



PATIENT

Bailey Roskothen

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

12 years

WEIGHT

4.56 kg

INTERPRETED BY

Bradley Harris, DVM,
 DACVECC, DACVIM
 (cardiology)

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Clarkson Village

REFERRING VET

Dr. Mundi

INVOICE

11033

DATE

1/6/2026

PRESENTING CLINICAL SIGNS

Patient was presented last on December 21, 2025 for hyporexia, losing weight and lethargy. His physical exam was generally normal other than muscle mass loss and grade 2 periodontal disease. He has history of urinary crystals and PU surgery. Patient is now anorexic and is being syringe fed by the owner. Patient threw up today, once (01/04/2026) and had grass or plant foreign material in it. Current Medications Mirtazapine and maropitant.

Abnormal PE/Chem/CBC/UA Results: ALT 333, AST 166, ALP 87, Creatine kinase 539, Creatine 79, Magnesium 1.05, chloride 112 Radiographic Findings not performed Primary Question to Be Answered in This Exam cause of anorexia.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is minimally distended with anechoic urine. The bladder wall appears mildly thickened however, it's inadequately distended for complete evaluation. The trigone and pelvic urethra appear patent with no concern for obstruction.

The kidneys are normal in size. The cortices are hyperechoic with a loss of corticomedullary distinction. There are mild cortical cystic changes with no significant pyelectasis or pelvic dilation. The cortex to medulla ratio appears appropriate and the renal capsules are mildly irregular bilaterally. Left kidney measures 4.43 cm, and the right kidney measures 4.80 cm.

Adrenal Glands

Both adrenal glands are visualized and have normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. Left adrenal measures 0.33 cm, and the right adrenal measures 0.41 cm.

Spleen

The spleen is smooth with homogeneous parenchyma and hyperechoic to liver and renal cortical parenchyma. The capsule is without noticeable irregularity or deformation. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis. No evidence of acute or chronic inflammatory, neoplastic, or infarct are documented. The spleen measures 0.64 cm at the hilus.

Liver

The liver is subjectively enlarged, and the parenchyma is diffusely mottled with mixed hypoechoic ill-defined nodular to mass like changes. The largest of which measures 3.07 cm x 1.8 cm in the mid dorsal liver. The gallbladder has thin walls which contain anechoic bile. There is no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal. No hepatic lymphadenopathy is documented. There is no overt structural evidence of inflammatory, infiltrative or regenerative pathology evident.

Gastrointestinal



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The stomach is non-distended with normal wall thickness and layering. There is a large hypoechoic eccentric mural small intestinal mass that obliterates normal wall layering. The remainder of the small intestine appears non-distended and there is no overt evidence of a mechanical obstruction lesion at this time. There's suspected to be a second mural small intestinal mass however, it's possible that this is the distal or proximal end of the same previously mentioned mass affect.

Pancreas

The visible pancreas is enlarged and hypoechoic with irregular margins.

Free Abdomen

There is no overt lymphadenopathy noted, but a mild to moderate volume of anechoic free peritoneal effusion is noted.

ULTRASONOGRAPHIC FINDINGS

- There is increased renal cortical echogenicity and thickening with a mildly irregular capsular contour. Multifocal cystic cortical changes are noted. This is secondary cystic formation consistent with chronic age related degeneration and remodeling. There is no evidence of abscessation or suspicion of neoplasia.
- The hypoechoic mass affect within the liver is suspected to be metastatic neoplastic disease secondary to the changes within the small intestine.
- The large, hypoechoic small intestinal mass is most likely neoplastic in origin. Round cell neoplasia or carcinoma are considered the most likely possibilities.
- The hypoechoic and enlarged pancreas may represent secondary inflammation or pancreatitis given the presence of the small intestinal mass effect. However, secondary infiltrative metastatic disease cannot be completely excluded. The free peritoneal effusion is suspected to be neoplastic in origin.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urinalysis and urine culture via cystocentesis are recommended to evaluate the urinary tract changes for potential urinary tract infection.

Fine needle aspirates of the liver and small intestinal mass with cytology are recommended. A coagulation profile and platelet estimate prior to sampling are indicated to ensure the absence of coagulopathy. Occasionally some tissues are poorly exfoliative, or cytology is non-specific, in which case biopsy with histopathology may be required for a definitive diagnosis.

A gastrointestinal panel (TLI, PLI, B12, folate) via Texas A&M gastrointestinal laboratory is indicated to further evaluate for potential chronic enteropathy. Ultimately, gastrointestinal biopsies may be required for a definitive diagnosis.

Abdominocentesis with fluid analysis and cytology is also recommended to further characterize the peritoneal effusion.



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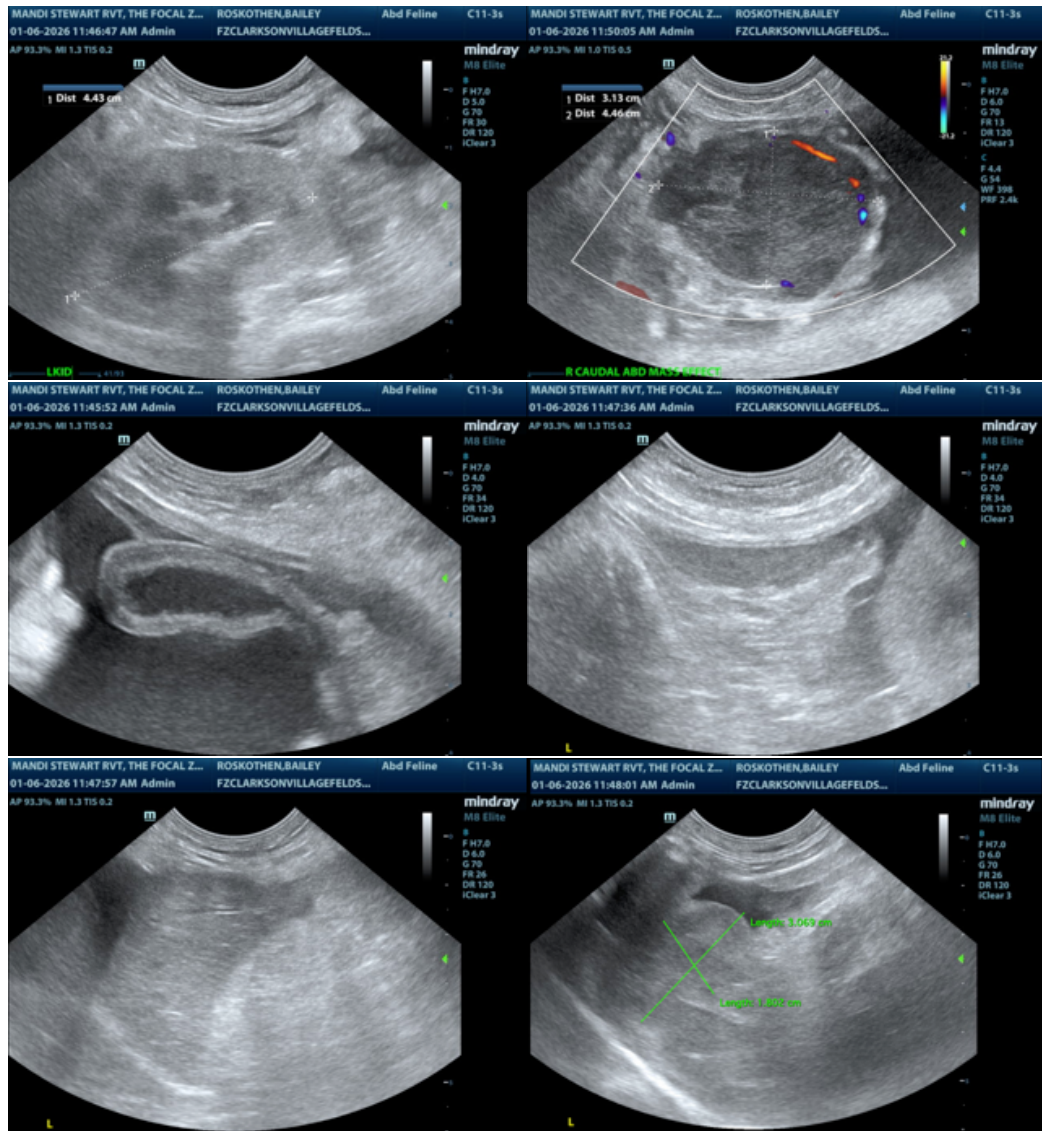
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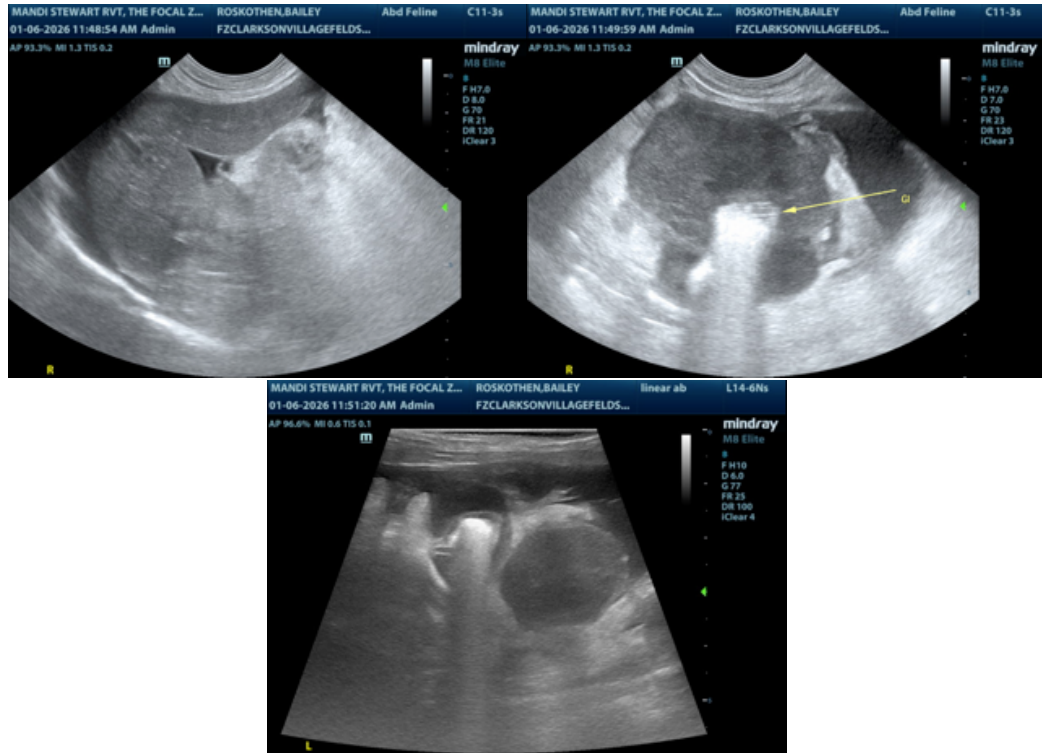
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

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