



## PATIENT

Maxine Cooley

## SPECIES

Feline

## BREED

DSH

## SEX

Spayed Female

## AGE

15 Years

## WEIGHT

11.8 lbs

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Julia Bakker, DVM

## HOSPITAL NAME

Orange Blossom  
Veterinary Imaging

## REFERRING VET

Harrison Pearl, DVM

## INVOICE

72190

## DATE

1/13/26

## PRESENTING CLINICAL SIGNS

Patient presented for evaluation of upper respiratory congestion. Physical exam revealed significant dental disease and recommended COHAT. Patient has had persistent ALT/AST elevations, most recently Dec 23rd ALT 272 (H) and AST 76 (H). Bile acids performed unremarkable. Recommended ultrasound for further evaluation of liver prior to anesthetic procedure.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a large amount of echogenic non-shadowing debris, most consistent with exfoliated cells, crystals, mucous and/or small blood clots likely combined with incidental suspended lipid. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measured 3.84 cm. Right kidney measured 3.66 cm.

### Adrenal Glands

The right adrenal gland is normal in size (0.35 cm at cranial pole and 0.43 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.27 cm at cranial pole and 0.32 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

### Spleen

Spleen measures right at the upper ends of normal limits for thickness (1.0 cm thick) with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a mildly coarse/heterogenous echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

### Liver

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. 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



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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 intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. The lumen is diffusely moderately distended with soft stool.

### **Pancreas**

Pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. No pancreatic duct dilation is noted.

### **Free Abdomen**

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

Mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

### **PRIMARY FINDINGS**

- Scalloped spleen – can be associated with benign or malignant infiltrative disease. Common causes include a reactive spleen secondary to immune stimulus or early infiltrative round cell neoplasia such as lymphoma or mast cell tumor.
- Hyperechoic hepatomegaly – This appearance is most consistent with benign hepatic lipidosis or endocrine/DM hepatopathy. Infiltrative disease such as amyloidosis or round cell neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.
- Chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- Mildly reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

### **SECONDARY FINDINGS**

- Moderate amount of echogenic urinary bladder debris.
- Age related kidney changes.

### **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

There is not a definitive ultrasonographically visible explanation for patient's reported increased liver enzymes, suggesting a microscopic or secondary reactive hepatopathy. Therefore, further recommendations include:

- T4 +/- free T4 if not already evaluated.



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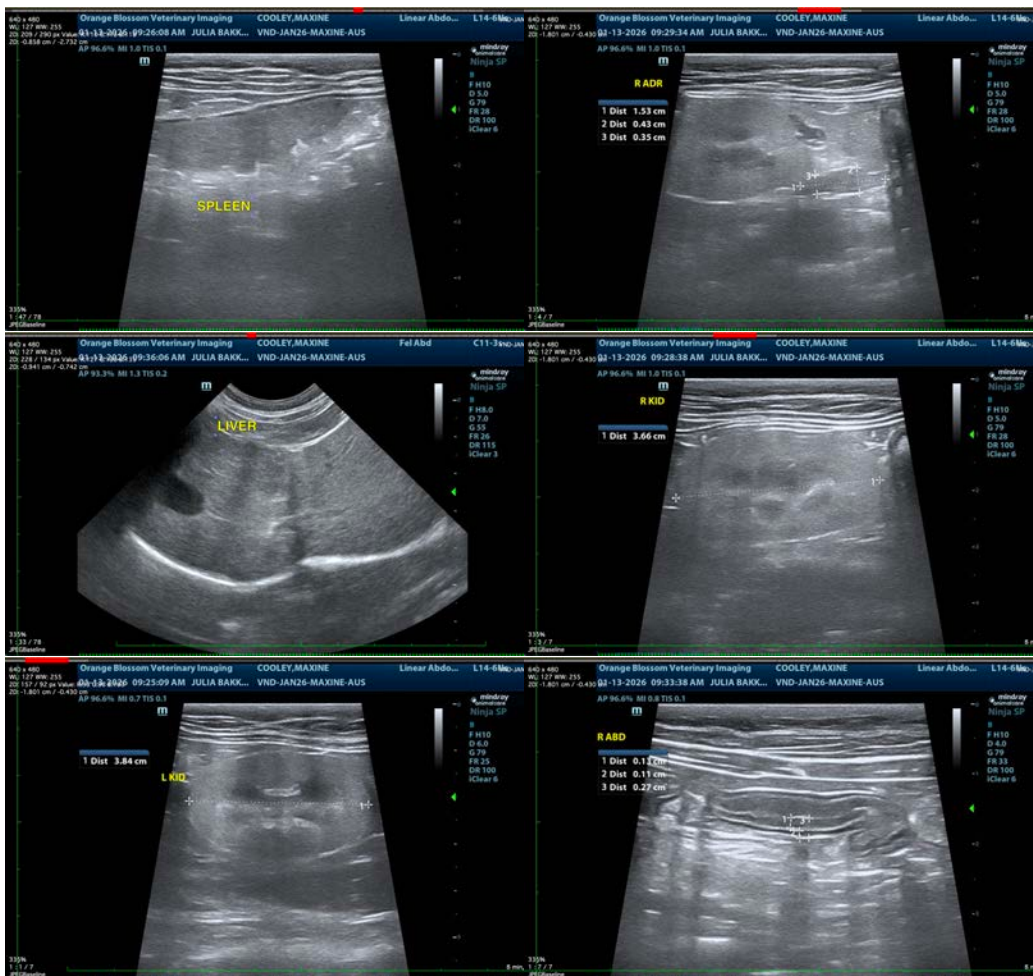
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- Fine needle aspirates of the liver, spleen +/- pancreas could be considered if patient's coagulation status is appropriate.
- A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.
- Given the findings described above, a urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.





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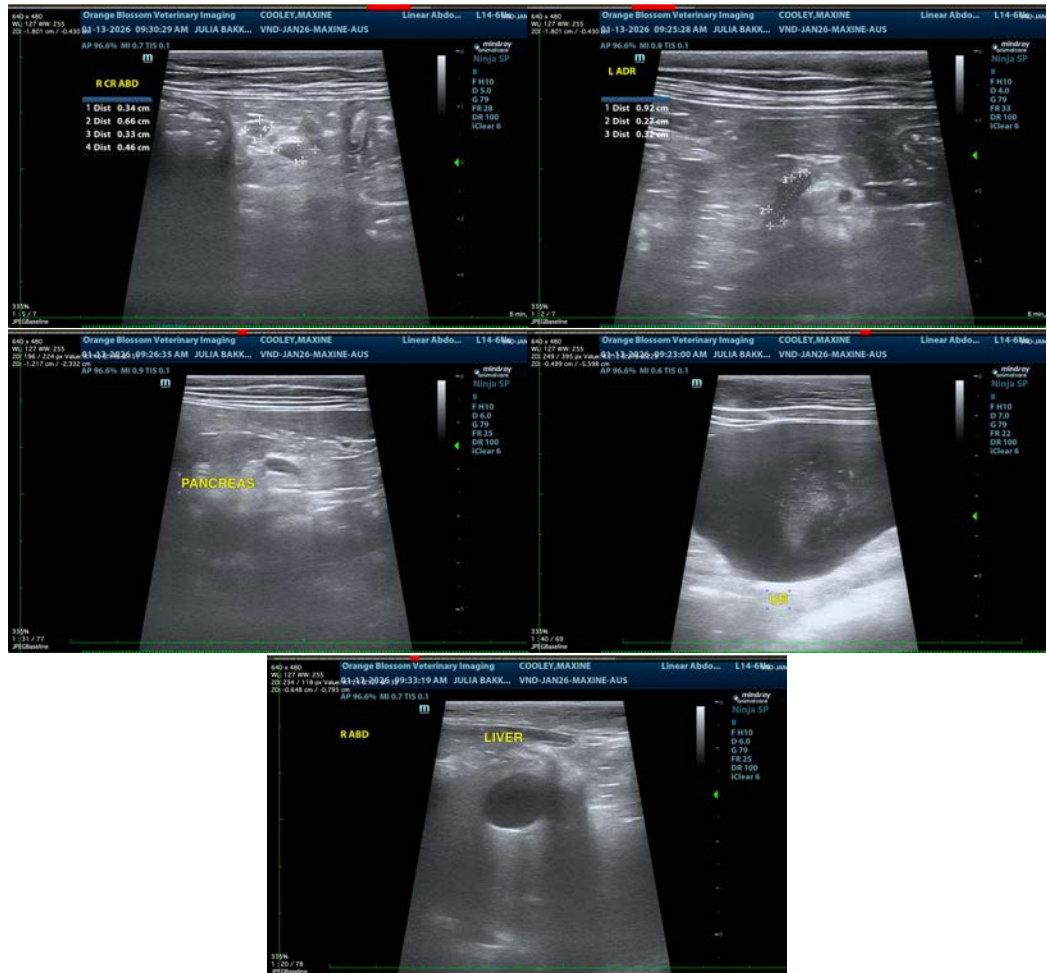
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**Beth Johnson, DVM, DACVIM**  
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