

PATIENT

Missy Mandeville

SPECIES

Feline

BREED

DLH

SEX

FS

AGE

14 years

WEIGHT

3.1 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Loetitia Saint-Jacques,
LVT

HOSPITAL NAME

Brighton Greens
Veterinary Hospital

REFERRING VET

Dr. Amber Murphy

INVOICE

11836

DATE

4/30/2026

PRESENTING CLINICAL SIGNS

No vet history for 12 years. Stopped eating on Wednesday of last week. Lethargic and unable to get up and walk to litter box anymore. Unsure if got into anything. No heart murmur or arrhythmia present. Radiographs revealed equivocal mild generalized cardiomegaly. Consider underlying cardiomyopathy, valvular disease, or less likely anatomic variation. Echocardiography could be considered for further evaluation if cardiac disease is strongly suspected clinically. Scant pleural fluid versus incidental pleural thickening or tangential pleura. Thoracic ultrasound may assist with further evaluation. Otherwise unremarkable thorax. No definitive evidence of pulmonary metastasis. Pro BNP abnormal.

Admin Pantoprazole 4 mg/ml 0.72 ml (2.9 mg) IV slow @ 9:05 am Cerenia 10 mg/ml 0.29 ml (2.9 mg) IV @ 9:08 am Unasyn 375 mg/ml 0.11 ml (43 mg) IV slow @ 9:10 am Mirtazapine 1 1/2" ribbon to the left pinna Syringe fed A/D 12 mls po Offered canned A/d and water Continue fluids at 10 mls/hr.

Abnormal PE/Chem/CBC/UA Results: T4 WNL, BUN 39 (14-36), BUN/CR ratio 43 (4-33), Ca+ 8 (8.2-10.8), Mg 3.3 (1.5-2.5), Na/K ratio 31 (32-41), amylase 1303 (100-1200), PSL 30 (8-26), WBC 24.4K, PMNS 22.5K (2500-8500), HCT 28% (>29), lymphocytes 976K (2k-8.5K), UA USG 1.056, pH 6.0, 3+ proteinuria, UPCR 0.9 (<2) Working diagnosis Pancreatitis, mild anemia.

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 a large amount of echogenic non-shadowing debris, most consistent with exfoliated cells, crystals, mucous and/or small blood clots likely combined with incidental suspended lipid. Both sterile inflammation as well as urinary tract infection can 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.

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 3.67 cm, and the right kidney measures 3.76 cm.

Adrenal Glands

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

The left adrenal gland is normal in size (0.35 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



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Liver is subjectively enlarged (swollen contour) with a diffusely mildly coarse architecture and subtly increased portal markings. Mildly mixed echogenic changes are noted diffusely. 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 mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material, or infiltrative disease; however, visualization is partially inhibited by gas. 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

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 a mild amount of anechoic free fluid noted.

Mesenteric and cranial abdominal 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

- Moderate 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.
- Concurrent chronic low grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- Similarly, chronic low grade smoldering cholangitis/cholangiohepatitis, as is seen with "triaditis" can't be ruled out and should be suspected in the face of appropriate clinical signs, lab changes, etc. Infiltrative neoplastic disease affecting the liver can't be ruled out without tissue sampling.
- Mildly reactive mesenteric and cranial abdominal lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.



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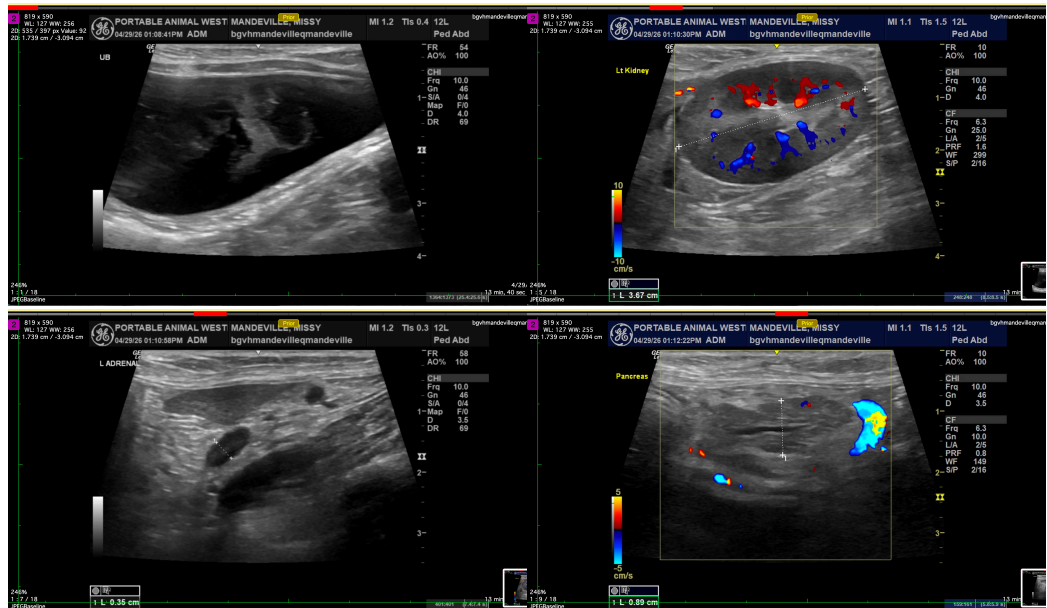
- A mild amount of free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.

SECONDARY FINDINGS

- Mild age-related kidney changes.
- A moderate amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- 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 less invasive sampling is elected prior to pursuing biopsies, fine needle aspirates of the liver, and if they can safely be reached, the enlarged lymph nodes could be considered if patient's coagulation status is appropriate but sampling those organs may or may not be representative of the GI change etiology.
- 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.).





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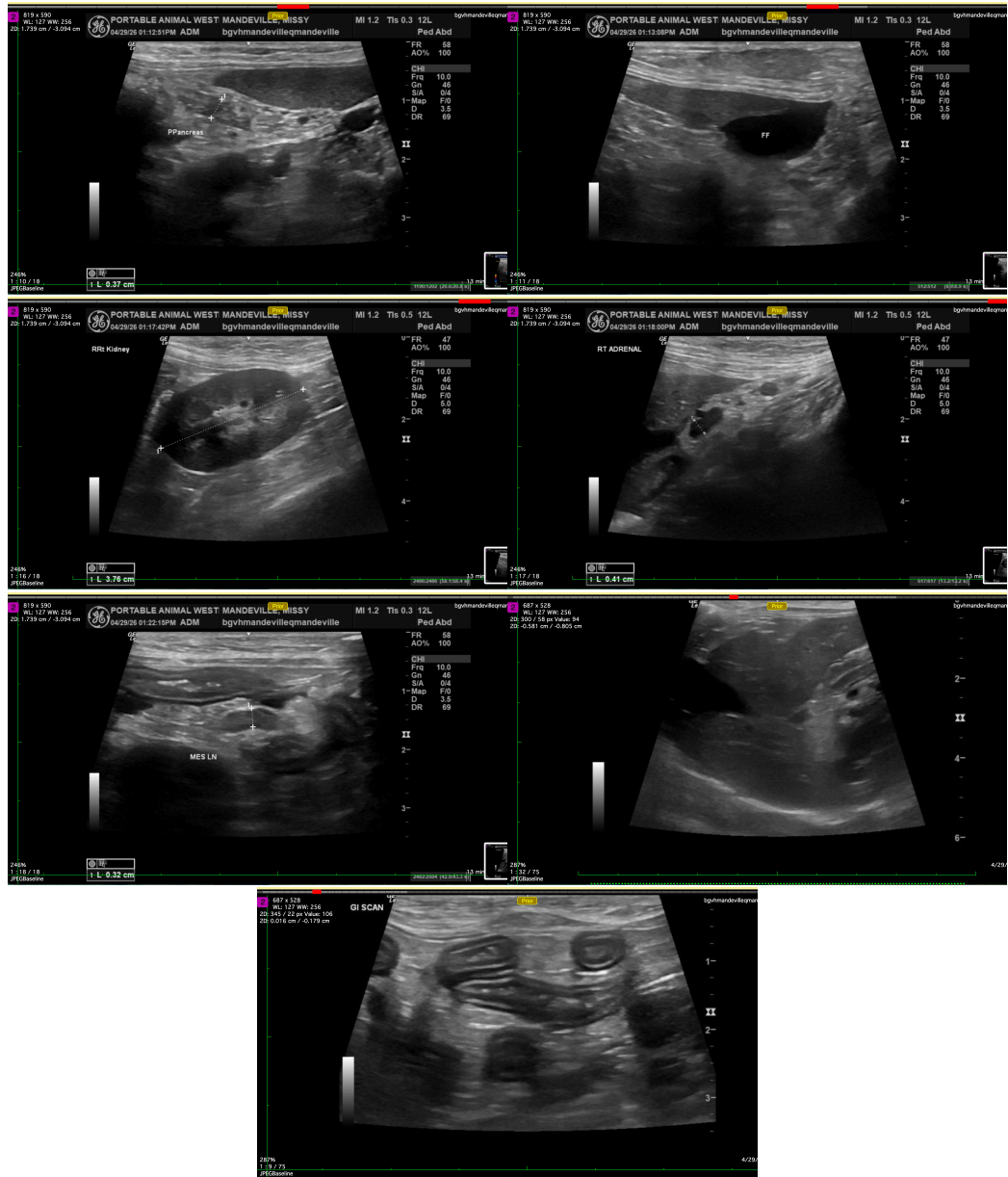
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

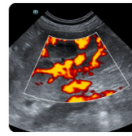
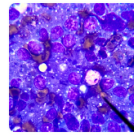
Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

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info@sonopath.com

Imaging
performed by



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