



PATIENT	PRESENTING CLINICAL SIGNS
Mickey Pflugler	Elevated LE's, jaundice. Current Meds: Gabapentin
SPECIES	Abnormal PE/Chem/CBC/UA Results: pDVM bloodwork 3/27/26: Glob-6; ALT-843; ALP-201; GGT-12; TBili-2.3; Chol-27
Feline	
BREED	ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN
Ragdoll	Urinary System
SEX	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.
Neutered Male	The right kidney is normal is size (3.99 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.
AGE	The left kidney is normal is size (4.0 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.
14 Years	
WEIGHT	Adrenal Glands
Pending	The right adrenal gland is normal in size (0.41 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.
INTERPRETED BY	The left adrenal gland is normal in size (0.45 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.
Beth Johnson, DVM DACVIM	
IMAGING PERFORMED BY	Spleen
Shari Reffi, CVT	Spleen is subjectively large in size (1.6 cm thick at the hilus) with normal smooth margins. Parenchyma is normal in echogenicity with a diffusely coarse/heterogenous echotexture. No discrete sizable focal nodules or masses are observed. Splenic vasculature appears normal.
HOSPITAL NAME	Liver
Pet Stat Animal Urgent Care	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.
REFERRING VET	Gallbladder
Dr. Payne	Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. The cystic and common bile ducts are diffusely subjectively tortuous in appearance with mild concurrent dilation suspected.
INVOICE	Gastrointestinal
74348	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.
DATE	The visible small intestine demonstrates areas of moderately thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular,
4/9/26	



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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. Subjective mild duct dilation is suspected.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

Mesenteric, cranial abdominal/pancreaticoduodenal, and medial iliac 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

- Coarse 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.
- The liver changes are non-specific and could represent a benign infectious or inflammatory process i.e., bacterial or lymphoplasmacytic cholangiohepatitis, potentially a “Triaditis” pattern given the concurrent pancreas and bowel changes, although, especially given the splenic findings, infiltrative neoplasia such as round cell neoplasia versus other can’t be ruled out without tissue sampling.
- 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.
- Chronic low-grade smoldering pancreatitis is suspected.
- Reactive mesenteric, cranial abdominal, and medial iliac lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, 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.



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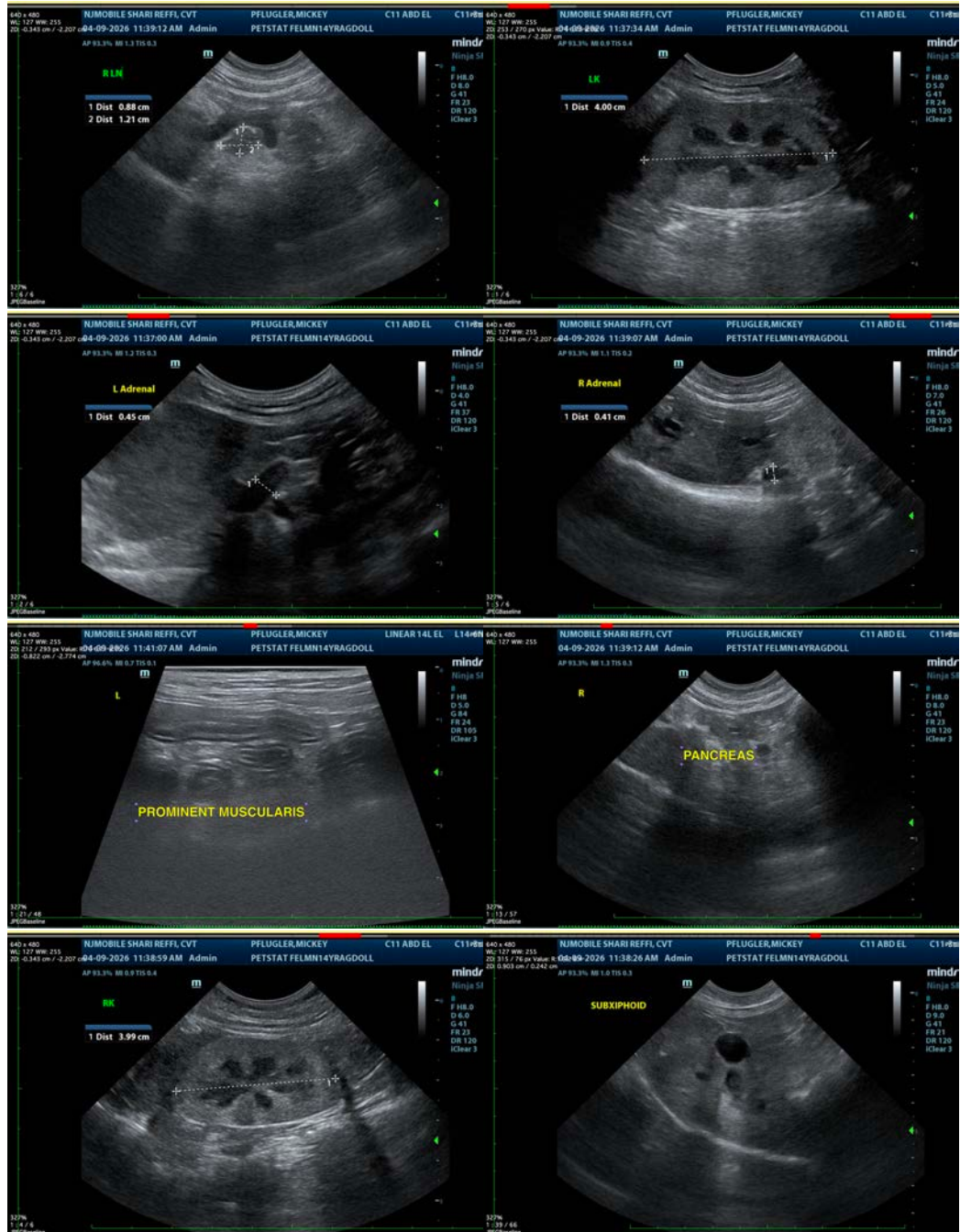
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Fine needle aspirates of the spleen, liver +/- enlarged lymph nodes (if they can safely be reached) are recommended if patient's coagulation status is appropriate.

In the meantime, treatment recommendations include fluid therapy, anti-emetics, gastroprotectants, hepatic nutraceuticals such as ursodiol and/or Denamarin, and broad-spectrum antibiotics. Nutritional support is critical to prevent/manage concurrent hepatic lipidosis, so appetite stimulants and/or, if indicated, feeding tube placement is also recommended.





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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