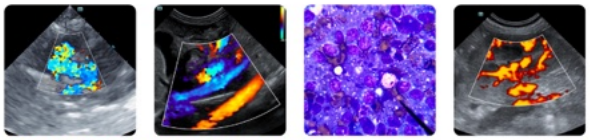


PATIENT

Boo Mader

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

14 years

WEIGHT

8.2 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Miranda Fritz

HOSPITAL NAME

Richmond AH

REFERRING VET

Dr. Fritz

INVOICE

78794

DATE

6/17/26

PRESENTING CLINICAL SIGNS

History: P presented for blood in stool last 2 weeks. No diarrhea but frank blood present. P intermittently vomiting but hasn't vomited within the past few days. Appetite is low especially in the morning but usually eats normally in the afternoon/evening. Energy level is good - still has zoomies but overall maybe sleeping more. Seen for ADR, vomiting, and anorexia in February. Hospitalized and seen by IM. Hepatic cysts on ultrasound. Treated IH and did have feeding tube placed at that time. Since then o states p occasionally vomits but had been doing well.
PE - BCS 3/9, mild muscle wasting, mild progressive weight loss, doughy and uncomfortable on abdominal palpation, marked periodontal disease with resorptive lesions, TPR wnl. CBC - HCT 36% (wnl, was 23% in Feb), mild lymphocytosis Chem - mild hypokalemia, ALP <10, all else wnl TT4 - 2.3 ug/dL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is anechoic. The trigone and proximal urethra have a normal ultrasonographic appearance. No calculi are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic disease.

The left kidney is normal in shape and size, measuring 3.09×2.11 cm, with a cortical thickness of 0.27 cm in the sagittal plane.

The right kidney is normal in shape and size, measuring 3.24×2.00 cm, with a cortical thickness of 0.41 cm in the sagittal plane.

Both kidneys demonstrate normal cortical echogenicity. Corticomedullary distinction and corticomedullary ratio are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler interrogation demonstrates a normal vascular pattern.

Adrenal Glands

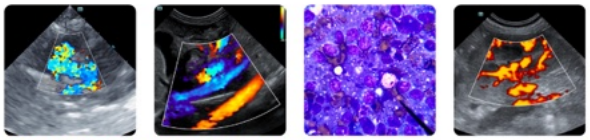
The left adrenal gland is not confidently visualized. The right adrenal gland measures 0.27 cm in dorsoventral thickness and is within normal limits.

Spleen

Splenic thickness is 0.58 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The hepatic parenchyma is extensively replaced by innumerable cystic lesions of varying sizes distributed throughout all visualized hepatic lobes. Very little normal-appearing hepatic parenchyma remains identifiable.



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The gallbladder lumen is normally distended. The wall is thin and smooth, and the contents are predominantly anechoic. No ultrasonographic evidence of cystic duct or common bile duct dilation is identified.

Gastrointestinal tract

The stomach is empty and folded, containing a small volume of luminal fluid. Gastric wall thickness measures 1.80 mm, with preserved wall layering.

The duodenum measures 2.10 mm in thickness and has preserved wall layering.

The jejunum measures 2.99 mm in total wall thickness, with mucosa measuring 1.45 mm, submucosa 0.67 mm, and muscularis propria 0.87 mm. Wall layering is preserved.

The ileum measures 3.36 mm in total wall thickness, with mucosa measuring 1.10 mm, submucosa 0.89 mm, and muscularis propria 1.10 mm. Wall layering is preserved.

The ileocecal junction is not visualized.

The colon measures 0.87-0.97 mm in wall thickness and contains a small amount of soft fecal material within the descending segment.

Pancreas

The pancreatic regions included in the examination do not show evidence of overt inflammation or neoplastic disease.

Free Abdomen

No abdominal effusion or ultrasonographic evidence of peritonitis is identified.

Cranial mesenteric lymph nodes measure 3.44-5.42 mm and are not enlarged. Ileocecal lymph nodes are not visualized. The iliac trifurcation region is normal.

PRIMARY FINDINGS

- Extensive diffuse cystic replacement of the hepatic parenchyma by innumerable cystic lesions of varying sizes, with minimal residual identifiable normal hepatic tissue.
- Mild diffuse muscularis thickening of the jejunum.
- Ileal muscularis thickening with a muscularis:mucosa ratio of approximately 1.0.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The dominant abnormality is severe diffuse cystic hepatic disease characterized by near-complete replacement of the hepatic parenchyma by innumerable cystic structures of varying sizes. Given the diffuse distribution of these lesions, together with the previously documented improvement in clinical status, bilirubin concentration, and anemia, an aggressive infiltrative hepatic neoplasm is considered

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less likely. Extensive benign cystic hepatic disease, biliary-derived cystic disorders, or a polycystic-type process are considered more likely differentials. Nevertheless, ultrasonography alone cannot definitively differentiate these entities from less common cystic infiltrative diseases.

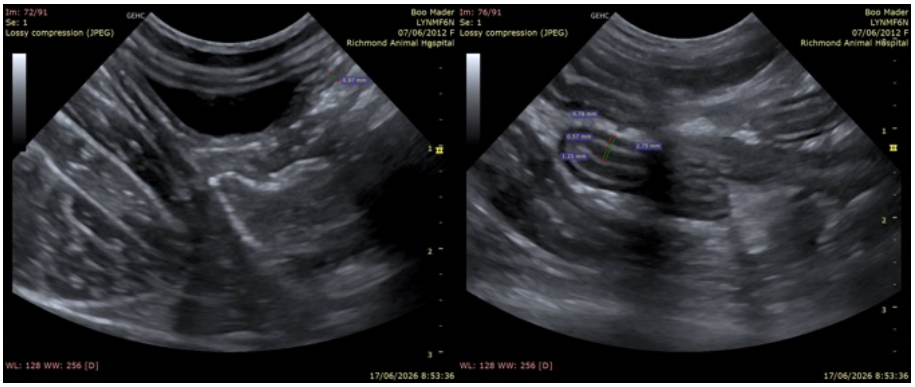
The gastrointestinal findings are subtle but potentially clinically relevant. The jejunum demonstrates mild muscularis thickening, while the ileum shows muscularis thickness approximately equal to mucosal thickness (muscularis:mucosa ratio approximately 1.0). In cats, increased muscularis thickness and muscularis:mucosa ratios are recognized features of chronic enteropathy and may be observed in both inflammatory bowel disease and low-grade alimentary lymphoma. The preservation of normal wall layering, overall normal intestinal wall thickness, absence of focal masses, and lack of significant abdominal lymphadenopathy favor a chronic inflammatory enteropathy over advanced intestinal neoplasia. However, there remains substantial ultrasonographic overlap between inflammatory bowel disease and low-grade alimentary lymphoma.

Mild colitis, mucosal disease, inflammatory lesions confined to the colon or ileocecocolic region, and other early gastrointestinal abnormalities may not be detectable ultrasonographically, particularly as the ileocecal junction could not be evaluated during this examination.

Recommendations

- Correlate the hepatic findings with prior imaging studies to assess progression or stability of the diffuse cystic hepatic disease.
- Continue monitoring serial CBC and serum biochemistry profiles, including bilirubin, liver enzymes, albumin, and electrolytes.
- Given the chronic vomiting, weight loss, low body condition score, and intestinal muscularis thickening, further investigation of chronic enteropathy may be warranted, including serum cobalamin/folate testing and a feline gastrointestinal panel if not previously performed.
- If gastrointestinal signs, weight loss, or hematochezia persist despite medical management, endoscopic or surgical intestinal biopsies may be considered to differentiate inflammatory bowel disease from low-grade alimentary lymphoma.
- Repeat abdominal ultrasonography may be useful for monitoring the hepatic cystic disease and reassessing the gastrointestinal tract if clinical signs progress.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status.



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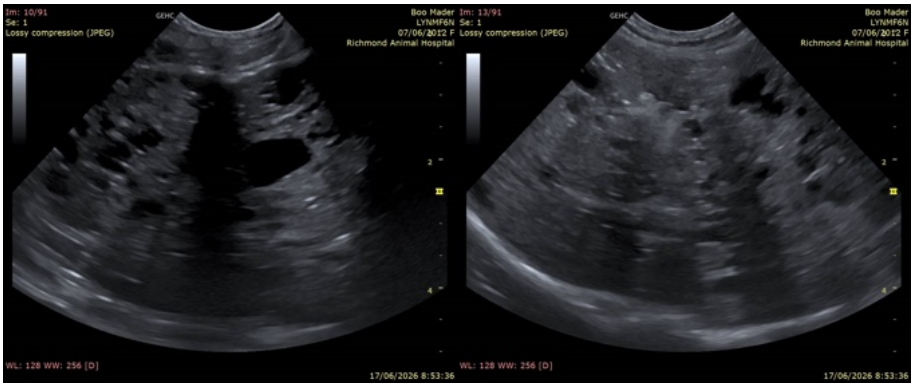

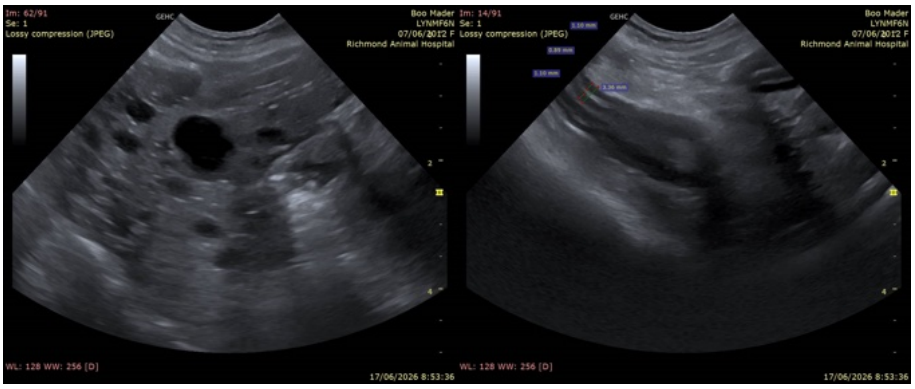

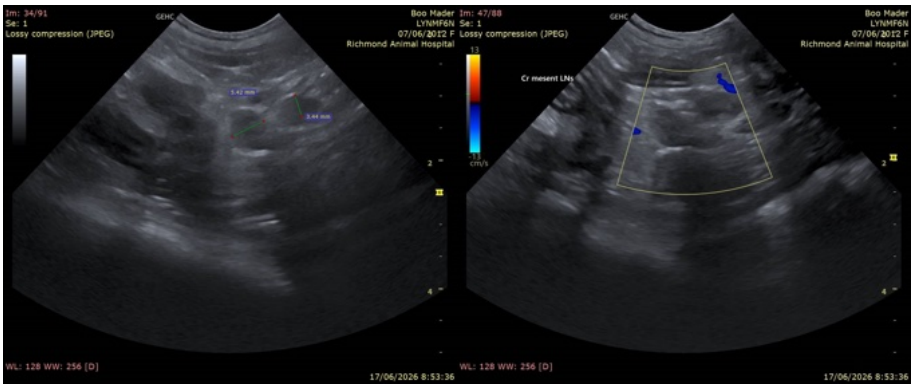

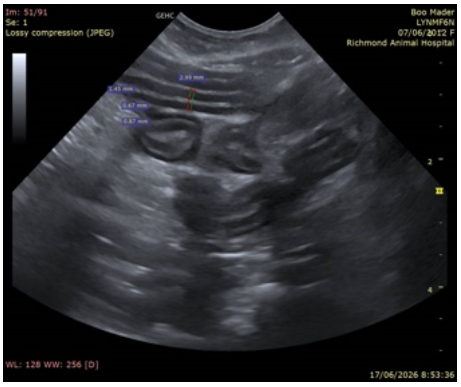

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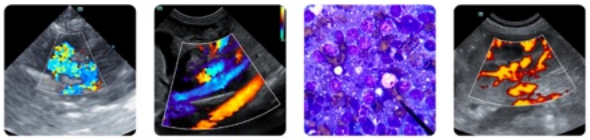

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

info@SonoPath.com