



PATIENT

Ginger Rhodes

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

18 years

WEIGHT

3.63 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Loetitia Saint-Jacques,
LVT

HOSPITAL NAME

Grass Valley Veterinary
Hospital

REFERRING VET

Dr. KAC

INVOICE

11192

DATE

1/28/2026

PRESENTING CLINICAL SIGNS

- Presented for V and D. P has been V off and on, the last time P V was yesterday. P has been vomiting up food after eating for about 4 years now. P also goes through bouts of normal stool and D. P also poops around the house, this has been an on going issue as well. P also had a cyst drained back in october, O said the growth has grown again. O wondering if the cyst is causing these symptoms. Appetite normal, water intake seems normal. O has a fountain for P so he is unsure how much water P actually drinks. P was on zenoquin back in october, this was for UTI seen on annual bloodwork and urine with coccibacillus . O finished a full course and then picked up another script. O never finished giving the second round, O claims she stopped giving at the end of december. Indoor only.
- As reviewed prior history: 2023 abd US that revealed thickened bowel loops and early IBD/lymphoma even suppossed then: long history of chronic V& D and diarrhea is real problem now as pooping in house with gradual weight loss over last 2-3 years from 11# to 8 # Also on urine and blood repeated issues with either UTI or more likely pylonephritis responsive to marbofloxin which owner has rx for that never used . Told worried as tretment IBD with prednisolone could make this issue worse but ideally would repeat blood and urine for progression and abd US to see if different as to how to medicate

Abnormal PE/Chem/CBC/UA Results: Na/K Ratio 31 LOW PrecisionPSL 56 HIGH Lymphocytes 18 LOW Absolute Lymphocytes 1170 LOW pH 7.5 HIGH RBC >50 HIGH Microalbuminuria 15.9 HIGH Na/K Ratio 31 LOW PrecisionPSL 56 HIGH Lymphocytes 18 LOW Absolute Lymphocytes 1170 LOW.

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 irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. Mild pyelectasia is noted bilaterally, as is hyperechoic thickened pelvic fat. Additionally, punctate non-obstructive nephroliths are noted bilaterally. Left kidney is small in size measuring 3.27 Right kidney is small/normal in size measuring 3.48 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.39 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.32 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



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Liver is subjectively enlarged with mildly irregular margins. Parenchyma is moderately heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. 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

The visible stomach wall is normal in thickness and layering, except for just past the lower esophageal inlet where there appears along what I believe is the lesser curvature to be an intramural 0.9 cm x 1.1 cm hypoechoic nodule/density. 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 moderate 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. While there's no definitive loss of layering, in at least two spots there's a focal area of jejunum with a slightly thicker muscularis than the remaining bowel creating a nodular appearance. One measures 0.8 cm x 0.4 cm. One measures 0.2 cm x 0.6 cm.

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. In the left limb there is an approximately 0.5 cm x 0.2 cm in size hypoechoic nodule.

Free Abdomen

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

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

- While there's no definitive loss of layering within the small bowel or stomach, the nodular appearance in both organs is concerning for early or emerging infiltrative round cell neoplasia such as lymphoma versus other. Having said that, a benign inflammatory process cannot be ruled out without tissue sampling.
- Similarly, the pancreatic nodule could represent infiltrative neoplasia but benign pancreatic nodular hyperplasia versus cyst versus other can't be ruled out without tissue sampling.



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- The liver changes are subtle and non-specific with both benign microscopic hepatopathies including bacterial or lymphoplasmacytic cholangiohepatitis, hepatic lipidosis, other chronic inflammatory or infectious hepatopathy versus infiltrative round cell neoplasia such as lymphoma, all being differentials.
- The appearance of the kidneys is consistent with emerging chronic kidney disease. Potentially, given the pyelectasia and pelvic fat, chronic pyelonephritis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

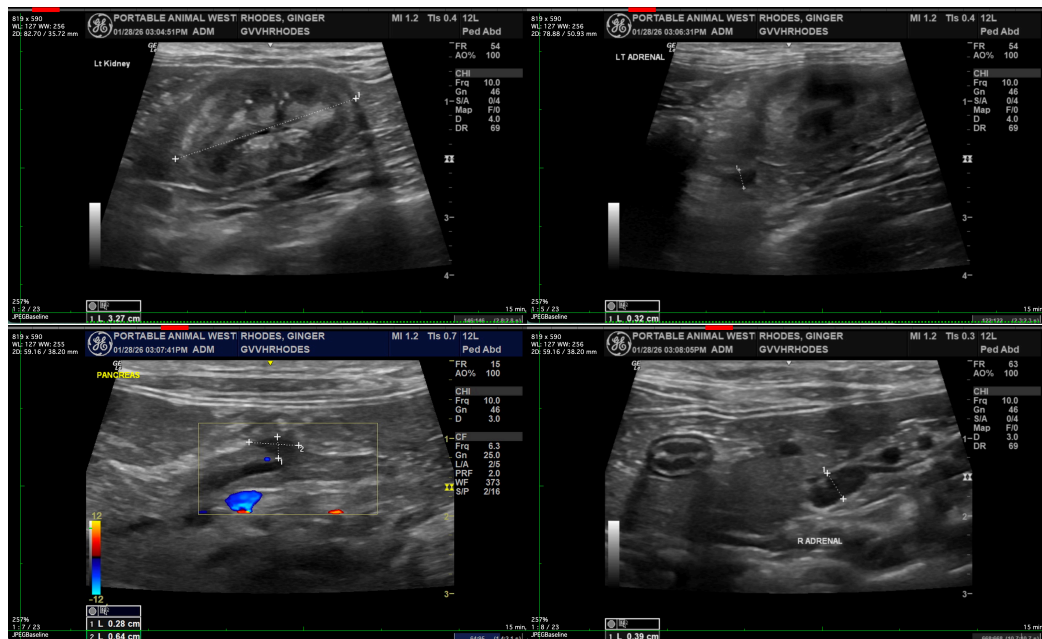
Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

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.

If not recently evaluated, 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 ration is recommended.

Ultimately, tissue sampling is recommended. Fine needle aspirates of the gastric nodule +/- the liver +/- if they can safely be reached, but they may not be able to be reached, the focal jejunal nodules and pancreatic nodule could be considered if patient's coagulation status is appropriate. If a cytologic diagnosis is unable to be reached, however, biopsies of the areas may be necessary.

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



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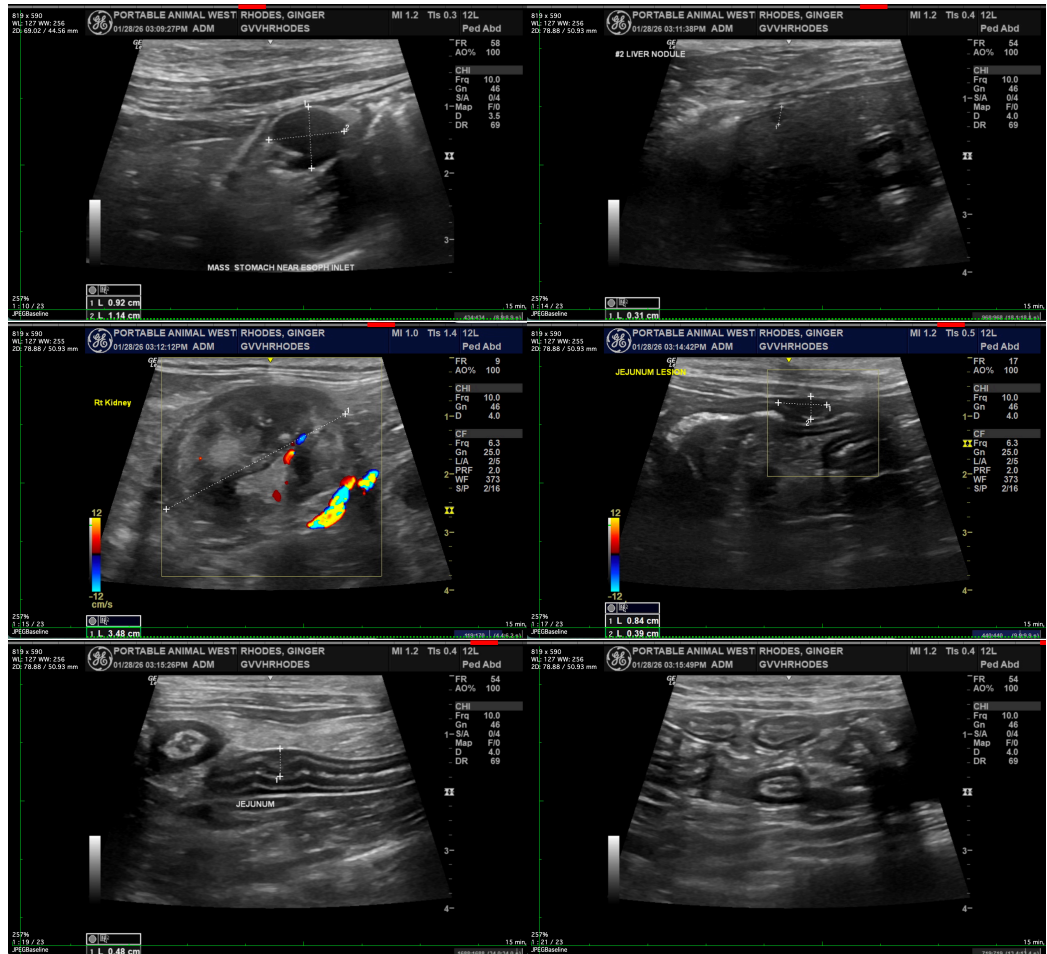
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@sonopath.com