



**PATIENT**

Allie Smith

**SPECIES**

Feline

**BREED**

DSH

**SEX**

FS

**AGE**

13 years

**WEIGHT**

2.7 kg

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING  
PERFORMED BY**

Loetitia Saint-Jacques,  
LVT

**HOSPITAL NAME**

Grass Valley Veterinary  
Hospital

**REFERRING VET**

Dr. Yoffe

**INVOICE**

11837

**DATE**

4/30/2026

**PRESENTING CLINICAL SIGNS**

P has been vomiting for years now. The vomiting has increased recently. Some days P will V every time after eating and drinking, other days P does not. O is interested in getting al ultrasound done. O got BW done at Pine Creek on March 16th. O also concerned that P has been losing weight. O wants to rule out whether or not P has irritable bowel disease (IBD). P has not had vaccines done since she was a kitten. P is about 13 and indoor only. P still has a normal appetite and no C/S. For the last few days P has had D. O also reports that P was 7.25 lb on March 16th. Working DDx: Infection/IBD/ Neoplasia/Other.

Meds: Metronidazole and Cerenia.

Abnormal PE/Chem/CBC/UA Results: Dehydration V/D Weight loss Elevated WBC.

**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. Trace pyelectasia is noted bilaterally. There is no evidence of mineral or infarcts observed. Left kidney measures 3.08 cm, and the right kidney measures 3.2 cm.

**Adrenal Glands**

The right adrenal gland is normal in size (0.46 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.29 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.

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.



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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 very prominently 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.

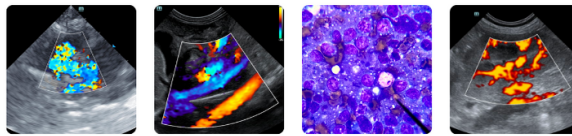
**Free Abdomen**

There is a scant/trace amount of anechoic free fluid noted.

Mesenteric and sub lumbar 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.

**PRIMARY FINDINGS**

- Marked/significant 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.
- Moderately reactive mesenteric lymph nodes, and mildly reactive sub lumbar lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Scant/trace free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.
- Pancreatic age-related remodeling/Chronic pancreatitis – Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.
- Moderate 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



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as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

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**SECONDARY FINDINGS**

**SPECIES**

- Mild to moderate age related kidney changes with trace bilateral pyelectasia.

Feline

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

**BREED**

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.

DSH

**SEX**

Ideally, tissue sampling is recommended. Fine needle aspirates of the enlarged lymph nodes could be considered if patient's coagulation status is appropriate. If a cytologic diagnosis is unable to be obtained, then biopsies of the GI tract, being sure to include ileum, if possible, are recommended to definitively diagnose and therefore manage the suspected infiltrative bowel disease.

FS

**AGE**

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.

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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.).

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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