



PATIENT

Rose Lemme

SPECIES

Feline

BREED

DLH

SEX

Spayed Female

AGE

12 Years

WEIGHT

2.81 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Jill Rankin

HOSPITAL NAME

Elizabeth Street Pet
Hospital

REFERRING VET

Dr. Pavol

INVOICE

71961

DATE

11/19/25

PRESENTING CLINICAL SIGNS

This feline patient presents with a history of non-regenerative anemia and abdominal abnormalities, including hepatomegaly and a suspected hepatic mass, discovered during a workup for a planned mass removal surgery. During a visit originally scheduled for a mass removal, diagnostic imaging revealed multiple abdominal concerns. Radiographs showed a loss of serosal detail, hepatomegaly, distended colon, and spondylosis. An abdominal AFAST scan was also performed, which suggested the presence of a possible hepatic mass and distended ducts within the gallbladder. Following these findings, an abdominal ultrasound was booked for further evaluation. Concurrent blood work supported the imaging findings, revealing a non-regenerative anemia and an elevated Alanine Aminotransferase (ALT), consistent with potential liver pathology.

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 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, expected in this age patient. There is no evidence of infarcts observed. Left kidney measures 3.1 cm. Right kidney measures 3.7 cm. Mild to moderate pyelectasia is noted bilaterally. Additionally, punctate non-obstructive nephroliths are noted bilaterally.

Adrenal Glands

The right adrenal gland is normal in size (0.41 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The area of the left adrenal gland is examined without visible adrenal gland pathology.

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

The liver is subjectively enlarged with mildly irregular margins. Parenchyma is mottled by multifocal discrete, homogeneous, hyperechoic nodules of varying sizes, some with a subtly hypoechoic center. 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. The wall is smooth without visible thickening. The cystic and common bile duct are diffusely tortuous without visible pathologic distention noted in these images at this time.



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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. Hyperechoic mucosal fogging or speckling is noted. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

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.

Mesenteric lymph nodes are 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

- Aggressive mesenteric lymph nodes – concerning for infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.
- Chronic low-grade smoldering pancreatitis is suspected.
- Mucosal speckling – Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state.
- The hepatobiliary changes could represent a benign process such as ongoing cholangiohepatitis, bacterial lymphoplasmacytic versus other infectious or reactive disease, hepatic lipidosis, or, given the subtle “target lesion” appearance of some of the nodules, infiltrative neoplasia is also a differential and can’t be ruled out without tissue sampling.

SECONDARY FINDINGS

- Age related kidney changes with bilateral pyelectasia and punctate non-obstructive nephroliths.

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



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Laboratory is recommended for further evaluation of GI and pancreatic function.

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Fine needle aspirates of the liver, enlarged lymph nodes +/- pancreas are recommended if patient's coagulation status is appropriate.

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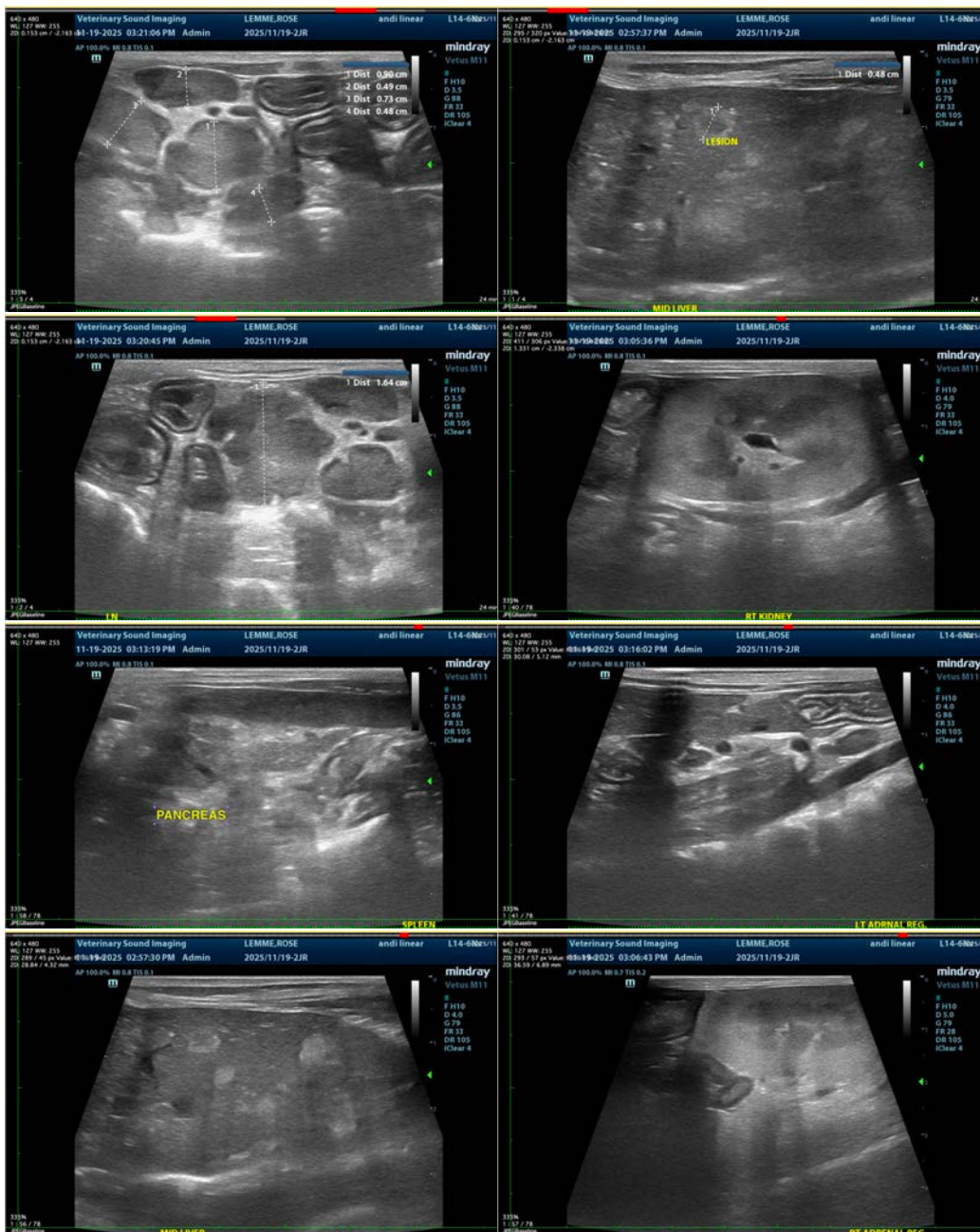
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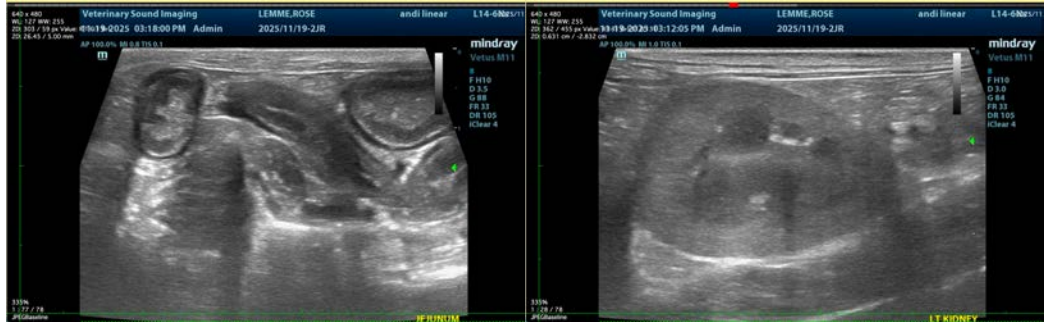
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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