



PATIENT

Fatty Espinosa

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

9 years 4 months

WEIGHT

15.8 lbs

INTERPRETED BY

Beth Johnson, DVM,
DACVIM

IMAGING PERFORMED BY

Dr. Megan Cassels-
Conway

HOSPITAL NAME

Central Broward AH

REFERRING VET

Dr. Janeen Lazcano

INVOICE

11996

DATE

5/20/2026

PRESENTING CLINICAL SIGNS

P has h/o megacolon since 2023. P was lost to follow up since then. Presented to us 2 days ago w h/o hyporexia for last week or so. P presently only on fiber response diet (no lactulose or miralax as recommended in 2023). P is indoor/outdoor and prefers to have bm and urinate outside. No c/s that o is aware of. Did have 1 episode of vomiting and diarrhea last week.

Abnormal PE/Chem/CBC/UA Results: On PE p was noted to be thin, lost almost 2lbs since 2023. Formed fecal material noted on PE and rectal exam, CBC: WBC: 28H, neut: 24H; Chem: phos: 3.0L, creat: 1.4, T4: 1.0, UA: SG: 1.051, bact, 2+ prot, quiet sediment, fecal PCR: ALL NEG, FeLV/FIV: NEG for both. 1. Mild diffuse small intestinal fluid and gas dilation with mildly prominent jejunal wall. Functional ileus is prioritized, and differentials include enteritis, IBD, or LSA. Partial mechanical ileus is less likely. 2. Equivocal wispy soft tissue opacities adjacent to kidneys. Summation artifacts are prioritized over trace effusion. 3. Severe left cf joint incongruity and osteoarthritis. 4. Mild diffuse bronchial pulmonary pattern. 5. Obesity.

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 normal in size, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. Left kidney measures 4.07 cm, and the right kidney measures 4.63 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.36 cm at cranial pole and 0.33 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.25 cm at cranial pole and 0.32 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size (1.2 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. This appears to be a bilobed gallbladder which is most often an incidental, normal anatomic variant in cats.



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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.

The visible small intestine demonstrates areas of very prominently 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

- Marked/significant 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.
- Mildly 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

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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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.

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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.

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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.

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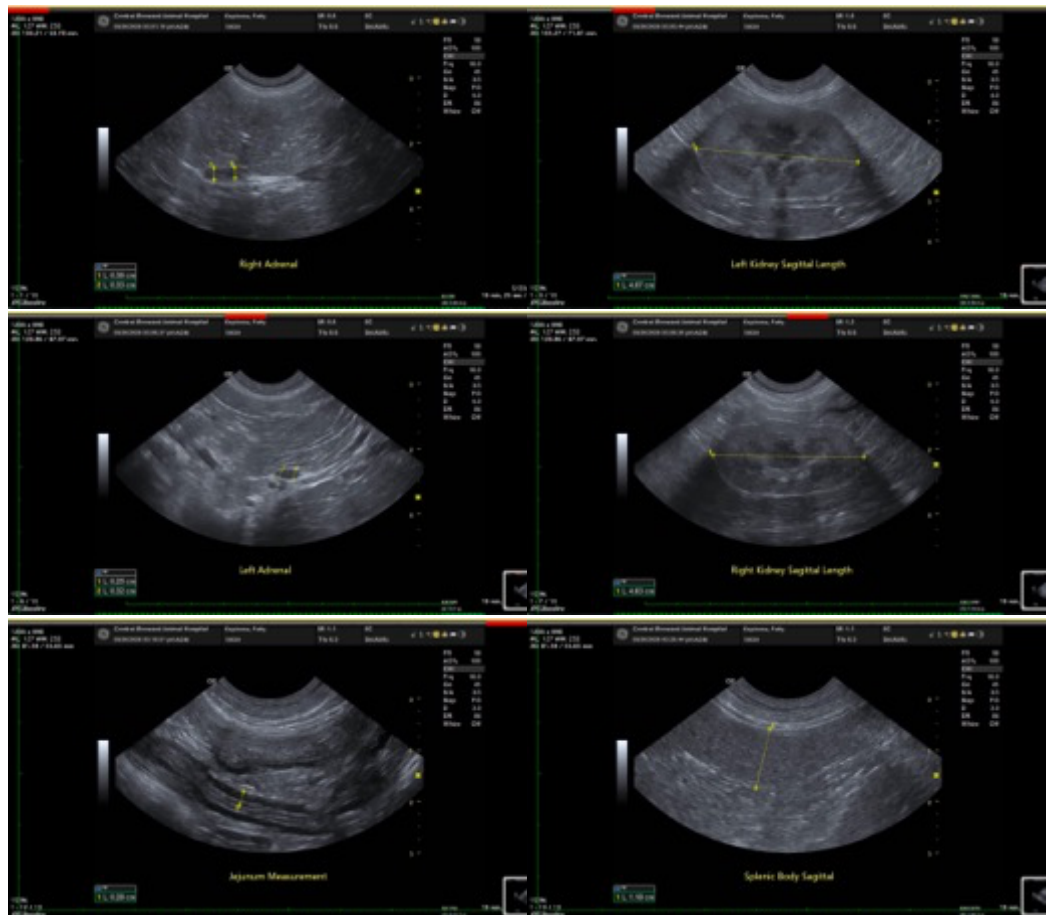
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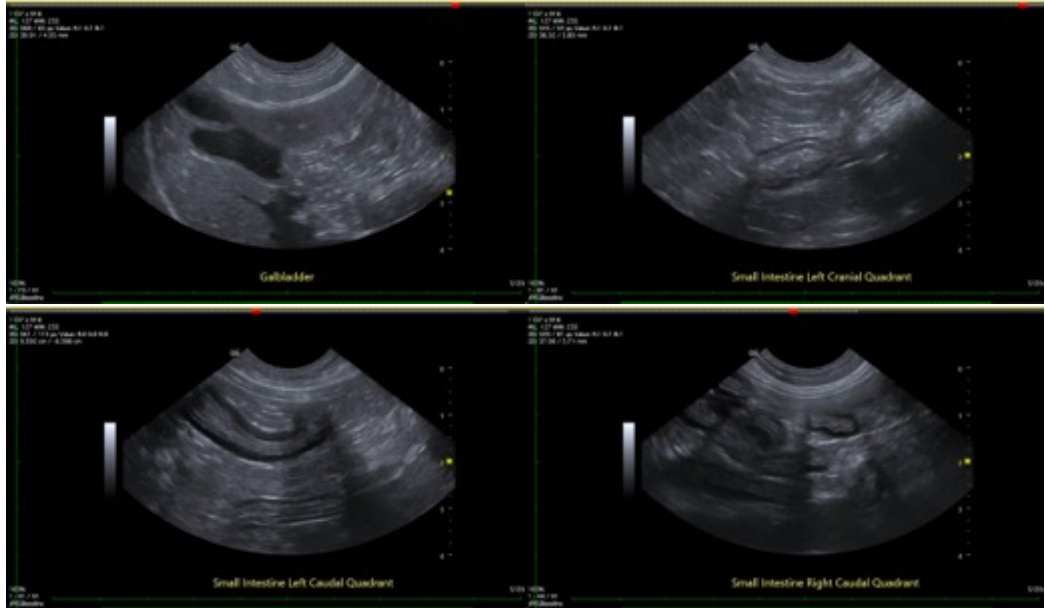
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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