

PATIENT PRESENTING CLINICAL SIGNS

Missy Phillips

History: The pet was presented for anorexia and frequent coughing. Thoracic and abdominal radiographs revealed a severely gas-distended gastrointestinal pattern. Omeprazole and sucralfate were started at that time. The patient returned for repeat radiographs. Gastrointestinal clinical signs have improved; however, the radiographs continue to show a similar gas-filled GI pattern.

SPECIES

Feline

Current Medications: PREDNISOLONE 5 MG TABS

BREED

Siberian

Abnormal PE/Chem/CBC/UA Results: labs-WNL Radiographic Findings 1. Mild to moderate intestinal gas distention can be due to aerophagia alone or in combination with a concurrent enterocolonopathy (e.g. infectious or inflammatory etiologies versus infiltrative disease). 2. Organomegaly (liver and spleen) may represent infiltrative disease such as a malignant neoplasm, but benign etiologies (e.g. extramedullary hematopoiesis, venous congestion, metabolic, or inflammatory) is also possible. However, the rounded soft tissue density superimposed with the liver could represent the summation of an intra-abdominal mass originating from the liver, splenic tail, mesenteric fat, or less likely intestinal.

SEX

Spayed Female

AGE

13 Years

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

WEIGHT

5.96 kg

Urinary System

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.

INTERPRETED BY

Beth Johnson, DVM,
 DACVIM (SAIM)

Left kidney is normal in size (3.7 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.

IMAGING PERFORMED BY

Kelly Reschny

Right kidney is normal in size (4.4 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.

HOSPITAL NAME

Vetopia AH

Adrenal Glands

Left adrenal gland is normal in size (0.37 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

REFERRING VET

Dr. Awad

Right adrenal gland is normal in size (0.47 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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Spleen

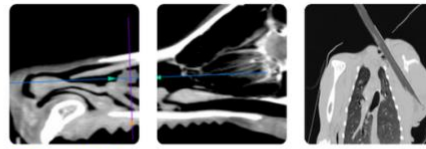
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

DATE

5/11/26

**See Free Abdomen section.

Liver



PATIENT

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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. **See Free Abdomen section.

SPECIES

Feline

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.

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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

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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 empty with no evidence of obstruction or foreign material.

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

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Pancreas

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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.

IMAGING PERFORMED BY

Kelly Reschny

Free Abdomen

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

There is no definitively visible pathologic lymphadenopathy noted in these images.

HOSPITAL NAME

Vetopia AH

In the left cranial abdomen, very superficially, is an approximately 2.0 cm x 3.0 cm, slightly larger depending on the view, oblong homogenous hypoechoic density that could potentially be originating from the caudal liver, or even spleen, versus pancreas, versus free abdomen.

REFERRING VET

Dr. Awad

ULTRASONOGRAPHIC FINDINGS

- The left cranial abdominal structure is of unknown definitive origin with liver, spleen, pancreas, free abdomen, lymph node, other, all being differentials, and benign inflammatory etiologies, as well as infiltrative neoplasia unable to be differentiated without tissue sampling.
- Mild /emerging inflammatory bowel disease 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. This finding could be in part normal patient variant in a senior cat.

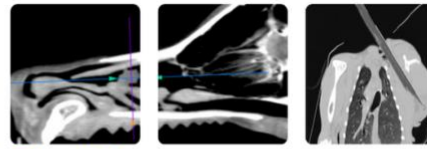
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS



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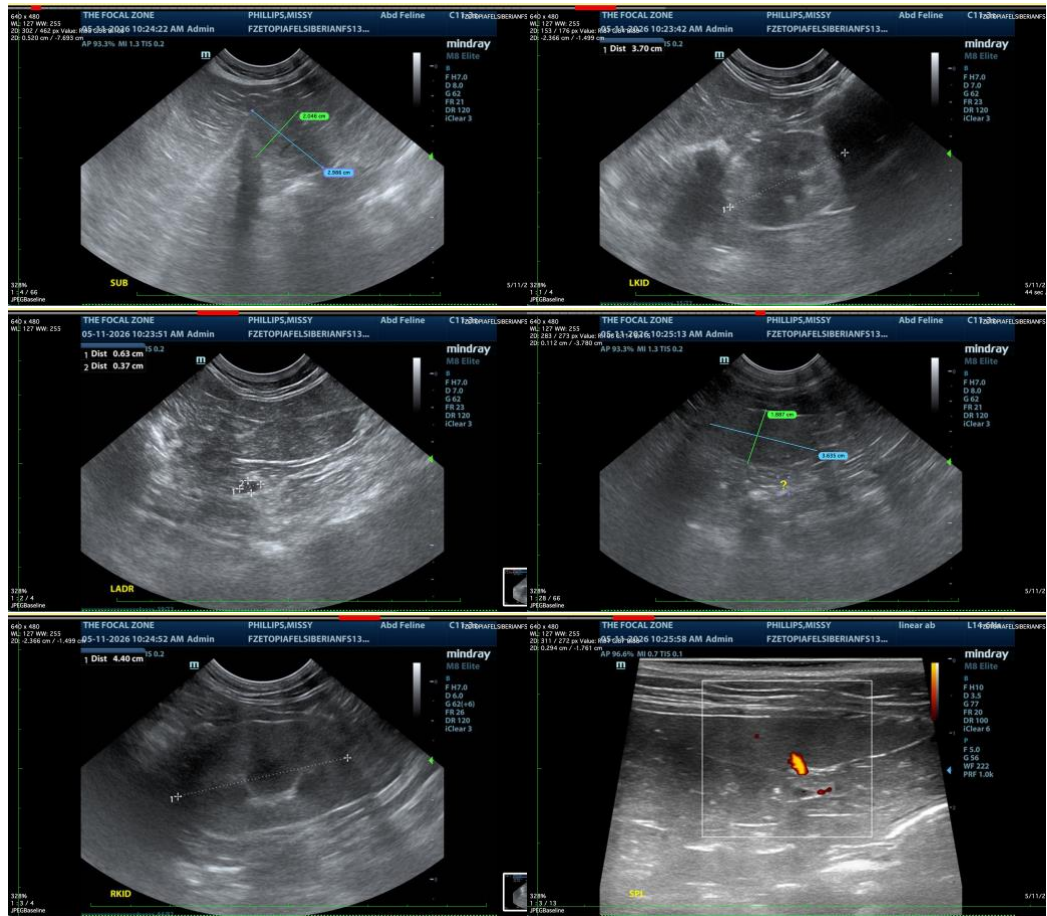
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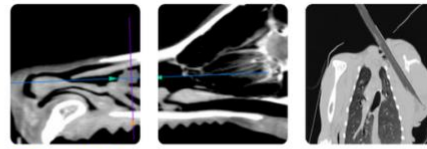
Fine needle aspirates of the structure described above could be considered if patient's coagulation status is appropriate.

Additionally, given the mild bowel changes in history 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.

Further workup of patient's cough, if a diagnosis has not been made and clinical signs persist, may also be warranted.

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





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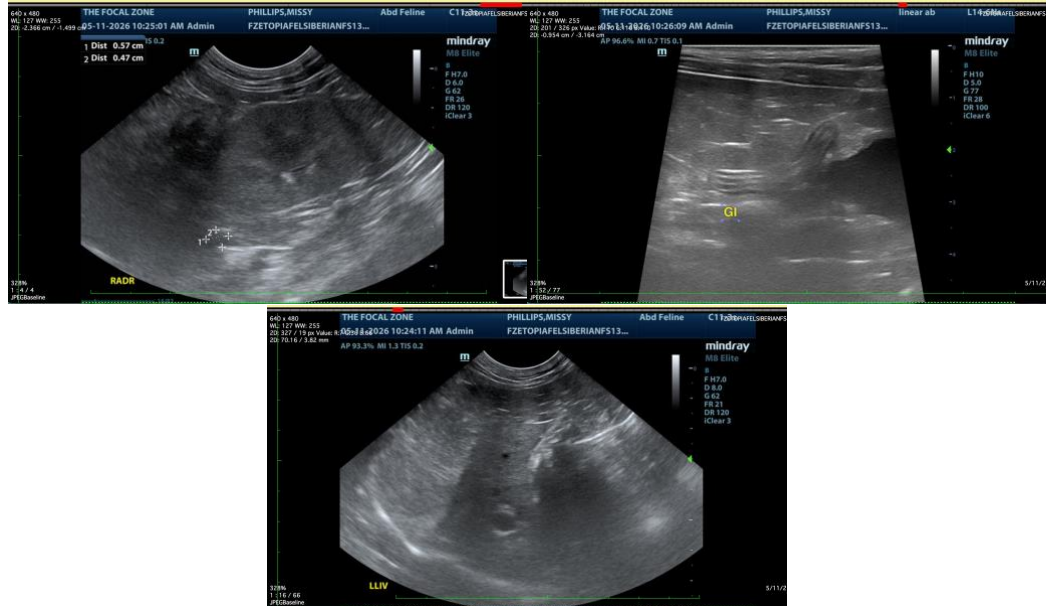
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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