is recommended, including a probiotic (such as visbiome or proviable), empirical deworming with a 5-day course of Panacur and, if tolerated, a transition in diet, based on trial-and-error response, beginning possibly with a gastrointestinal biome diet vs a hydrolyzed protein diet vs other. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several brand attempts may be required.

Additionally, not previously mentioned, if not recently evaluated, urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.



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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