PATIENT

Ruby McKiddie

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

1 year

WEIGHT

6.5 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Sage Veterinary Clinic

REFERRING VET

Dr. StHill

INVOICE

11821

DATE

4/28/2026

PRESENTING CLINICAL SIGNS

Chronic abdominal bloating, intermittent diarrhea, soft stools, and malodorous flatulence since November of 2025. Treated symptomatically with Proviable, Metronidazole. 3 view AXR radiologist reports NSF and recommends AUS, diet trial, and GI bloodwork. Otherwise, pet has normal energy intake outputs with no other concerns. Working diagnosis Maldigestion versus malabsorption versus inflammatory versus infectious versus functional. Patient was sent home with a written rx for liquid Metronidazol. Patient is directed to take 1.2mL PO Q12 hours for 7 days. Patient was sent home with this medication on 3/19/26. Not sedated, Squirmy.

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 (4.2 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 (4.2 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 (0.51 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.28 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen measures just over the normal limits in thickness, at just over 1.0 cm thick at the hilus, with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. 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

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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.

Diffusely the visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease. Focally, in one loop of jejunum there's an approximately 1.3 cm long area that is very subtly focally thicker than the remaining bowel with a hypoechoic, almost cystic appearance to the wall.

The visible colon is normal but in the area of the ileocecal colic junction, the cecum appears prominent and fluid distended and measures 1.0 cm x 1.5 cm in size.

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.

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.

ULTRASONOGRAPHIC FINDINGS

- The focal jejunal changes and fluid dilated cecum are both concerning for underlying bowel disease with both benign, infectious, even parasitic inflammatory, dietary related, etc. as well as infiltrative neoplastic disease being possible differentials.
- Moderately reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely
- Mild Splenomegaly– can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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 spleen, as well as the enlarged lymph nodes could be considered if they can safely be reached and if patient's coagulation status is appropriate.

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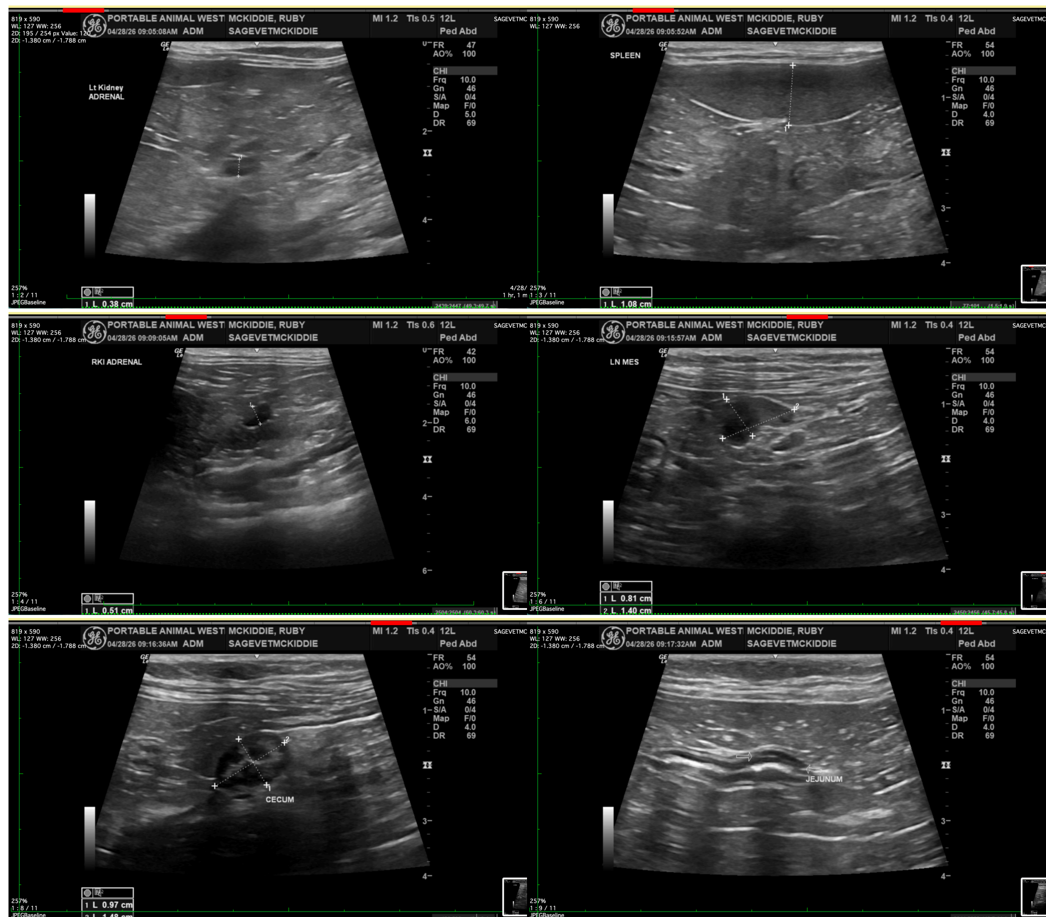
Ultimately, however, if clinical signs persist and a diagnosis is not made, further evaluation and biopsies of the bowel, including the ileum, if possible, as well as the cecum, and the focally abnormal jejunum, may be necessary for a definitive diagnosis and therefore to further guide medical management. Ultrasound may be helpful to best identify these areas in that scenario.

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, fecal microbe transplant therapy may be helpful.



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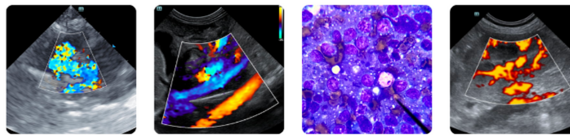

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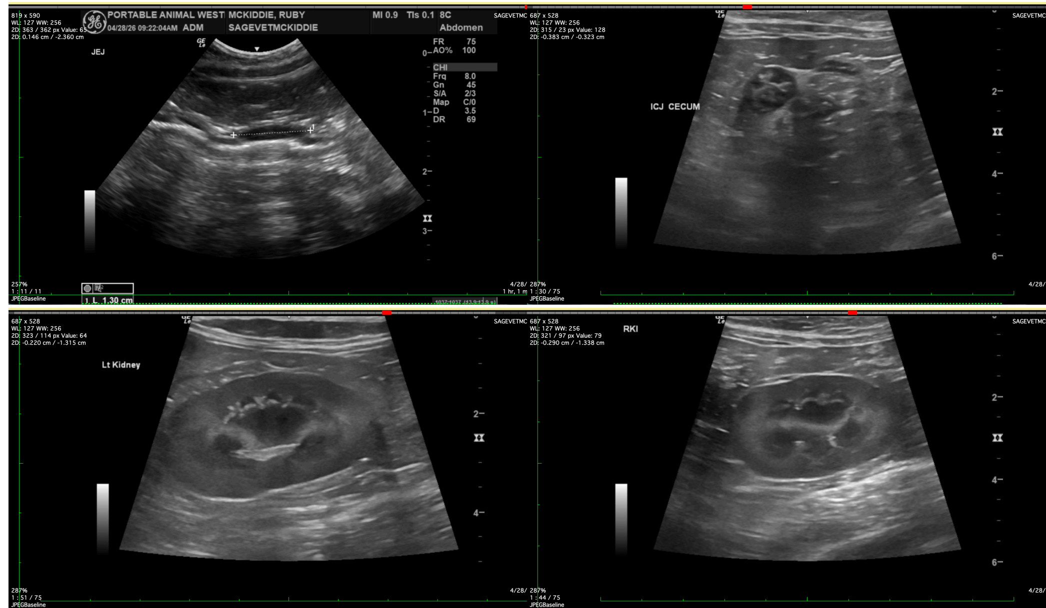

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@sonopath.com