

**PATIENT**

Flapjack Houtz Nutter

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

9 Years

WEIGHT

5.7 kg

INTERPRETED BYBeth Johnson, DVM
DACVIM**IMAGING
PERFORMED BY**

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VETEagles Peak Animal
Hospital**INVOICE**

75309

DATE

5/20/26

PRESENTING CLINICAL SIGNS

AUS to further evaluate chronic diarrhea, intermittent vomiting and low cobalamin level on TAMU GI panel. Evaluating for SI enteropathy. Previous treatments have been probiotics and metronidazole. Diarrhea has not been responsive to these therapies. Meds: Provable kit, Metronidazole.

Abnormal PE/Chem/CBC/UA Results: TAMU GI Panel: - Cobalamin 262 L (290-1500) - TLI 39.9-n (12-82) - PrecPSL 21-n (8-26) - Folate 16-n (9.7-21.6) Keyscreen Fecal: NPD No further BW or Rads

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 overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measures 3.86 cm. Right kidney measures 4.04 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.53 cm at cranial pole and 0.26 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.22 cm at cranial pole and 0.34 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

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.

The visible small intestine demonstrates areas of markedly/significantly thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly



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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 colon demonstrates some focal mildly thick areas in what I believe is the mid descending colon, measuring 0.36 cm thick. The remaining colon is normal in thickness and there is no definitively visible loss of layering. The lumen appears to contain normal stool.

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. Mild duct dilation measuring 0.32 cm dilated is noted at the level of the subjectively prominent duodenal papilla.

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.

PRIMARY 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.
- The focally mildly thick colon likely represents the same underlying pathology as the suspected small bowel disease, although a different process can't be ruled out.
- Reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Concurrent chronic low-grade smoldering pancreatitis can't be ruled out.

SECONDARY FINDINGS

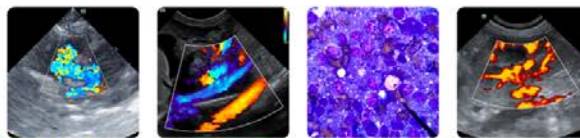
- Moderate age related kidney changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a general metabolic health screen (CBC, chemistry panel with electrolytes and urinalysis) is recommended.

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.

Fine needle aspirates of the enlarged lymph nodes could be considered if patient's coagulation status is appropriate, but ultimately biopsies of the GI tract are likely warranted for a definitive diagnosis and to further guide medical management.



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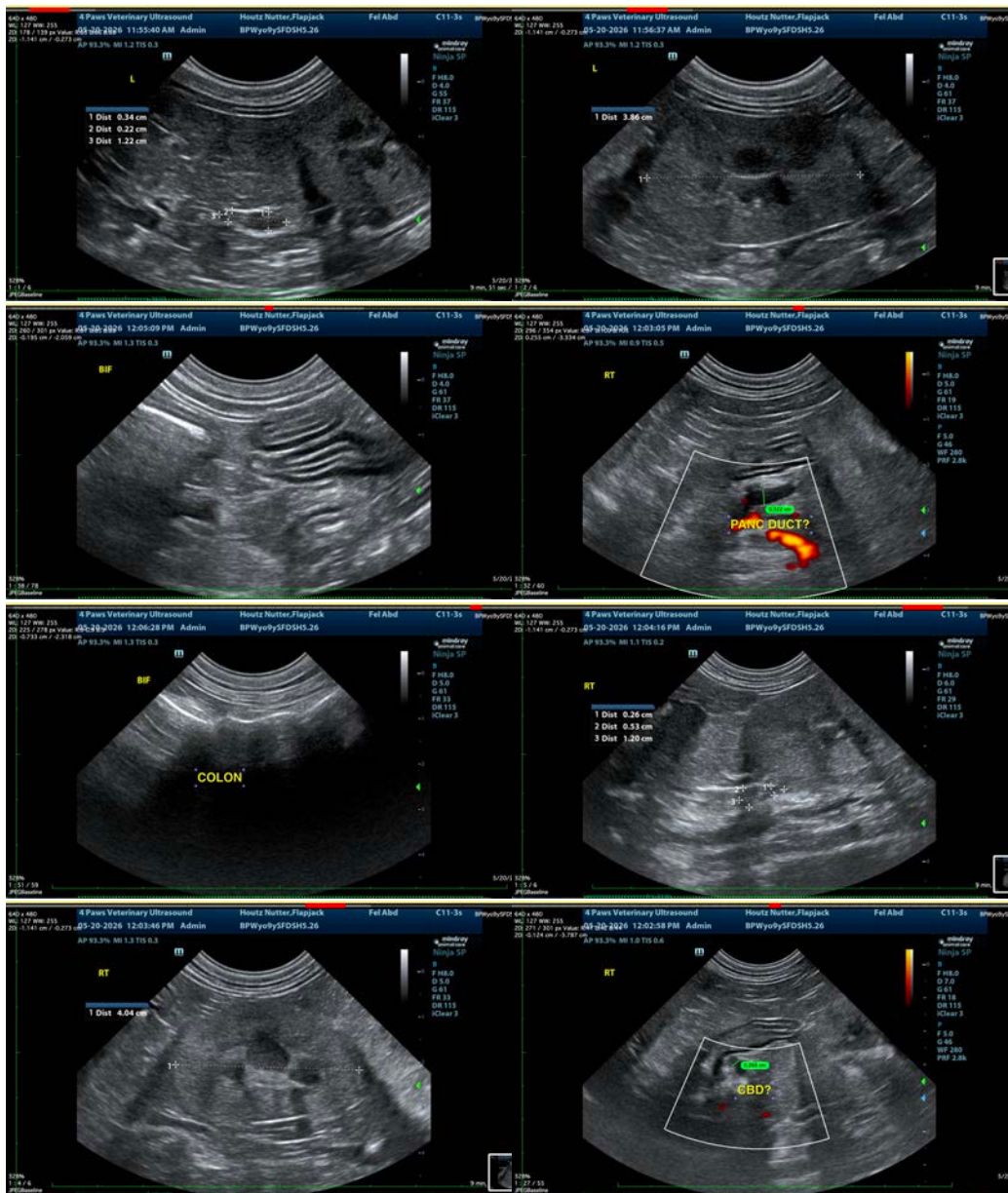
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If biopsies cannot be obtained, empirical therapies could include a probiotic (if diarrhea is present, such as visbiome or proviable), empirical deworming with a 5-day course of Panacur and, if tolerated, a transition in diet, based on trial-and-error 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.

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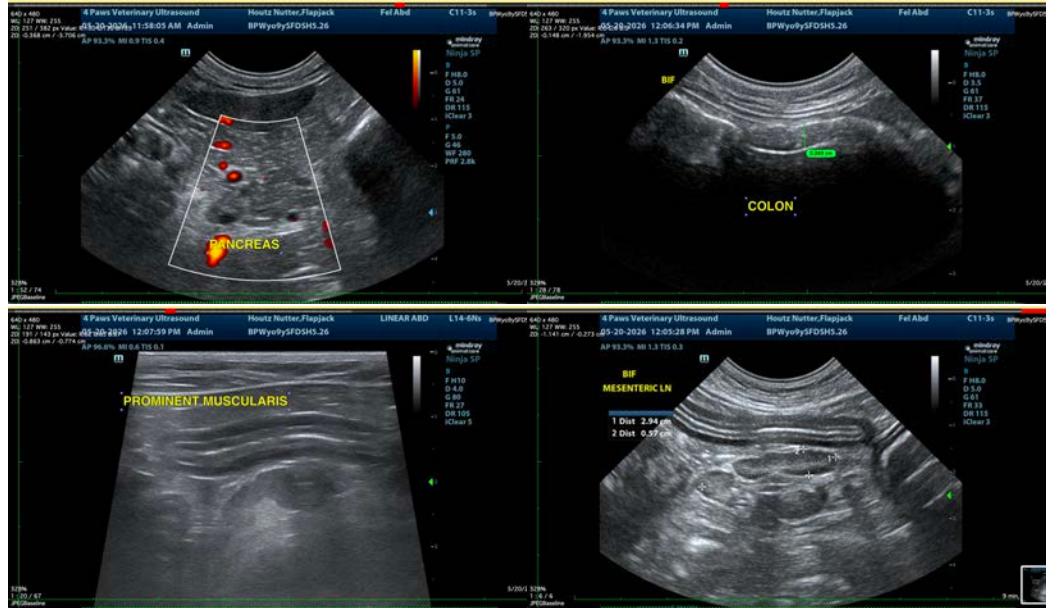
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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