



PATIENT

Shanti Repass

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

17 years 2 month

WEIGHT

7.4 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Lucas Budden

HOSPITAL NAME

Frontier Veterinary
Hospital

REFERRING VET

Dr. Lucas Budden

INVOICE

11882

DATE

5/5/2026

PRESENTING CLINICAL SIGNS

History of hyperthyroidism and CKD. Has an intermittent appetite at home and intermittently vomits. Has lost weight (7.4# now, was 8# on 10/5/25). Ultrasound to assess for underlying cause of vomiting and weight loss.

Abnormal PE/Chem/CBC/UA Results: Current medications: gabapentin to facilitate ultrasound methimazole 2.5 mg PO q12h RC GI food Physical exam: BCS 3/9, MCS 2/3, mild dental tartar, no obvious pain on abdominal palpation, peripheral LNs normal, historical mature cataract left eye Lab work: Senior labs 4/20/26 Creat high 2.1 Chol high 244 T4 normal 2 USG 1.012 quiet sediment FeLV/FIV neg/neg HWT negative fecal negative GI panel pending.

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 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 is small in size measuring 2.88 cm, and the right kidney is small/normal in size measuring 3.26 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.3 cm at cranial pole and 0.3 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.3 cm at cranial pole and 0.3 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.



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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. In addition to the above diffuse changes, in one focal area of the jejunum, there's a focally rounded, mildly thicker of jejunum characterized by a focally rounded thickened muscularis layer measuring 0.4 cm x 0.6 cm in size.

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 in size with swollen irregular contour. Parenchyma is heterogenous characterized by hyperechoic tissue remodeling intermixed with ill-defined hypoechoic nodules. There is mild pancreatic duct dilation suspected. There is no evidence of active peripancreatic inflammation.

Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

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. This finding is likely in part normal patient variant in a senior cat, except for the focal jejunal thickening described above which is slightly more concerning for an infiltrative process with both benign and/or emerging infiltrative neoplasia being differentials.
- Pancreatic nodular hyperplasia – Infiltrative neoplasia cannot be ruled out but is considered less likely. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.
- Moderate chronic kidney disease changes most visibly significant in the left kidney.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

As is reportedly already pending, 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.

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

A blood pressure is recommended if not recently evaluated.

Ultimately, biopsies of the GI tract, being sure to include both ileum, if possible, as well as the focal jejunal loop described above, may be necessary for ad definitive diagnosis and therefore to further guide medical management. Intraoperative ultrasound could be used in this scenario. Otherwise, supportive/symptomatic medical management of clinical signs, including potentially decreased appetite, sub clinical nausea or gastritis secondary to progressive chronic kidney disease, etc. could be



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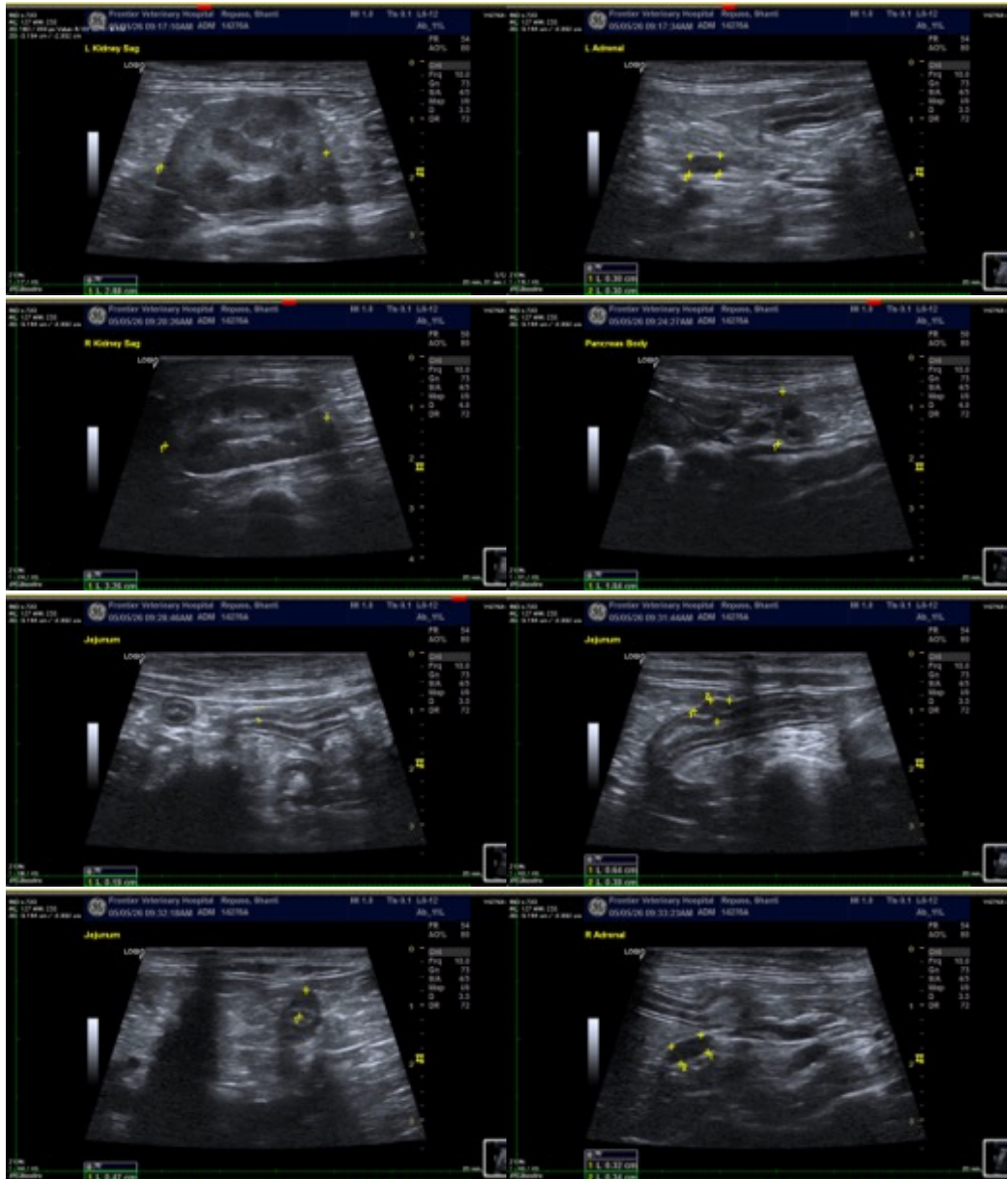
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considered while monitoring for improvement i.e. antiemetics, gastroprotectants, appetite stimulants +/- fluid therapy if hydration is a concern, etc.



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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