



<b>PATIENT</b>	<b>PRESENTING CLINICAL SIGNS</b>
Benjamin Schifano	History of elevated Spec FPL. Patient presented for vomiting one month ago. Spec FPL and total T4 elevated, total protein and globulin slightly decreased. Patient began methimazole and metronidazole. Vomiting resolved. Recheck blood work 4 weeks later—all values WNL other than elevated Spec FPL. Screening for GI, pancreatic disease.
<b>SPECIES</b>	
Feline	
<b>BREED</b>	Abnormal PE/Chem/CBC/UA Results: Spec FPL on 6/29/23 = 11.3 (0-4.4) Spec FPL on 7/27/23 = 33.3
DSH	
<b>SEX</b>	<b>ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN</b>
Neutered Male	<b>Urinary System</b>
	The urinary bladder is moderately 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.
<b>AGE</b>	The right kidney is normal in size (4.4 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.
12 Years 7 Months	
<b>WEIGHT</b>	The left kidney is normal in size (4.34 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.
16.3 Pounds	
<b>INTERPRETED BY</b>	<b>Adrenal Glands</b>
Beth Johnson, DVM DACVIM	The adrenal glands are unable to be well visualized in these images.
	<b>Spleen</b>
<b>IMAGING PERFORMED BY</b>	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.
M. Kermendy, CVT	
<b>HOSPITAL NAME</b>	<b>Liver</b>
Wauwatosia VC	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.
<b>REFERRING VET</b>	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.
Dr. Ericka Haynes	
<b>INVOICE</b>	<b>Gastrointestinal</b>
44577	The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.
<b>DATE</b>	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
8/8/23	



<b>PATIENT</b>	hyperechoic, without evident loss of layering appreciated. The lumen is empty with no evidence of obstruction or foreign material.
Benjamin Schifano	
<b>SPECIES</b>	The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.
Feline	<b>Pancreas</b>
<b>BREED</b>	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 no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.
DSH	
<b>SEX</b>	<b>Free Abdomen</b>
Neutered Male	There is no evidence of free peritoneal effusion noted in these images.
	There is no apparent lymphadenopathy noted in these images.
<b>AGE</b>	<b>ULTRASONOGRAPHIC FINDINGS</b>
12 Years 7 Months	<ul style="list-style-type: none"> <li><b>Inflammatory bowel disease (IBD) pattern</b> – 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.</li> </ul>
<b>WEIGHT</b>	<ul style="list-style-type: none"> <li><b>Pancreatic nodular hyperplasia</b> – Infiltrative neoplasia cannot be ruled out but is considered less likely.</li> </ul>
16.3 Pounds	
<b>INTERPRETED BY</b>	<b>INTERPRETATION OF THE FINDINGS &amp; FURTHER RECOMMENDATIONS</b>
Beth Johnson, DVM DACVIM	Given this patient's resolution in clinical signs following treatment of the hyperthyroidism, the vomiting/weight loss, etc. may have been largely related to the hyperthyroidism. Having said that, there is evidence of suspected infiltrative bowel disease +/- concurrent chronic smoldering pancreatitis in these images. Therefore, further diagnostic considerations could include:
<b>IMAGING PERFORMED BY</b>	A fine needle aspirate of the pancreas if patient's coagulation status is appropriate to better assess inflammatory cell type, rule out round cell neoplasia. Followed by:
M. Kermendy, CVT	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.
<b>HOSPITAL NAME</b>	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.
Wauwatosa VC	
<b>REFERRING VET</b>	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.
Dr. Ericka Haynes	
<b>INVOICE</b>	
44577	
<b>DATE</b>	
8/8/23	



**PATIENT**

Benjamin Schifano

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.).

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

12 Years 7 Months

**WEIGHT**

16.3 Pounds

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

M. Kermendy, CVT

**HOSPITAL NAME**

Wauwatosa VC

**REFERRING VET**

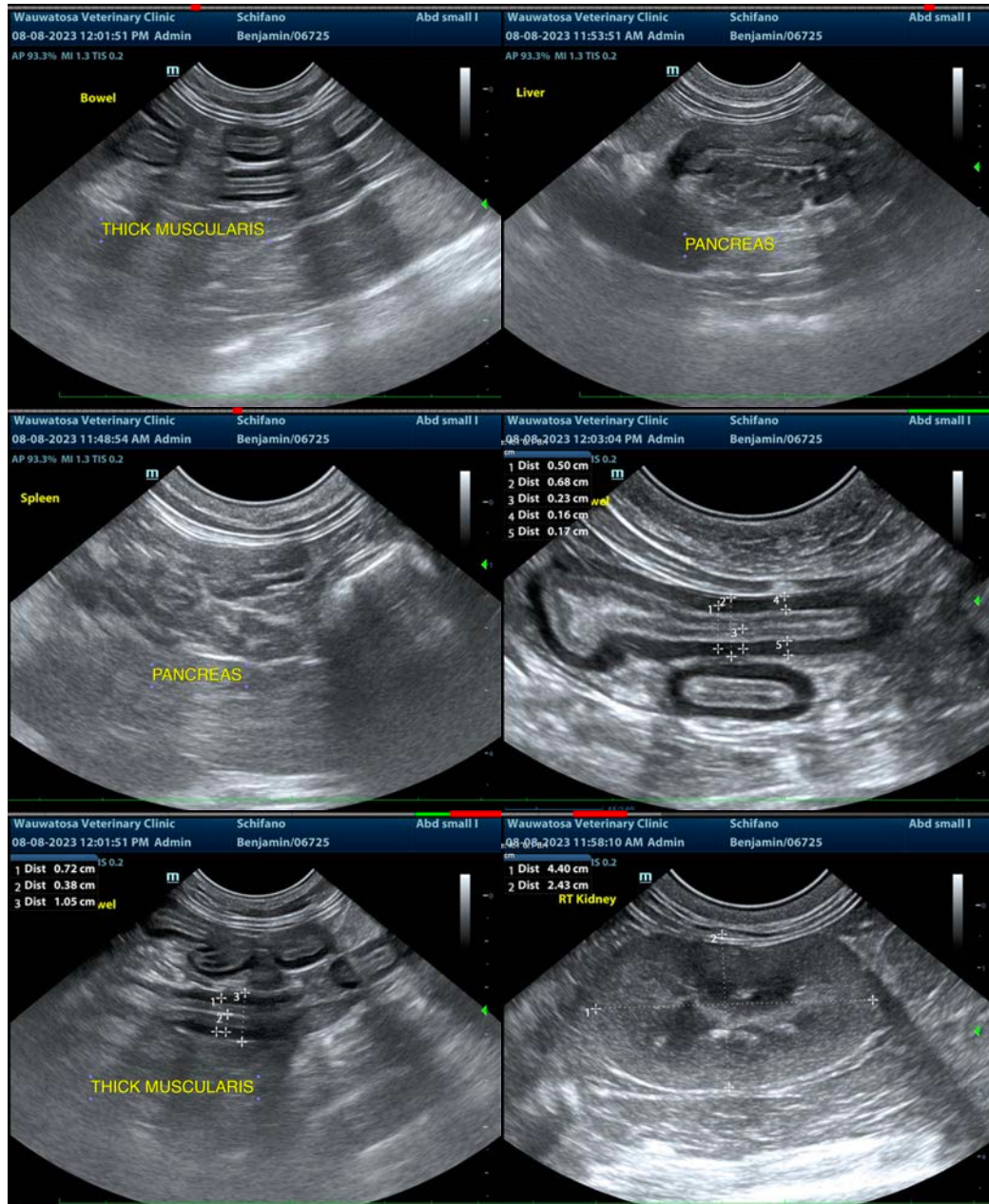
Dr. Ericka Haynes

**INVOICE**

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**DATE**

8/8/23



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