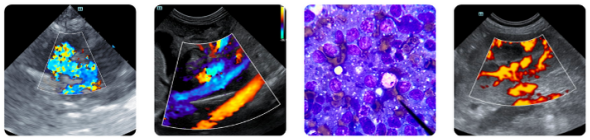


PATIENT

Gigi Eshelman

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

13 years 6 months

WEIGHT

7.8 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge Animal Hospital

REFERRING VET

Dr. Jen Makem

INVOICE

11112

DATE

1/14/2026

PRESENTING CLINICAL SIGNS

Patient given buprenex for comfort. Presented 1/7/26 for sudden abdominal distension noted at home. Appetite, activity level is good. No v/d. Radiographs: Loss of detail in abdomen and AFAST confirmed moderate to severe abdominal effusion and suspect liver mass. Bloodwork: HCT29% (L), WBC 27,000 (H), Neutrophils 24,200 (H), Eosinophils 2,300 (H), platelets adequate. Blood glucose 68 (L), liver enzymes including Tbili normal. Albumin 2.4 (N). Globulin 3.7 (N). Patient here for abdominocentesis and US today. NSF on exam except muscle wasting, weight loss (approx 2 pounds since 2023), and mod - severe abdominal distension with fluid wave. 300 mL sanguinous to serosanguinous fluid removed prior to AUS. Current meds: Prednisolone 2 mg PO BID since 1/7/26.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately 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.

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 measures 3.43 cm, and the right kidney measures 3.77 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.45 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.42 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

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.

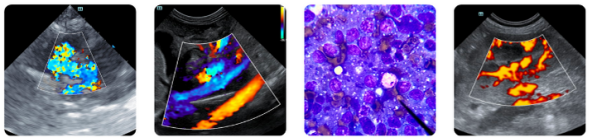
Liver

The liver contains a large 5.2 cm x 4.4+ cm in size, heterogenous, largely cystic, but primarily hyperechoic mass in the mid caudal area. The liver parenchyma surrounding the mass is normal in appearance.

The gallbladder is unable to be well visualized.

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.



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The visible small intestine demonstrates areas of moderately 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.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is a large amount of anechoic, subtly echogenic in some areas, free fluid.

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- Moderate 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 loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.
- A large amount of free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.
- The liver mass may be an incidental, benign finding in a senior cat, such as a benign biliary cystadenoma. Other benign differentials include cysts, hematomas, abscess, other. Infiltrative neoplasia such as a carcinoma versus round cell neoplasia versus other, however can't be definitively ruled out without tissue sampling.

SECONDARY FINDINGS

- Age related kidney changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

As is reportedly already pending, sampling of the free abdominal fluid for analysis and cytology is recommended, if patient's coagulation status is appropriate. Additionally, sampling via fine needle aspirate of the liver mass could be considered.

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.

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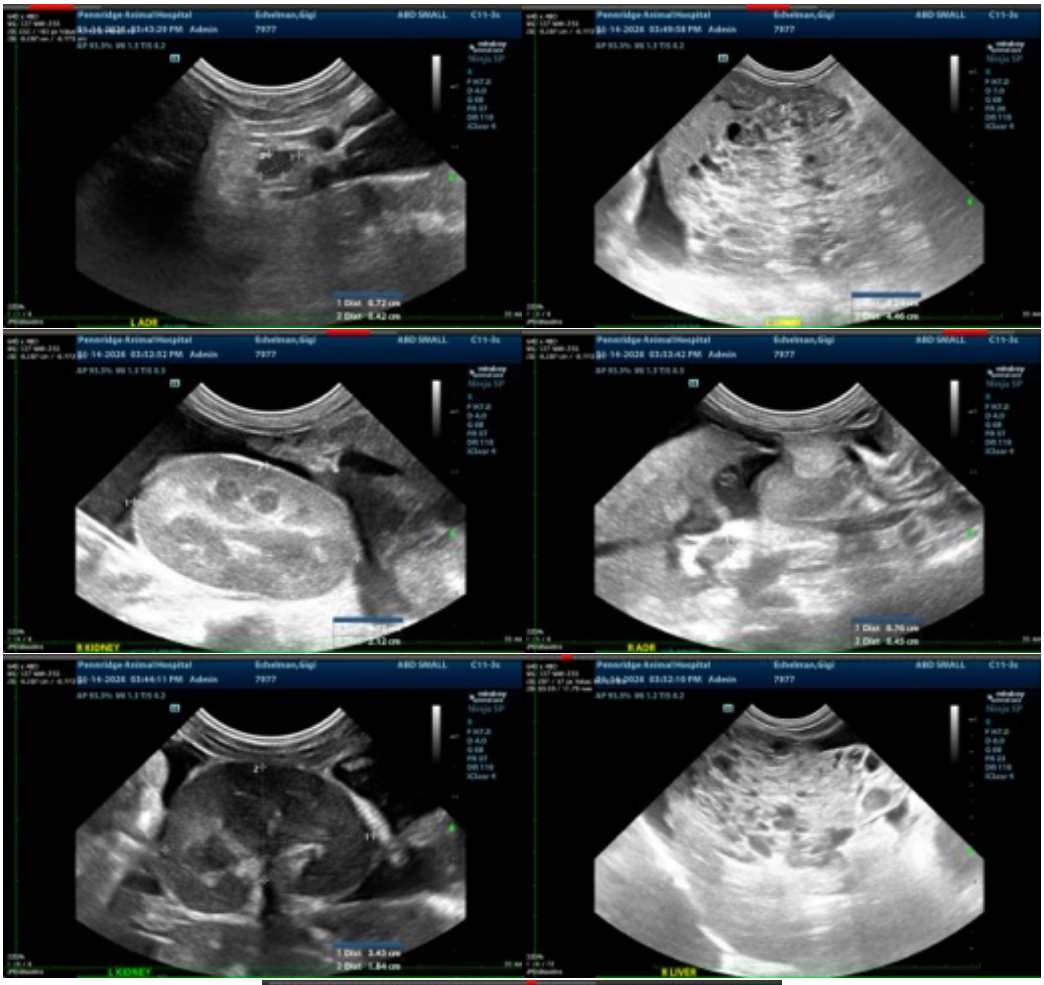
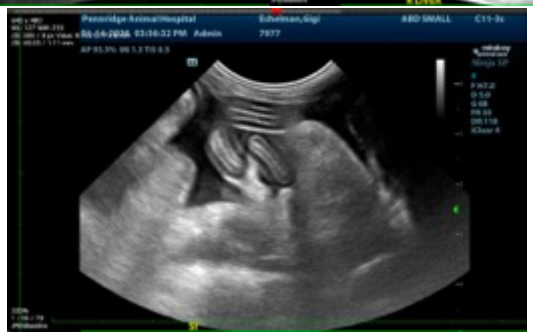
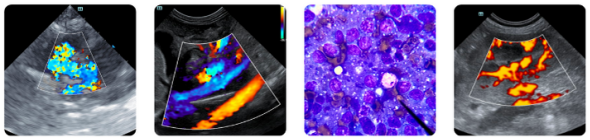
It's difficult to know the significance of the liver mass based on ultrasound alone. Therefore, other than supportive/symptomatic medical management of clinical signs, further diagnostic and therapeutic recommendations are largely dependent on results of above.

Having said that, pending fluid analysis, further cardiac evaluation i.e. echocardiogram may be warranted.





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



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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