



PATIENT

Maizey Peterson

SPECIES

Feline

BREED

DMH

SEX

FS

AGE

15 years 3 months

WEIGHT

8.3

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Penridge AH

REFERRING VET

Dr. Kristen Carpenter

INVOICE

11986

DATE

5/20/2026

PRESENTING CLINICAL SIGNS

Hx of previously dx HOCM in 2018 (echo report unavail), regulated with atenolol. Presented for wellness 4/9/26 - 3 lb wt loss was noted since last year. O noted she had become picky with food and there was intermittent V+. No D+. Full bw and BNP done. T4 in grey zone, free t4 suspicious for early hyperthyroidism. Started on methimazole. Early renal insufficiency also suspected. Recheck bw normalized but pt continues to have ongoing wt loss (pt lost almost another lb. in 1 month.) Pleural effusion was noted when doing the abd scan, thoracic rads performed (attached for supplemental information). Pt was mildly dehydrated on exam. Grd II heart murmur is stable. Pt has mild resp effort.

Chronic meds: Atenolol 6.25 mg PO SID, Methimazole 2.5 mg PO SID.

Diagnostics: 4/10/26 Full bloodwork: HCT 33%, mild monocytosis. Chem: Creat 1.7, BUN 41 (H). UA - USG 1.014, quiet sediment. Total t4 2.9, free T4 2.6 (high normal). Fecal NOS. proBNP 1500 (H). 5/13/26 Thyroid Monitoring Panel: HCT 34%, mild monocytosis persistent. Chem: Creat 2.0, BUN 40. Total t4 2.2 (on methimazole). 5/20/26: Thor rads: Mild pleural effusion, heavier pulmonary pattern R caudodorsal lungs but pulmonary vasculature does not look overly distended. Effusion r/o early CHF vs neoplastic vs other.

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.

The right kidney is normal in size (3.58 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. A hyperechoic band parallel to the corticomedullary border is present. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal in size (3.55 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. A subtle hyperechoic band parallel to the corticomedullary border is present. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

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

The left adrenal gland is normal in size (0.39 cm), 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



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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. An approximately 1.0 cm x 1.4 cm in size anechoic cystic area is noted in the mid cranial liver. 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 mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material, or infiltrative disease; however, visualization is partially inhibited by gas. Pyloric outflow tract appears patent.

The visible small intestine demonstrates areas of moderate to severely thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic. Some bowel loops demonstrate less distinct than normal layering/early or emerging loss of layering. The lumen of the small intestine is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material, or infiltrative disease; however, visualization is partially inhibited by gas.

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. No pancreatic duct dilation is noted.

Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

There is pleural effusion noted in these images.

PRIMARY FINDINGS

- The bowel changes described above have been reported with infiltrated bowel disease, including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. Neoplasia is a slightly higher concern given the emerging loss of layering suspected in some loops.
- Concurrent chronic low grade smoldering pancreatitis is suspected.
- Subtle bilateral medullary rim sign - This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including FIP, lymphoma, hypercalcemic nephropathy, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as



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isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.

- Pleural effusion is visible in these images as well as reportedly previously suspected/diagnosed.

SECONDARY FINDINGS

- Suspect incidental/benign hepatic cyst, potentially feline biliary cystadenoma.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not already being reviewed, an echocardiogram is recommended.

A blood pressure is also recommended if not recently evaluated.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M Laboratory is recommended for further evaluation of GI and pancreatic function.

Fine needle aspirates of the pancreas, as well as sampling of the pleural effusion could be considered for analysis and cytology if patient's coagulation status is appropriate. Ultimately, however, biopsies of the GI tract are likely necessary for a definitive diagnosis and therefore to further guide medical management.

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





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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.

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info@sonopath.com



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