



PATIENT

Oliver McQuaide

SPECIES

Feline

BREED

DSH

SEX

Male Neutered

AGE

3 years

WEIGHT

9.8 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Keisha Smitley, CVT

HOSPITAL NAME

Geary Veterinary
Services

REFERRING VET

Dr. Curtis Geary

INVOICE

11040

DATE

1/7/2026

PRESENTING CLINICAL SIGNS

Patient was seen yesterday from another vet. Patient was diagnosed with an abdominal mass in November. Patient has been losing weight and is now barely eating and is lethargic with a fever.

Abnormal PE/Chem/CBC/UA Results: Total Protein and Globulins Elevated Albumin Low Eosinophils elevated BW attached.

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. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measures 3.99 cm, and the right kidney measures 3.97 cm.

Adrenal Glands

The adrenal glands are unable to be well visualized in these images.

Spleen

Spleen is subjectively large in size (2.0 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.

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 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

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 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,



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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. *See other*

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.

Other

In the mid abdomen, is an approximately 5.6 cm in diameter, mixed heterogenous, largely hyperechoic mass that appears to originate from bowel. Although, specific location of bowel is difficult to determine. Other there's no definitive lymphadenopathy, and there is no free fluid noted in these images at this time.

ULTRASONOGRAPHIC FINDINGS

- The mid abdominal/suspect bowel mass could represent a benign inflammatory or infectious change, granuloma versus other. Although, infiltrative neoplasia such as round cell neoplasia, i.e. lymphoma, carcinoma, other, are also possible and can't be differentiated without tissue sampling.
- Diffusely moderate inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.
- 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 kidney changes are mild/subtle and can be seen in a senior cat, although are atypical in a 3-year-old cat, concerning for some possible early or emerging chronic kidney disease. This finding should be interpreted in combination with lab work, urinalysis results, etc.
- A mild amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the bowel mass, splenomegaly, etc., recommendations are to further investigate/rule out infiltrative neoplastic disease, if possible, via tissue sampling. Therefore, fine needle aspirates of the mass, as well as the spleen, are recommended if patient's coagulation status is appropriate.

Ultimately, however, is a cytologic diagnosis is unable to be obtained, an exploratory laparotomy for excisional biopsy may be necessary. If pursued, a presurgical planning abdominal CT scan could be



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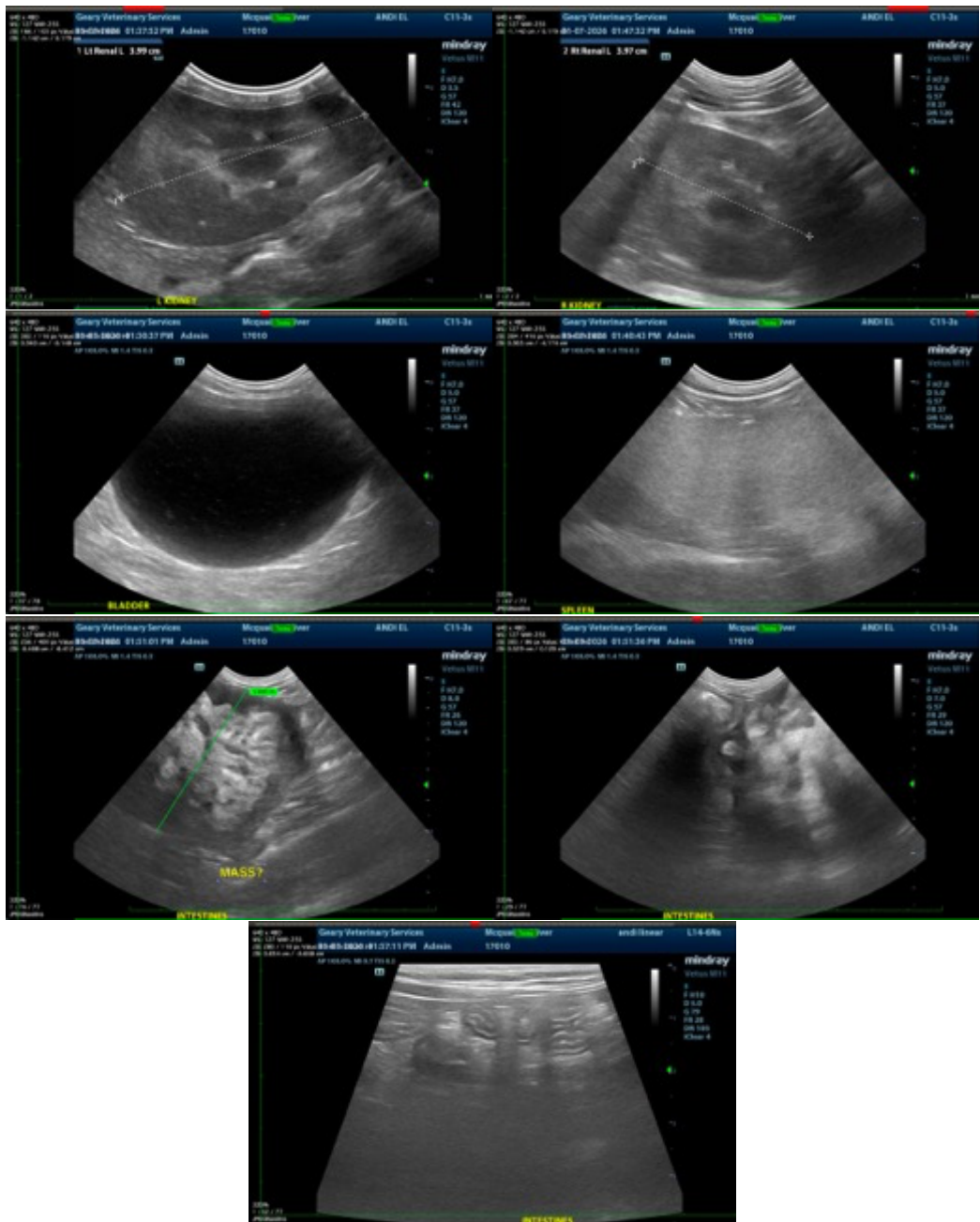
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considered to further localize the mass.

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



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.



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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