



PATIENT

Moochi Steingew

SPECIES

Feline

BREED

DSH

SEX

Female Spayed

AGE

4Y

WEIGHT

8.16lbs

INTERPRETED BY

Beth Johnson, DVM,
DACVIM (SAIM)

IMAGING PERFORMED BY

Dr. Wasserman

HOSPITAL NAME

Acreage Animal Clinic

REFERRING VET

Dr. Abed

INVOICE

74486

DATE

4-6-26

PRESENTING CLINICAL SIGNS

- Presented to Acreage Animal Clinic lethargic, mentally depressed, anorexic, white mm, marked hypovolemia, hypothermic at 96.7, hypotensive. Covered with fleas and thick layer of flea dirt. No sedation needed for sonogram today as patient mentation is bordering on obtunded.
- Patient reportedly dewormed with Drontal Plus 3-4 weeks ago, then repeated recently.
- B12 injection given by rDVM, supportive care with LRS IV, antiemetics

Abnormal PE/Chem/CBC/UA Results: Sluggish responses to stimuli. L nostril crusted, nasal discharge, non painful on abdomen, no masses or organomegally palpated. BCS 7/9, unknown if vomiting, no obvious heart murmur. CBC: Lymphocytes 780/uL, HCT (calculated) 34, rbc 5.9 Chem: Albumin 4.5, BUN 65, Magnesium 3.7, Phosp 9.4, Glu 241, Na 203, CL 157, TRIG 432, CPK 758, Precision PSL 13, FIV AB negative, Felv Ag Negative, Toxoplasma IgG,IgM pending, ' 4/4 UA via Cysto SG 1.027 (on IVF's), Protein 1+, Glucose detected in urine. Trace blood

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 (4.06 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 (3.79 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 mineral or infarcts observed. Trace pyelectasia is noted.

Adrenal Glands

The right adrenal gland is normal in size (0.35 cm at cranial pole and 0.42 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.38 cm at cranial pole and 0.36 cm at caudal pole), 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

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal



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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. Adjacent to the gallbladder is a second suspected to be fluid filled density that I suspect is an incidental bilobed gallbladder. Having said that, dilated biliary tract vs other cannot be definitively ruled out.

Gastrointestinal

Fundic mucosal hypertrophy with hyperechoic mucosa and some mucosal remodeling is noted. There is no loss of mural detail. Layering is normal. The lumen is mildly distended and contains an echogenic interface with some subtle distal progressively shadowing material that could represent normal ingesta and gas although a hairball density or other foreign material cannot be definitively ruled out. Having said that, the pylorus appears patent with no definitive and visible evidence of an obstructive pattern noticed.

The visible small intestine demonstrates areas of mildly 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/chyme. There is no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

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 a mild amount of free fluid present in these images primarily in the cranial abdomen. Additionally, there is subtly enhanced hyperechoic fat throughout the cranial abdomen.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

Primary

- Hyperechoic hepatomegaly – This appearance is most consistent with benign hepatic lipidosis or endocrine/DM hepatopathy. Infiltrative disease such as amyloidosis or round cell neoplasia, such as mast cell tumor or less likely lymphoma, is also possible.
- Suspect bilobed gallbladder although, as noted above, dilated biliary tree, while thought less likely, cannot be definitively ruled out.
- The free fluid and subtly enhanced hyperechoic fat and mesentery throughout the cranial abdomen could be secondary to hepatopathy +/- concurrent cholangitis although mild low grade smoldering pancreatitis, while not definitively visible, cannot be ruled out.



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- Concurrent gastritis is suspected and as described above, foreign material such as a hairball is possible. Having said that, normal ingesta and gas is also possible, therefore, pending patient's status, reassessment of the stomach, following an additional 12-24 hours of fasting, could be considered.
- Mild/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.

Secondary

- Trace pyelectasia in the left kidney.

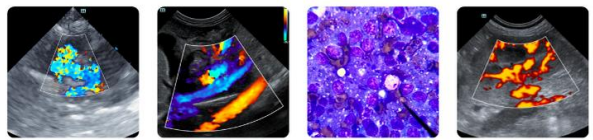
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The subtle hepatobiliary and gastrointestinal changes above could represent “triaditis,” although given patient’s history, comprehensive parasitic and infectious disease evaluation and empirical management of parasitic and infectious diseases is recommended. Pending results of that, 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. Additionally, if further diagnostics are warranted based on patient’s clinical status etc., FNA of the liver could be considered if patient’s coagulation status is appropriate.

Ongoing monitoring of the kidneys as well as the mild hyperglycemia is recommended to rule out emerging diabetes mellitus as well as to rule out emerging kidney disease as the specific gravity is difficult to use for interpretation while on fluid therapy.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.





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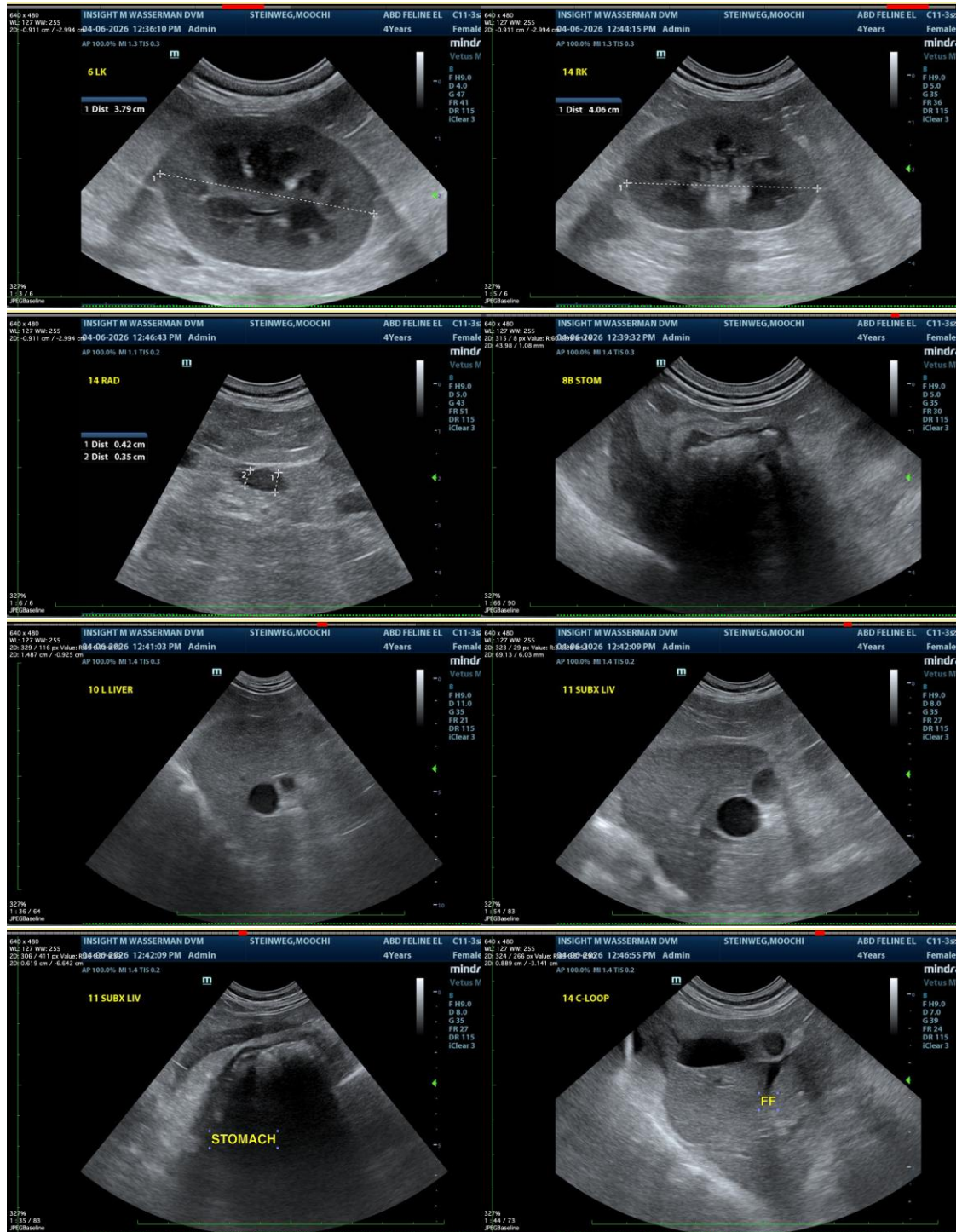
Dr. Abed

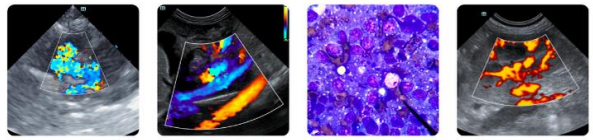
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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