

**PATIENT**

Mikela Jasionowicz

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Female Spayed

**AGE**

16 years

**WEIGHT**

5.68 lbs

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING  
PERFORMED BY**

Amy Mayhew, LVT

**HOSPITAL NAME**

SVS Imaging Michigan

**REFERRING VET**

Dr. Taylor

**INVOICE**

14038

**DATE**

8.10.23

**PRESENTING CLINICAL SIGNS**

History: Weight loss despite eating enough calories and controlled T4, hairballs every 2 weeks

Abnormal PE/Chem/CBC/UA Results: intestinal thickening, palpable thyroid (hyperthyroid managed with methimazole), underweight body condition 7-25-23; CBC: wnl Chem: SDMA 34 (was 33) Creat 3.0 (2.9) BUN 41 (45) K 5.5 H T4 3.1 UA - USG 1.018, mild hematuria, rest nsf. Treated UTI 5-16-23 - resolved. IRIS stage 3 7-25-23 BP 152

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.32 cm). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

Left kidney is normal in size (3.00 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Right kidney is normal in size (3.03 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

**Adrenal Glands**

Left adrenal gland is normal in size (0.28 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.35 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

**Spleen**

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). Several small (0.20-0.30 cm) hyper- to anechoic non-capsule-disrupting nodules are noted. Splenic vasculature appears normal.

**Liver**

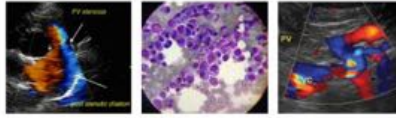
Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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 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.

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The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

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***Pancreas***

The observed pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Pancreatic duct dilation is noted. Enhanced hyperechoic ill-defined surrounding fat is noted.

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***Free Abdomen***

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

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**ULTRASONOGRAPHIC FINDINGS****AGE**

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- 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 aggressive lymphadenopathy, loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling
- Chronic smoldering pancreatitis should be suspected in the face of supporting clinical signs.
- Chronic Cystitis - Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes.
- Hypo to anechoic splenic nodules – likely represent benign lesions such as a cysts, hematomas, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions, and cannot be ruled out.

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**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.

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 diet change, empirical deworming with a 5-day course of Panacur, cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.). Other supportive therapeutic considerations could include fiber supplementation, especially with large bowel diarrhea and/or a probiotic.

**INVOICE**

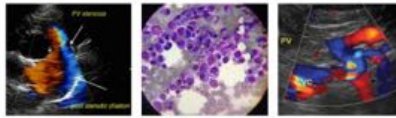
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svsimagingqc.net 309-737-3070



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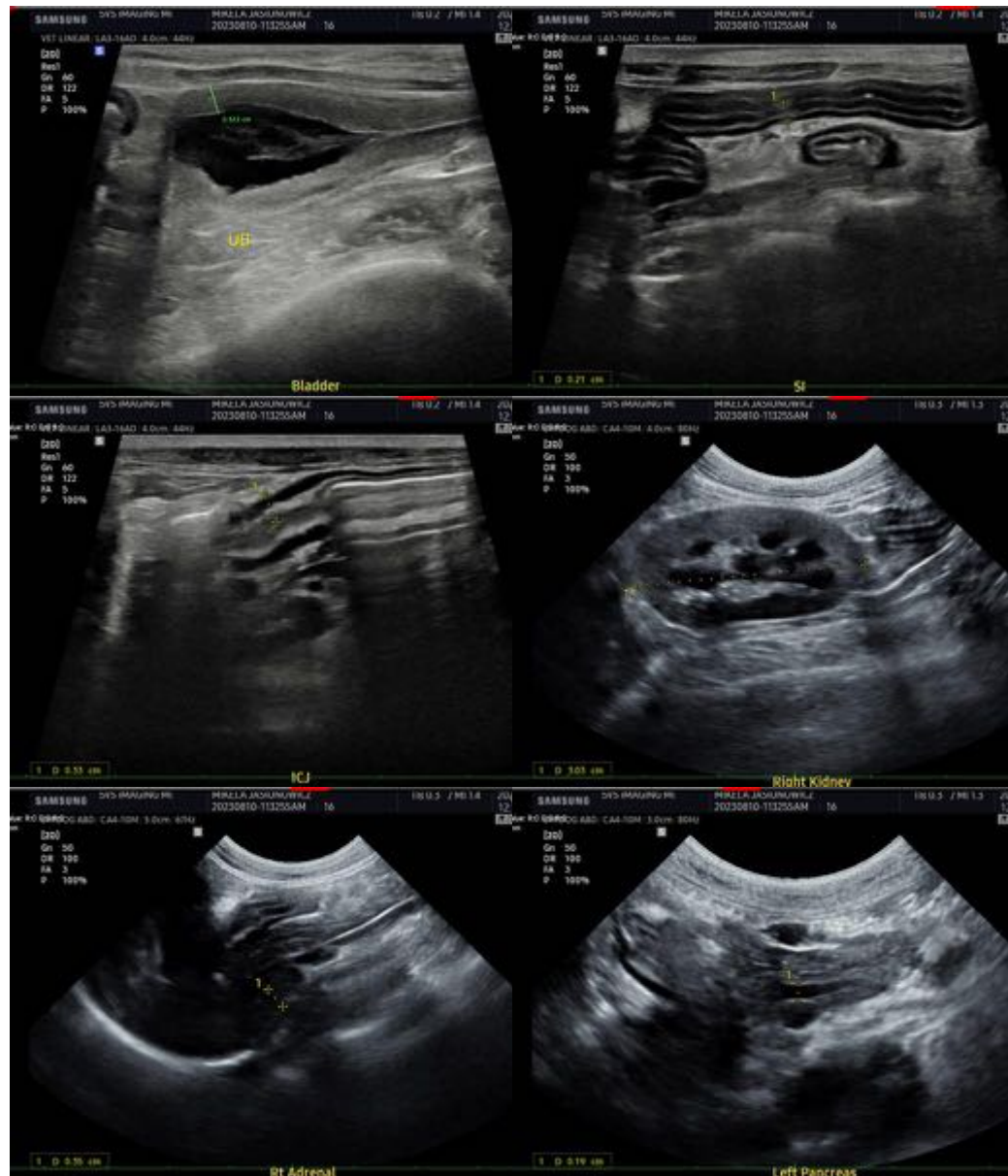
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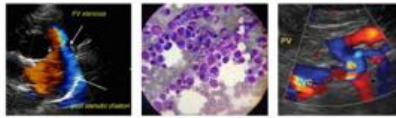
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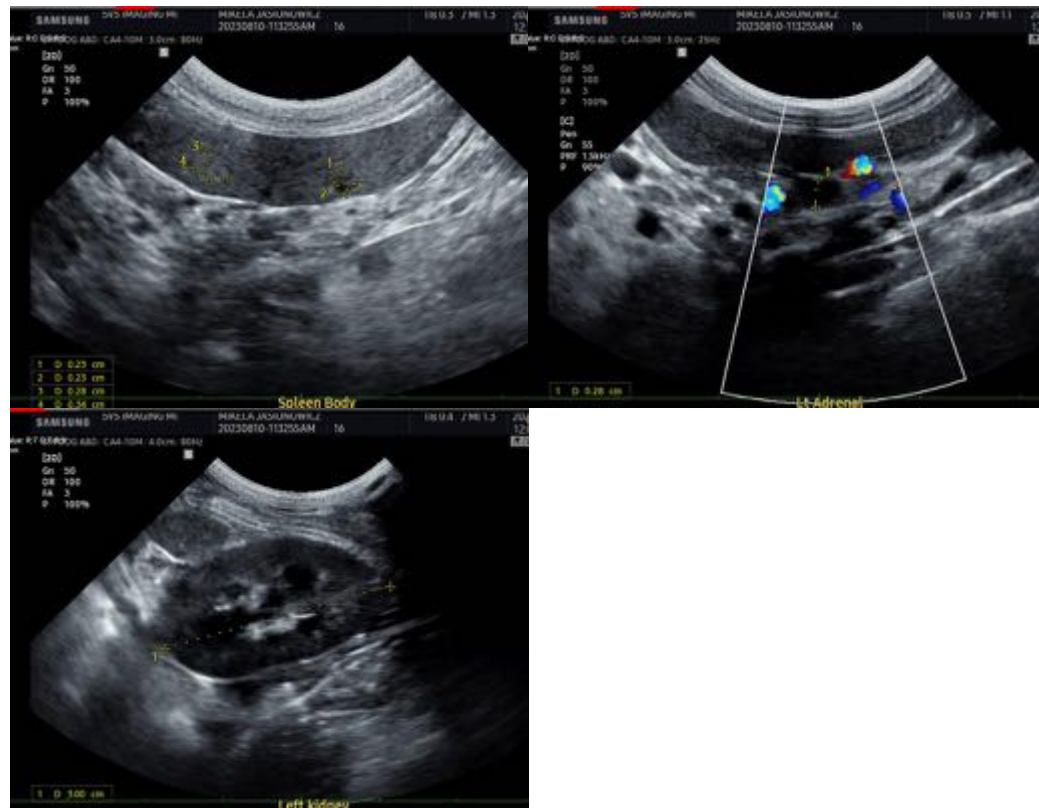
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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