



PATIENT

Bobby Morrissette

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

11 Years

WEIGHT

13.7 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Jessica Bailes

HOSPITAL NAME

All Creatures Great &
Small Veterinary Clinic

REFERRING VET

Dr. Jessica Bailes

INVOICE

72568

DATE

1/28/26

PRESENTING CLINICAL SIGNS

Acute onset lethargy 2 weeks ago. Prior hx of FIV positive status, diabetes mellitus, FM extractions. Initial exam 1 week ago - patient febrile @ 103.5; was hypoglycemic @ home that morning (51 mg/dl). Initial labs = mild NR anemia, neutrophilia and mild hypoproteinemia. Lack of improvement despite convenia, SQF, mirtazipine and cerenia. Re - examined 5 days later - patient visibly icteric w/ ascites on AFAST

Abnormal PE/Chem/CBC/UA Results: Icteric, no teeth, distended abdomen, otherwise NSF on PE Initial labs: Chem: Alb 2.3, SDMA 17.3, BG 65. All other UR. CBC: MCV 33, Hct 26, Hgb 8.2, WBC 18.6, Neut 15624. Retic 32600. All other UR. UA: USG 1.053. > 50 RBC (cysto). 2-3 bili crystals. Otherwise IS. Thoracic/abdominal rads : Thorax clear, decreased serosal detail abdomen; 4/4 positive AFAST - icteric fluid obtained Recheck labs: CHEM: decreased ALB(2.0), increased AST (138), increased Amylase (2110), hyperglycemia (333), mild increase SDMA (17.6), hyperbilirubinemia (5.0) - ALB WNL but A/G ratio = 0.4 CBC: non - regenerative anemia (HCT = 27% - retic count = 0.3%), leukocytosis (19.6) w/ neutrophilia (18,620) w/ L shift (196), lymphopenia (784), thrombocytopenia (28K) w/ decreased estimate - clots noted

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.

The left kidney is significantly enlarged in size (5.83 cm) with increased cortical echogenicity and disruption of normal corticomedullary architecture caused by multifocal heterogenous (primarily hypoechoic) nodules. A hypoechoic subcapsular rim "halo" is present. The pericapsular area is enhanced by hyperechoic fat and mesentery. No mineral is observed.

The right kidney is irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. The right kidney is normal in size at 4.028 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.20 cm at cranial pole and 0.30 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.20 cm at cranial pole and 0.20 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size (1.1 cm thick at the hilus) with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.



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Liver

Liver is subjectively enlarged (swollen contour). Mild parenchymal remodeling with diffusely mildly coarse architecture and increased portal markings is present. No focal nodules or masses are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. Multiple non-visibly obstructive mineral densities are noted within the gallbladder and throughout the intrahepatic biliary system. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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

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 moderate amount of free fluid present in these images as well as enhanced hyperechoic mesentery and fat, primarily adjacent to the kidneys, especially the left kidney.

There is no apparent pathologic lymphadenopathy noted in these images.

Assessment of heart base images is included when/if a splenic nodule/mass is present (as a complimentary add on). They are also assessed when a specific request is made for assessment of a limited second cavity (heart base and/or thorax) for an additional charge. Images of the heart (and/or) thorax were not assessed for this study. Please contact us if you would like a second cavity.

ULTRASONOGRAPHIC FINDINGS

- Renal lymphoma – This appearance is highly suggestive of renal lymphoma. Other malignant neoplasia, severe nephritis and feline infectious peritonitis can at times mimic this presentation. **This change is most significant in the left kidney.*
- Splenomegaly– can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.



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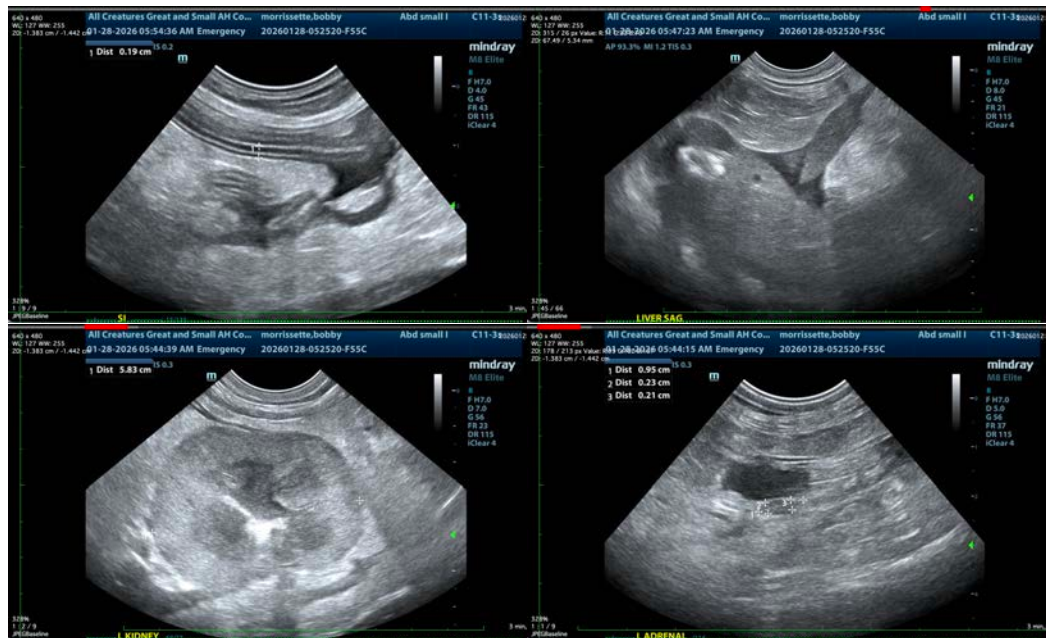
- Hypochoic hepatomegaly – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.
- The moderate amount of free fluid is of unknown origin. Differentials (unless already ruled out) could include increased 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.
- Moderate gallbladder debris – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness, however, it can also be associated with hepatobiliary disease in cats and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili. Non-visibly obstructive choleliths are suspected.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

While a benign infectious or inflammatory process is possible, especially given patient's history, recommendations are to further investigate/rule out infiltrative round cell neoplasia such as lymphoma if possible, beginning with fine needle aspirates of the left kidney, spleen, and liver if patient's coagulation status is appropriate.

Additionally, sampling of the free abdominal fluid is recommended.

In the meantime, treatment recommendations include fluid therapy, anti-emetics, gastroprotectants, hepatic nutraceuticals such as ursodiol and/or Denamarin, and broad-spectrum antibiotics. Nutritional support is critical to prevent/manage concurrent hepatic lipidosis, so appetite stimulants and/or, if indicated, feeding tube placement is also recommended.





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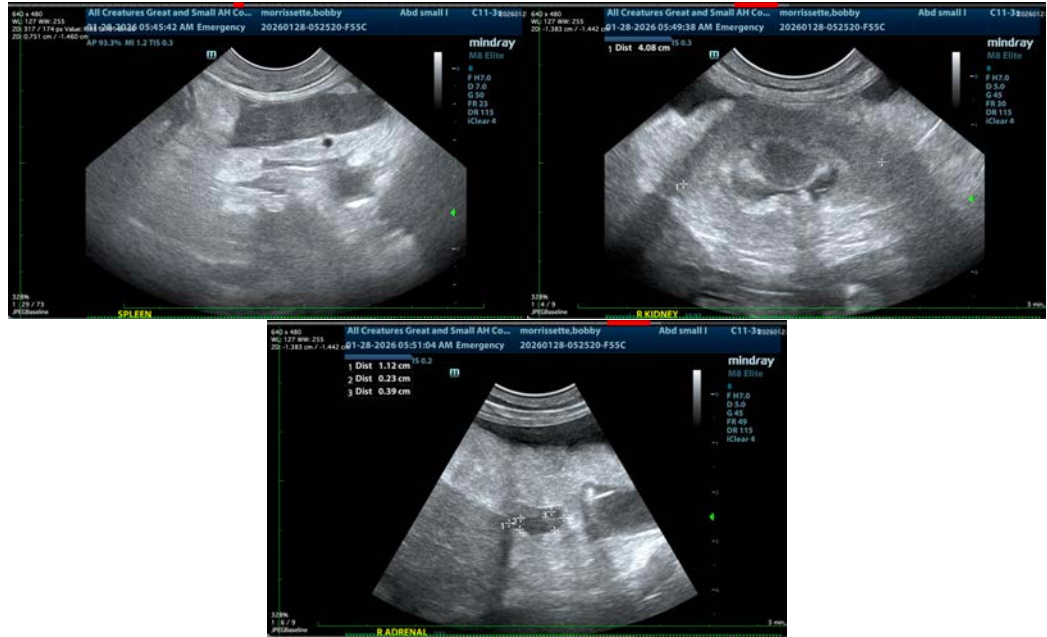
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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