



PATIENT

Montezuma Samra

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

9 Years

WEIGHT

9.1 pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

South Willamette
Veterinary Clinic

REFERRING VET

Dr. Willaman

INVOICE

15350

DATE

04/23/26

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Chronic history of diarrhea, intermittent hematochezia, some vomiting decreased appetite. P has been on GI Biome diet and recently started prednisolone for suspected IBD. P has been anorexic for the last 3-4 days with fluid diarrhea and lethargy. **ABNORMAL Labwork Values**

fecal and Giardia negative, chemistries all WNL, slight decreased platelets, rest of CBC WNL
Current Medications Mirtazapine Transdermal 20mg, Prednisolone 5mg daily, maropitant 12mg daily
Radiographic Findings none

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.

Left kidney is normal in 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. There is no evidence of pyelectasia, mineral or infarcts observed.

Right kidney is normal in size (4.17 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

Left adrenal gland is normal in size (0.38 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.41 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen measures at the upper ends if normal limits and thickness (1.0 cm thick at the hilus) with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a mildly coarse/heterogenous echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

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.

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.

Increase detail assessment of bowel is recommended by zooming in on the bowel wall or potentially using a linear probe. Having said that, I suspect 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 of the small intestine is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted.

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.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Suspect mild/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. Again having said this, detail wall layering is difficult to assess without zooming in on the bowel wall and or using a linear probe.
- Concurrent chronic low grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- Subtly scalloped spleen- can be associated with benign or malignant infiltrative disease. Common causes include a reactive spleen secondary to immune stimulus or early infiltrative round cell neoplasia such as lymphoma or mast cell tumor.
- Moderate amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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 subtle bowel wall changes are in part due to difficulty interpreting layers without higher zoom or



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linear probe, but are potentially in part masked by current prednisolone therapy. Therefore, more significant infiltrated bowel disease can't be ruled out.

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.

Ultimately, tissue sampling may be necessary for a definitive diagnosis and therefore to further guide medical management. Fine needle aspirates of the spleen could be considered if patient's coagulation status is appropriate or ultimately biopsies of the GI tract, being sure to include ileum if possible, may be warranted.

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.

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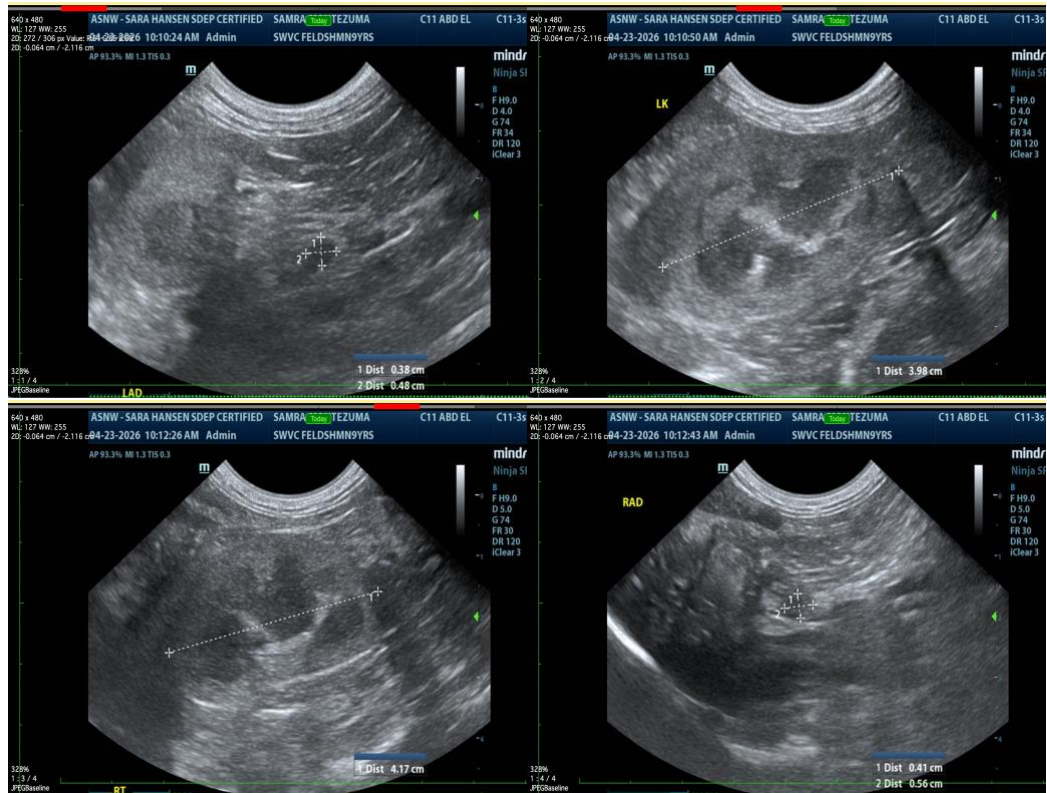
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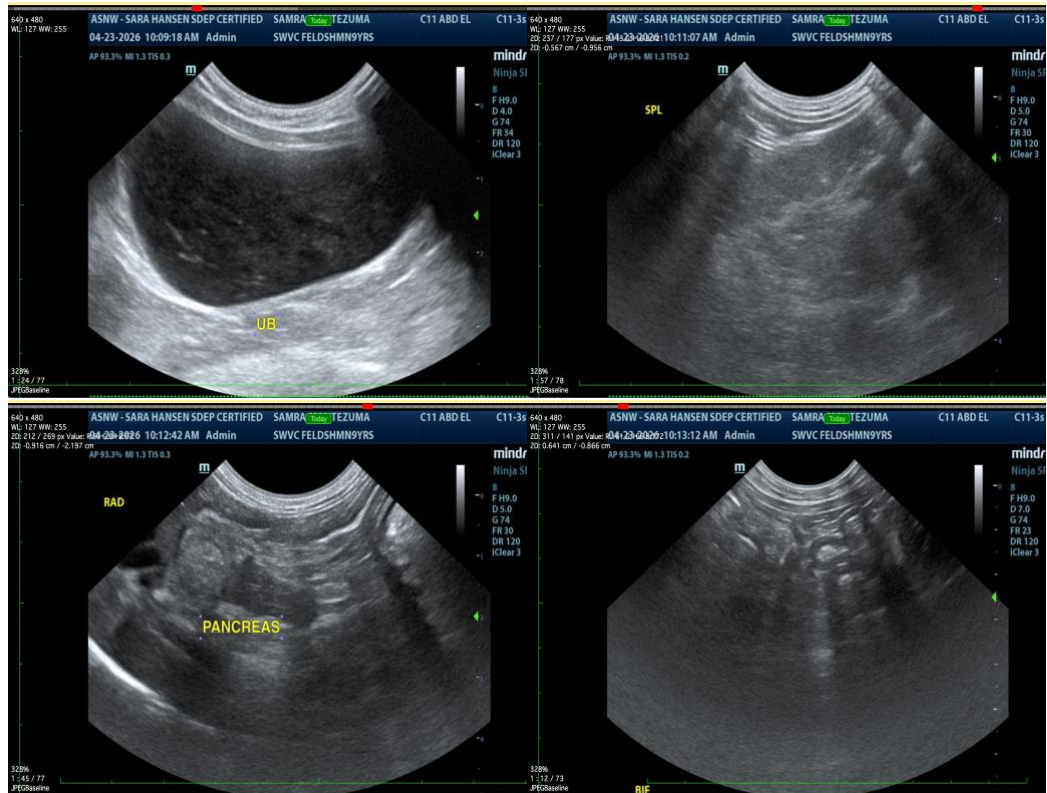
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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