



## PATIENT

Piscene Metzger

## SPECIES

Feline

## BREED

DLH

## SEX

Neutered Male

## AGE

12 Years 7 Months

## WEIGHT

9.3 kgs

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Renee Trionfetti, VMD

## HOSPITAL NAME

Brandywine Valley  
Veterinary Hospital

## REFERRING VET

Gail Rockwood, DVM

## INVOICE

75056

## DATE

5/12/26

## PRESENTING CLINICAL SIGNS

AUS to further evaluate vomiting x 4-5 days, hiding and sleepy. Vomiting started clear, then became brown. No diarrhea. Usually, a ravenous appetite but recently decreased. Is known to eat foreign body's (balloon string), but O's have been vigilant. Littermate had IBD and passed from disease per O. AUS sedation: Butorphanol 0.35 mg/kg IV. Tolerated well.

Abnormal PE/Chem/CBC/UA Results: AXR: ingesta in stomach despite vomiting, ventral abdominal soft tissue density not related to spleen?, segmental distension of intestine. CBC: Hct 38.5%, Plts 259-n, remainder NSF CHEM: Alb 3.4-n, normal LES, BUN 22-n, Cr 1.7, SDMA 14 high norm, remainder NSF UA: USG 1.047, pH 6.5, pro 2+, RBC 2-5/hpf, trace ketones, neg glucose UPC: 0.2 T4: 2.1-n

## 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 bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. The left kidney is normal in size at 4.15 cm. The right kidney is smaller than the left but still normal in size, measuring 3.83 cm.

### Adrenal Glands

The right adrenal gland is normal in size (0.27 cm at cranial pole and 0.29 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 0.49 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

### Spleen

Spleen is subjectively large in size (1.1 cm thick at the hilus) with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. 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.

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 empty with 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.

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 no visible free peritoneal effusion noted in these images.

Mesenteric 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**

- Mild/emerging 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.
- Mild reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- 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.
- Mild/subtle bilateral chronic kidney disease changes.

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Fine needle aspirates of the spleen could be considered if patient's coagulation status is appropriate. Pending results:

- 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 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



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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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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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