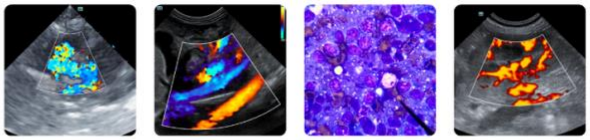


PATIENT

Bella Sandstrom

SPECIES

Feline

BREED

Siamese Mix

SEX

Spayed Female

AGE

15 Years

WEIGHT

11.7 Pounds

INTERPRETED BY

Beth Johnson, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Jessica Boudreaux-Milligan, DVM

HOSPITAL NAME

Dockside VI

REFERRING VET

Audry Frana, DVM

INVOICE

35598

DATE

1/26/26

PRESENTING CLINICAL SIGNS

- History of renal insufficiency, recent diabetes diagnosis (currently taking Senvelgo)
- Just diagnosed with malignant epithelial neoplasm carcinoma from new mammary bump. Discussed lumpectomy with owner, Abdominal U/S to see if pet is a candidate for surgery. Recommend Abdominal U/S with x-rays.
- rDVM requesting IM specialist opinion on rads attached to this study for any possible evidence of metastatic spread

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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.

Left kidney is uniformly enlarged/swollen (3.87 cm) with an overall hyperechoic echogenicity and slight loss of corticomedullary definition. Normal smooth peripheral margination and shape are maintained. The renal pelvis are dilated with anechoic fluid and hyperechoic thickened pelvic fat. No overt evidence of neoplasia or mineral is observed. The perinephric area is enhanced by hyperechoic fat and mesentery.

Right kidney is large in size (4.21 cm) with increased cortical echogenicity and disruption of normal corticomedullary architecture, as well as a hypo- to almost anechoic appearing mildly heterogenous nodule, resulting in an irregular shape. The nodule measures 1.3 cm x 0.8 cm in size. In some views, there also appears to be a very subtle, almost hypoechoic rim or “halo” surrounding the kidney. The pericapsular area on the right side is also enhanced by hyperechoic fat and mesentery. No mineral is observed.

Adrenal Glands

Left adrenal gland is normal in size (0.3 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

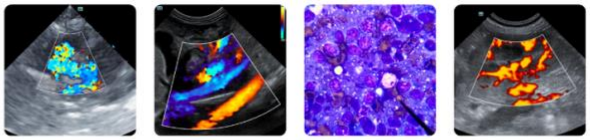
Right adrenal gland is normal in size (0.3 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a mildly coarse/heterogenous echotexture. Additionally, at least one discrete homogenous non-capsule-disrupting hyperechoic nodule is noted in the spleen. 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



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lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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

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. Contents are consistent with normal formed feces and gas.

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.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- The kidney changes could represent benign chronic kidney disease with some concern for possible pyelonephritis, at least in the left kidney. Although given the concern for possible nodule in the right, as well as the large size and the suspicion for possible emerging “halo” sign, infiltrative neoplasia, at least affecting the right kidney, including round cell neoplasia, such as lymphoma, metastatic neoplasia versus other, can’t be ruled out without tissue sampling. Having said that, benign cyst, hematoma, abscess versus a neoplastic nodule in the right kidney is equally possible.
- 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 splenic nodule- most consistent with benign myelolipoma. Other differentials such as fibrosis or calcification caused by old hematoma or infarct, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.
- 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.

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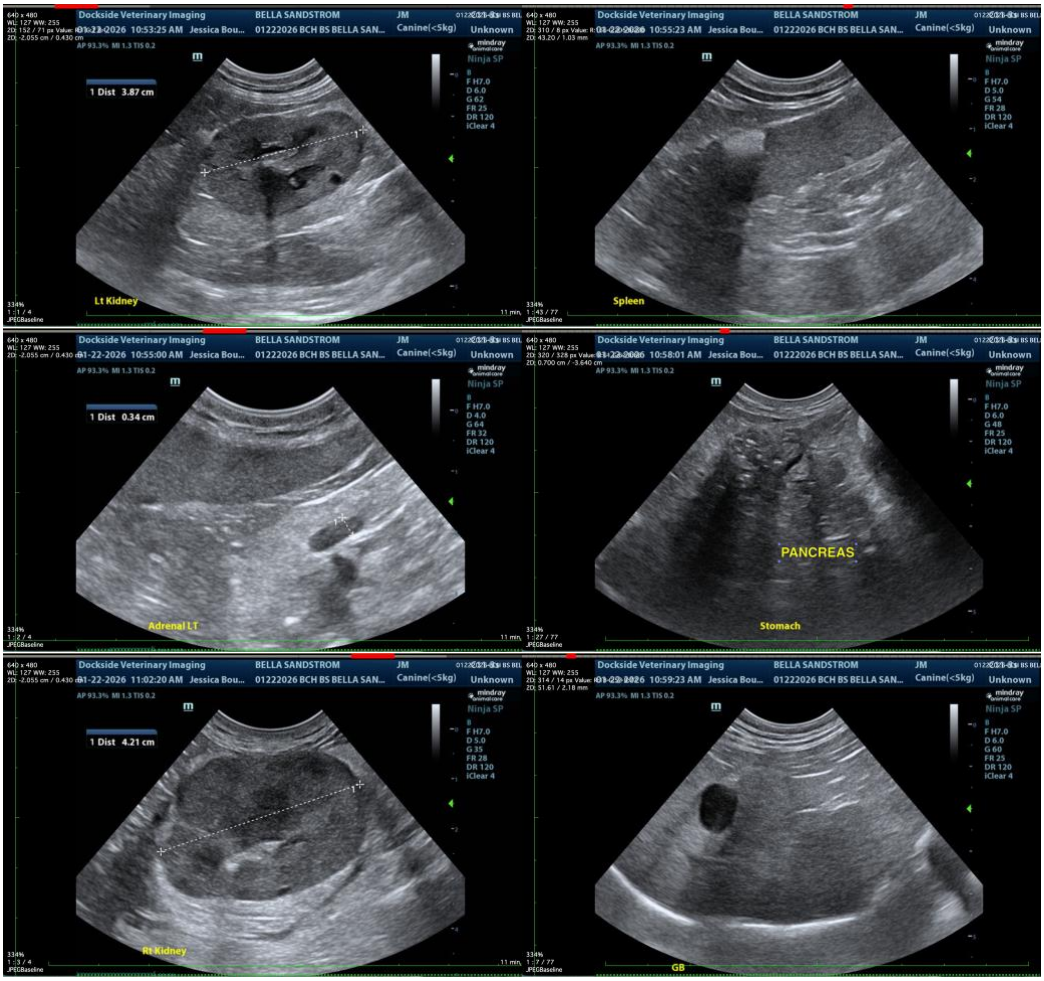
- Concurrent chronic low grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Tissue sampling is recommended to further investigate/rule out infiltrative neoplasia, including metastatic disease. Therefore, fine needle aspirates of the spleen, liver, and kidneys especially the right kidney nodule, if possible, are recommended if patient's coagulation status is appropriate.

If there is any concern for pulmonary metastatic disease or questions regarding that, submission of three view thoracic radiographs for radiology review is recommended.

Additionally, in the meantime, or after obtaining work up results, consultation with a veterinary oncologist could be considered.



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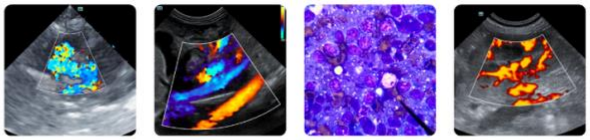

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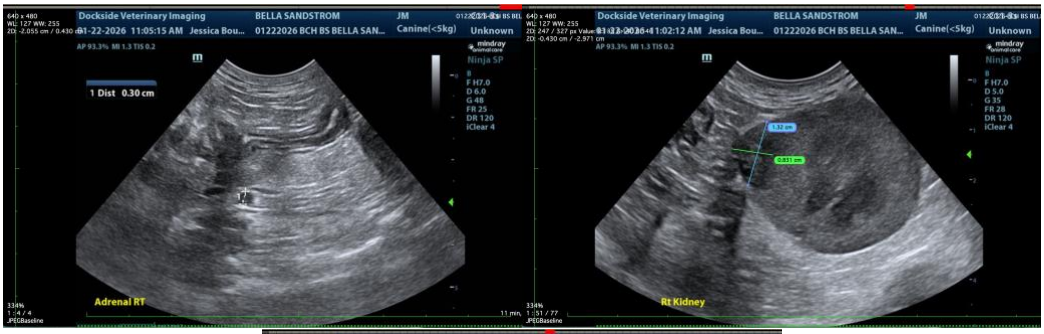

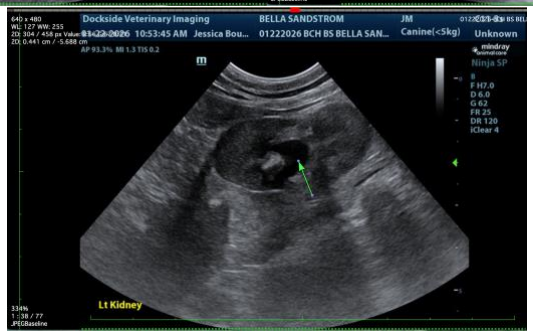

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

info@sonopath.com