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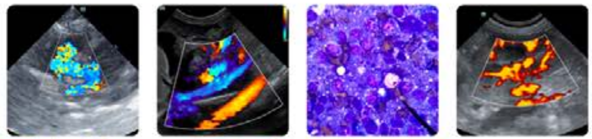


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT
Bella Weitering

SPECIES
Feline

BREED
DLH

SEX
Spayed Female

AGE
112 Years

WEIGHT
4.2 kg

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Dr. Goeresq

HOSPITAL NAME
Kelowna Veterinary Hospital

REFERRING VET
Dr. Forwood

INVOICE
72998

DATE
1/6/26

PRESENTING CLINICAL SIGNS

Gradual weight loss since dental last year (BW at that time was normal). This past week has not been eating or drinking much at all. Vomiting past 3-4 days. Very lethargic. Blood work showed mild-moderate non-regenerative anemia and thrombocytopenia, biochem NSF. Current tx: Cerenia 8mg SID, mirtazapine 1.88mg SID.

Abnormal PE/Chem/CBC/UA Results: Thin and muscle wasting very pale MM no bruising or petechiations HCT 24% Monocytes 2.76 x10^9/L Platelets 55 x10^9/L

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses or inflammatory changes are observed. A punctate 0.30 cm in diameter echogenic density/suspect cystolith is noted, settled along the dependent wall. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are bilaterally small, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. Left kidney is small-normal at 3.3 cm. Right kidney is small at 3.1 cm.

Adrenal Glands

The right adrenal gland is unable to be well visualized in these images.

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

Spleen

Spleen is subjectively large in size (1.5 cm thick at the hilus) with normal smooth margins. Parenchyma is normal in echogenicity with a diffusely coarse/heterogenous echotexture. No discrete sizable focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

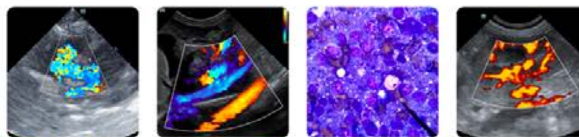
Liver is subjectively enlarged with mildly irregular margins. Parenchyma is moderately heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion

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. 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.



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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 trace/scant amount of free fluid noted in these images, primarily in the caudal abdomen adjacent to the urinary bladder.

Lymph nodes are diffusely 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

- Coarse 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.

- The liver changes are moderate in nature but non-specific and could similarly indicate a benign microscopic hepatopathy such as bacterial or lymphoplasmacytic cholangiohepatitis, hepatic lipidosis, other, or infiltrative neoplasia with round cell neoplasia such as lymphoma being a top differential. These differentials can't be differentiated without tissue sampling.

- Diffusely aggressive lymph nodes – concerning for infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.

- The trace/scant 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.

SECONDARY FINDINGS

- Mild to moderate chronic kidney disease changes.
- Suspect small urinary bladder cystolith.

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, fine needle aspirates of the spleen +/- liver +/- enlarged lymph node are recommended if patient's coagulation status is appropriate.

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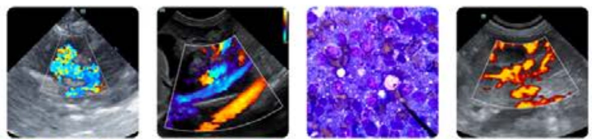

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A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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

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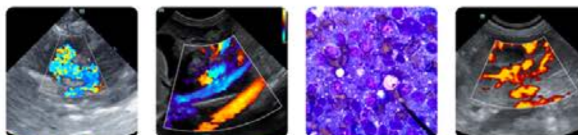

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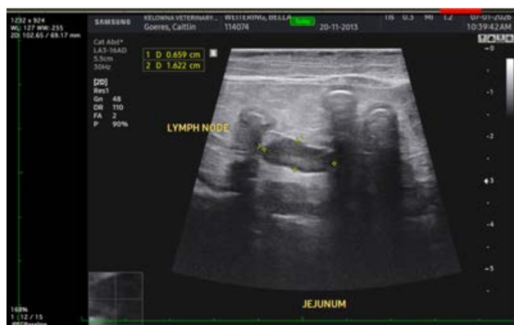

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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