



PATIENT

Willow Lerner

SPECIES

Feline

BREED

DLH

SEX

FS

AGE

9 years

WEIGHT

5.3 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

**IMAGING
PERFORMED BY**

Loetitia Saint-Jacques,
LVT

HOSPITAL NAME

Desert Hills AH

REFERRING VET

Dr. Teresa
Brandstetter

INVOICE

11822

DATE

4/29/2026

PRESENTING CLINICAL SIGNS

New patient (senior) adoption in 2025 - inappropriate defecation, weight loss 7.3kg - 5.3kg, hyporexia (had COHAT with extractions.) Working diagnosis: GI lesion/mass, IBD vs GI LSA, BP- 118mmHg (average out of 3.) COHAT 10/25 with extractions, unremarkable thoracic and abdo rads 4/26.

Abnormal PE/Chem/CBC/UA Results: 9/25: unremarkable cbc/chem/ua/t4 9/26: ALT 151 otherwise T4 wnl and cbc wnl RAD report- CONCLUSIONS: A mild bronchial pattern may be age-related but mild chronic airway disease of allergic or infectious etiology is possible. No coughing is reported. There is no radiographic evidence of cardiac disease. No abdominal cause for the weight loss is identified. The abdomen is radiographically normal. This does not exclude the presence of metabolic, endocrine or occult neoplastic disease. Chronic intervertebral disc disease is incidental.

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.

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 measures 3.95 cm, and the right kidney measures 4.01 cm.

Adrenal Glands

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

The left adrenal gland is normal in size (0.37 cm at cranial pole and 0.42 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. 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. An approximately 2.0 cm x 2.4 cm anechoic density/cyst is noted in the caudal liver. Visible vasculature and biliary tree appear normal without distension or congestion.



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Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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 moderate to severely 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

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. 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.

Cranial to the urinary bladder, there is an approximately 1.0 cm in diameter irregular hypoechoic density.

PRIMARY FINDINGS

- Moderately 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.
- Age related pancreatic remodeling.
- The density cranial to the urinary bladder likely represents an enlarged lymph node, although a mass of other origin can't be definitively ruled out.

SECONDARY FINDINGS

- Hyperechoic splenic nodules – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.
- Suspect incidental hepatic cyst.



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- Mild gallbladder debris – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness, however, it can also be associated with hepatobiliary disease in cats and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.
- Moderate age-related kidney changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

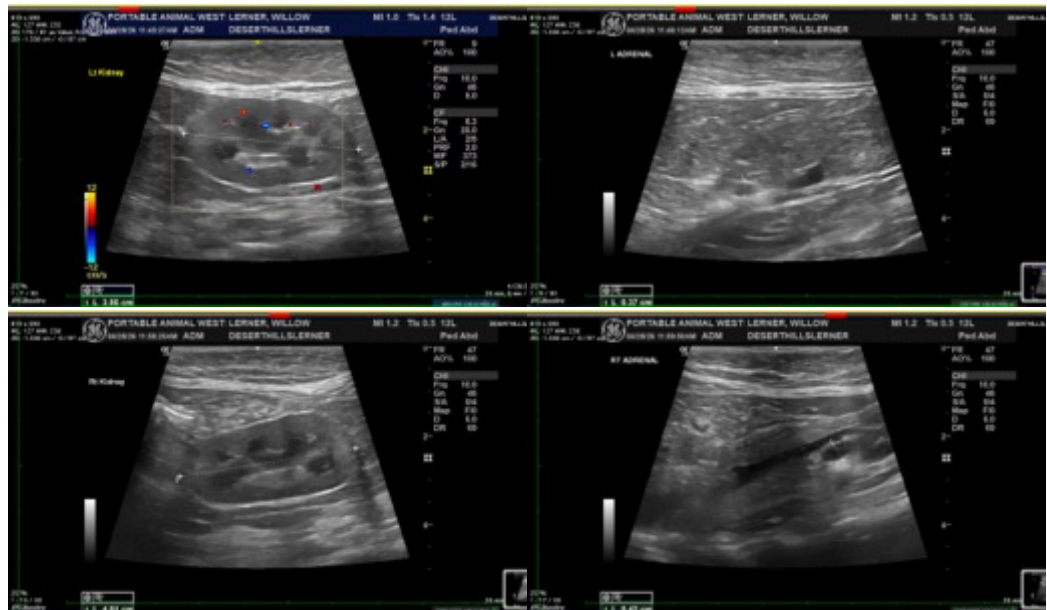
Fine needle aspirates of the density cranial to the urinary bladder could be considered if patient's coagulation status is appropriate.

Otherwise, 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.

Ideally, biopsies of the GI tract, being sure to include ileum if possible, are recommended to definitively diagnose and therefore manage the infiltrative bowel disease.

If biopsies cannot be obtained, empirical therapies could include a probiotic (if diarrhea is present, 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 with a hydrolyzed protein diet. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several trials may be required.

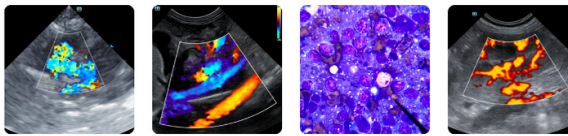
Additional considerations could include cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.).



Imaging performed by



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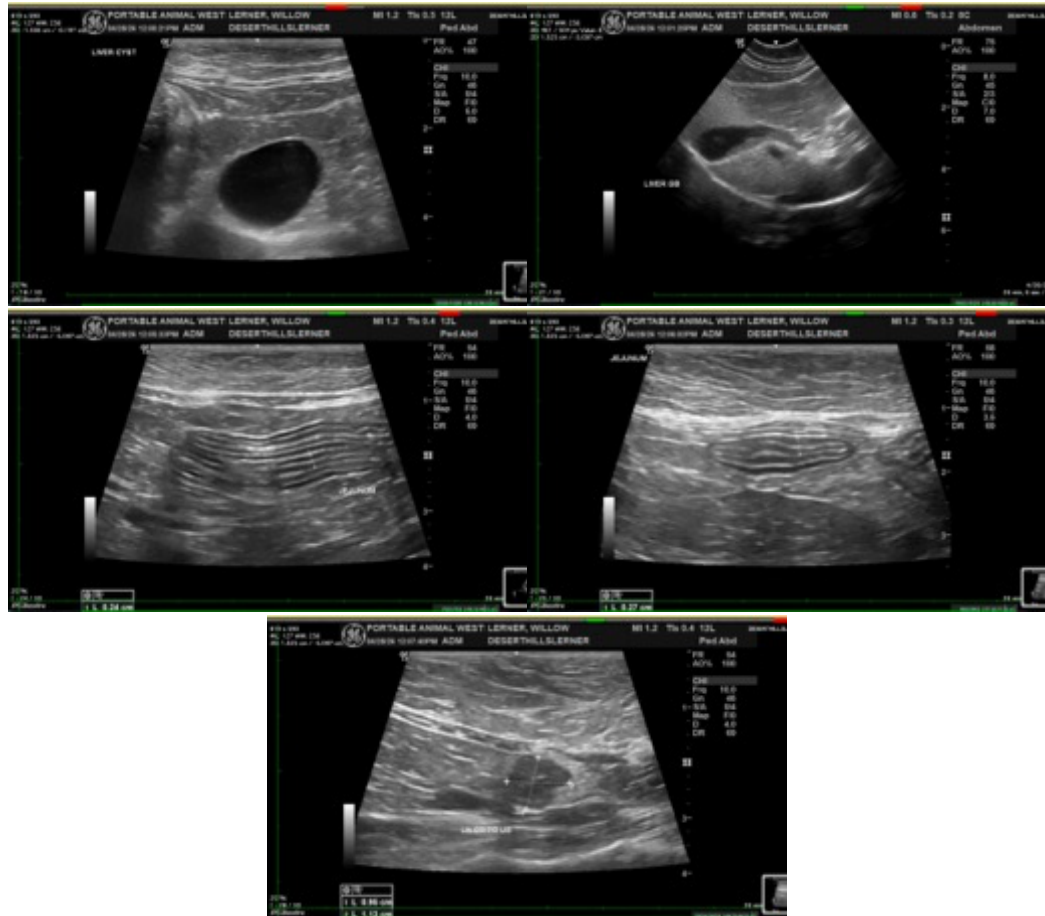
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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