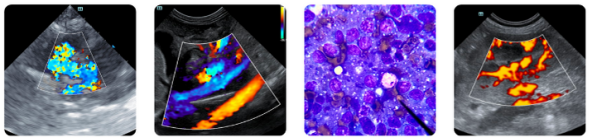


PATIENT

Ginger Schulman

SPECIES

Feline

BREED

Maine Coon Mix

SEX

Spayed Female

AGE

16

WEIGHT

8.4 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Melinda Persson

HOSPITAL NAME

At Home Veterinary

REFERRING VET

Dr. Melinda Persson

INVOICE

10772

DATE

11/20/2025

PRESENTING CLINICAL SIGNS

*Recent neurologic event - suspect stroke *Currently uncontrolled hyperthyroid - previously controlled *Recent diabetes diagnosis but recently able to come off insulin *Muscle wasting and weight loss *Hematuria - UA and culture pending.

Abnormal PE/Chem/CBC/UA Results: T4 5.8.

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 pyelectasia, mineral or infarcts observed. Left kidney measures 3.5 cm, and the right kidney measures 3.6 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.47 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.45 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size (1.1 cm thick) with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a moderately coarse/heterogenous echotexture diffusely. No definitive, discrete focal nodules or masses are observed but within the diffusely coarse, heterogenous parenchyma, there are several subtle, slightly more discrete bulges with the most significant one measuring approximately 1.0 cm in diameter, that could represent emerging nodules or masses. Splenic vasculature appears normal.

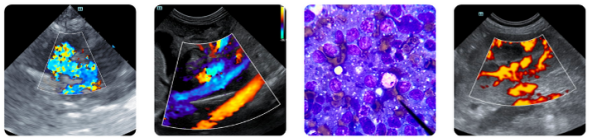
Liver

Liver is subjectively enlarged (swollen contour) with a diffusely mildly coarse architecture and subtly increased portal markings. Mildly mixed echogenic changes are noted diffusely. 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.



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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, 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.

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 no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- Scalloped spleen – can be associated with benign or malignant infiltrative disease. Common causes include a reactive spleen secondary to immune stimulus or early infiltrative round cell neoplasia such as lymphoma or mast cell tumor. Emerging discrete nodules or masses may be present.
- The liver changes are non-specific with differentials for a microscopic hepatopathy including bacterial cholangiohepatitis, lymphoplasmacytic hepatitis, hepatic lipidosis, other infectious or reactive hepatopathy versus infiltrative neoplasia which can't be ruled out without tissue sampling.
- 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, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.

SECONDARY FINDINGS

- Age related kidney changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

As is reportedly already pending, 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.

Given the recently reported suspect stroke event, a blood pressure is recommended.

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.

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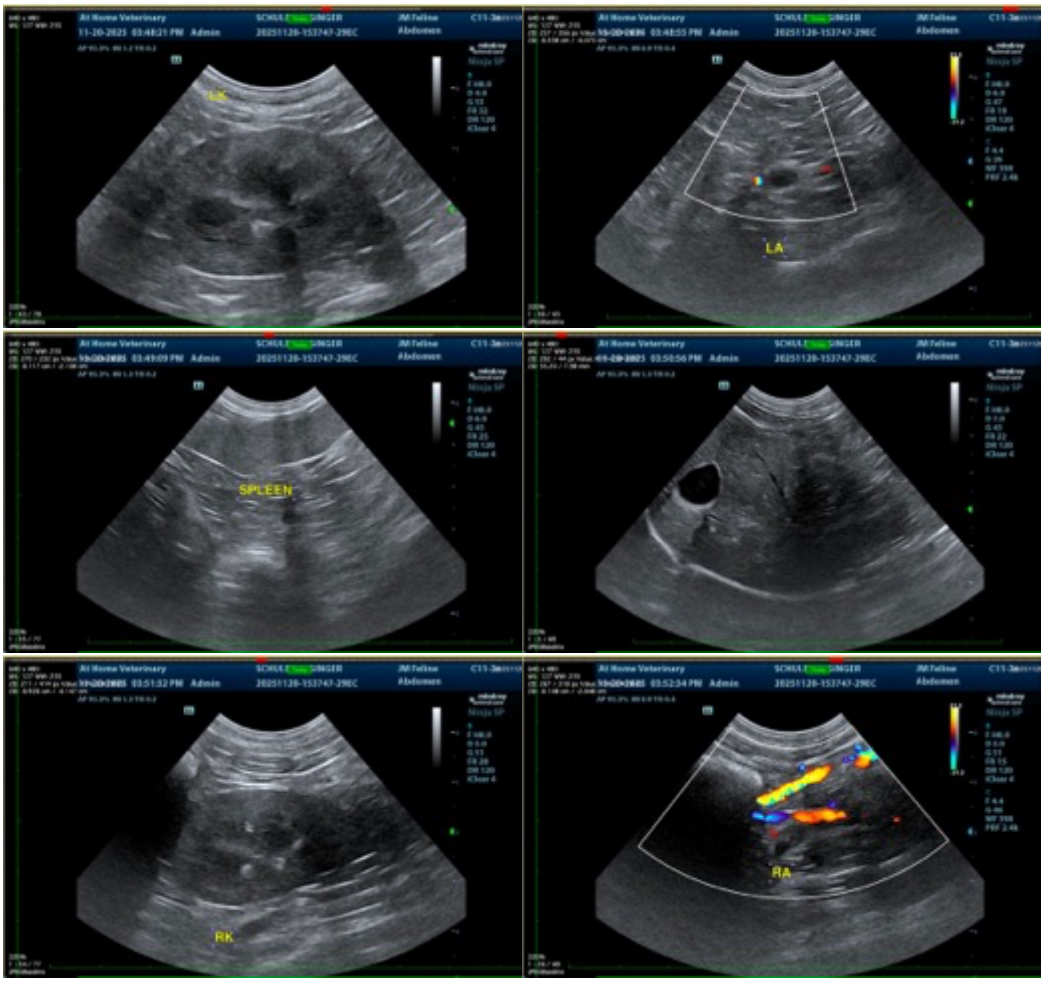
Fine needle aspirates of the spleen and liver are recommended if patient's coagulation status is appropriate.

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.

Overall, the most concerning ultrasound finding is the concern for possible infiltrative disease, even infiltrative neoplastic disease involving the spleen +/- liver. That finding is of unknown, if any relation to the concurrent bowel changes and/or the reported neurologic event. Therefore, additional treatment and diagnostic recommendations are dependent on the results of this initial workup.



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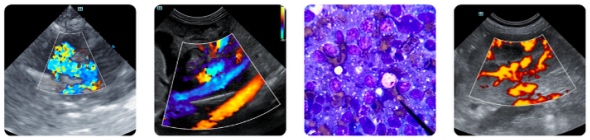

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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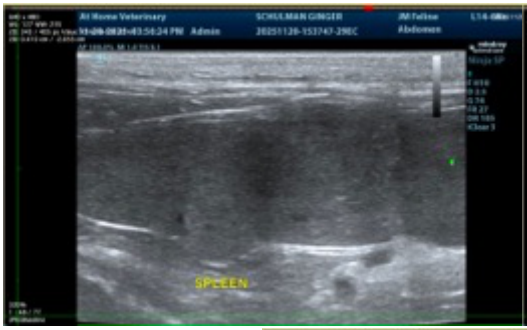

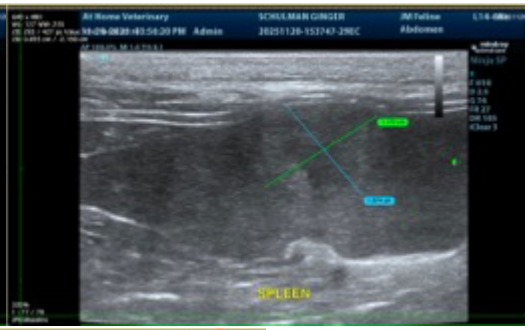

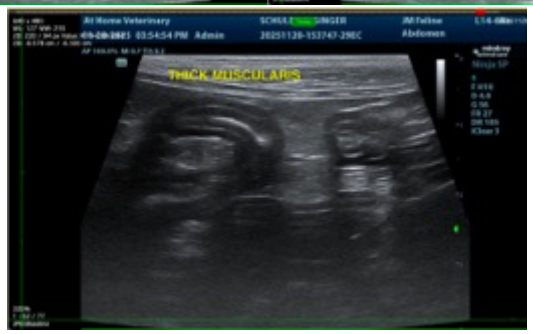

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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