



**PATIENT**

Ninja Meinzinger

**SPECIES**

Feline

**BREED**

DSH

**SEX**

MN

**AGE**

12 years

**WEIGHT**

4.64 kg

**INTERPRETED BY**

Beth Johnson, DVM  
 DACVIM

**IMAGING PERFORMED BY**

Kelly Reschny

**HOSPITAL NAME**

Beattie PH Stoney  
 Creek

**REFERRING VET**

Dr. Salib

**INVOICE**

11162

**DATE**

1/20/2026

**PRESENTING CLINICAL SIGNS**

Ninja presented for evaluation of clinical signs that began today. The owner reports that he did not come for breakfast this morning. Around noon to 1 o'clock, he was found hiding and hunched in the hallway in an unusual position. He was not responsive to being called, was walking gingerly, and has been hiding under the kitchen table. He has not eaten or had anything to drink today.

- Abdominal: Small firm structure in the upper part of the abdomen, possibly feces vs mass? no organomegaly or other mass effects. No pain on palpation.
- Oral: Dry lips and gums, difficult to assess color due to dark pigmentation.
- Current Medications: Ampicillin, Maropitant, Methadone all in hospital.

Abnormal PE/Chem/CBC/UA Results: Blood work: Elevated kidney values (creatinine 527), elevated pancreatic lipase, elevated white cell count (25), slightly elevated liver values (ALT 189, total bilirubin slightly elevated).

**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 occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also 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 measures 4.19 cm, and the right kidney measures 4.71 cm.

**Adrenal Glands**

The right adrenal gland is normal in size (0.46 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.33 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 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



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homogenous in echotexture. 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**

In the right to mid cranial abdomen there is approximately 2.2 cm x 3.5 cm largely solid, irregularly shaped, hypoechoic mass. That appears to surround bowel at a junction. I believe this mass involves the ileocecal colic junction. Although other small bowel and even in some views the pylorus, while thought less likely, can't be definitively ruled out. Other than that, the stomach 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 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 no visible free peritoneal effusion noted in these images.

Mesenteric lymph nodes are enlarged with swollen irregular capsular contour and loss of normal length to width ratio (rounded in shape). Nodes are hypoechoic with loss of normal parenchymal detail.

**PRIMARY FINDINGS**

- The bowel mass, which as described above, I suspect above the ileocecal colic junction, although other locations can't be definitively ruled out, is concerning for infiltrative neoplasia such as round cell neoplasia i.e. lymphoma versus carcinoma versus other. Especially given the concurrent adjacent lymphadenopathy. A benign inflammatory process can't be ruled out but is considered less likely.

**SECONDARY FINDINGS**

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

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**



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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 ration is recommended.

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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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Fine needle aspirates of the bowel mass, as well as the enlarged lymph nodes are recommended if patient's coagulation status is appropriate.

**SEX**

MIN

If a cytologic diagnosis is unable to be obtained, or that diagnosis warrants surgery, and an exploratory laparotomy is elected, a presurgical planning abdominal CT Scan could be considered and/or consultation with a veterinary surgeon advised.

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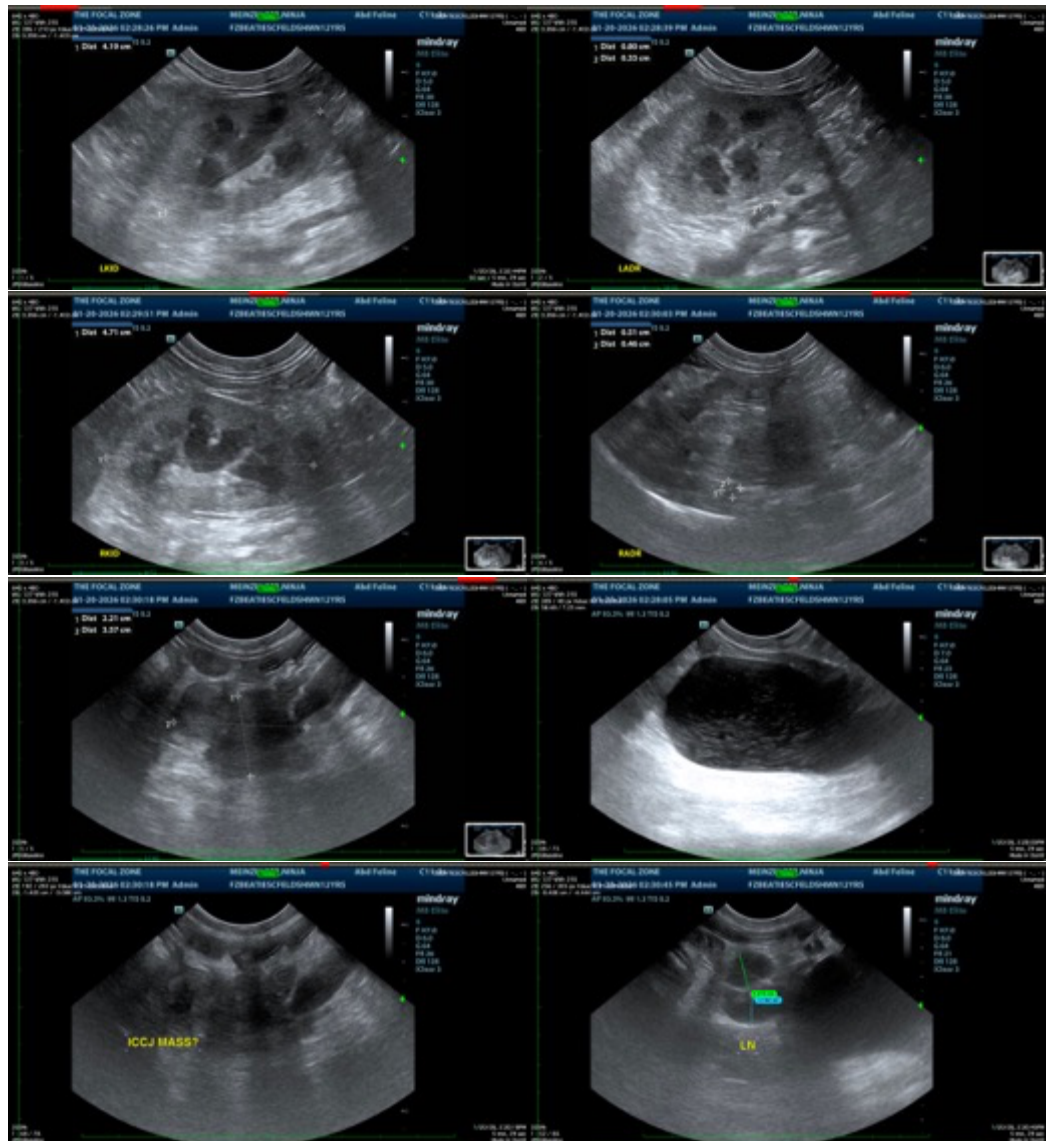
Dr. Salib

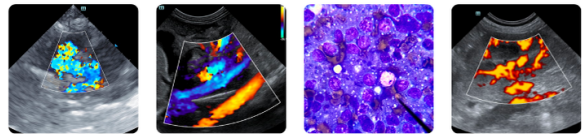
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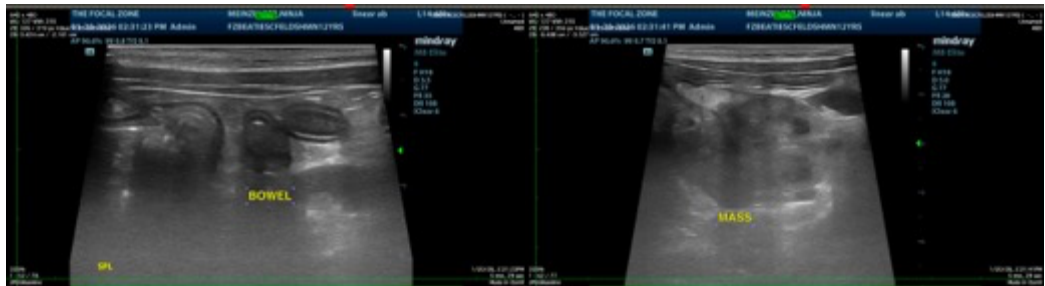
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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