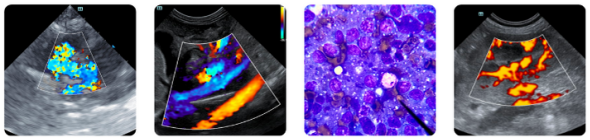


PATIENT

Axl Lester

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

12 years old

WEIGHT

4.85 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Jill Rankin

HOSPITAL NAME

Petzoic Vet Hospital

REFERRING VET

Dr. Ehab

INVOICE

10682

DATE

11/03/2025

PRESENTING CLINICAL SIGNS

Patient is a 12-year-old male cat presented for a 1-month history of significant weight loss, hyporexia, and vomiting of liquid/bile. The owner notes the onset of clinical signs corresponds with the introduction of a new kitten. Physical examination revealed significant muscle wasting along the spine and legs, and dry MM. The abdomen was soft and non-painful on palpation. Temperature was 37.5 °C. In-house blood work revealed a mild elevation in all liver values (ALT 133 U/L, ALP 169 U/L, GGT 7 U/L), Chol 1.62 mmol/L (L), GLU 3.94 mmol/L (L), BUN 5.2mmol/L (L) and a stress leukogram (high neutrophils (11.35)). Kidney values and urinalysis were within normal limits. The primary concern is an underlying hepatopathy.

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.

The right kidney is normal is size (3.8 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (3.7 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The areas of the adrenal glands are examined without evident adrenal gland pathology.

Spleen

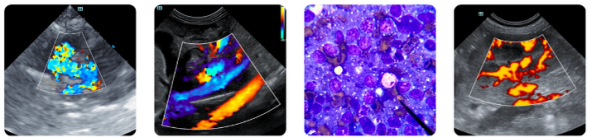
The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. At least two largely cystic, mildly hyperechoic nodules/densities are noted within the liver. One in the left, one in the right, both measuring approximately 1.3 cm to 1.4 cm in diameter. 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



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The gastric wall appears to contain an intramural mass involving the caudal suspect greater curvature area, characterized by a 1.6 cm to 1.7 cm thick, hypoechoic wall with loss of layering. The remaining gastric wall is normal in thickness and layering, and the lumen is empty.

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 a trace amount of anechoic free fluid, primarily in the cranial abdomen between liver lobes, in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- The gastric wall mass is concerning for infiltrative neoplasia such as round cell neoplasia i.e. lymphoma versus other. Having said that, a benign inflammatory process cannot 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.
- Trace 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.
- Diffusely hyperechoic hepatomegaly with focal densities that in a senior likely represent benign biliary cystadenoma. Malignancy can't be ruled out however without tissue sampling – This appearance is most consistent with benign hepatic lipidosis or endocrine/DM hepatopathy. Infiltrative disease such as amyloidosis or round cell neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.

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.

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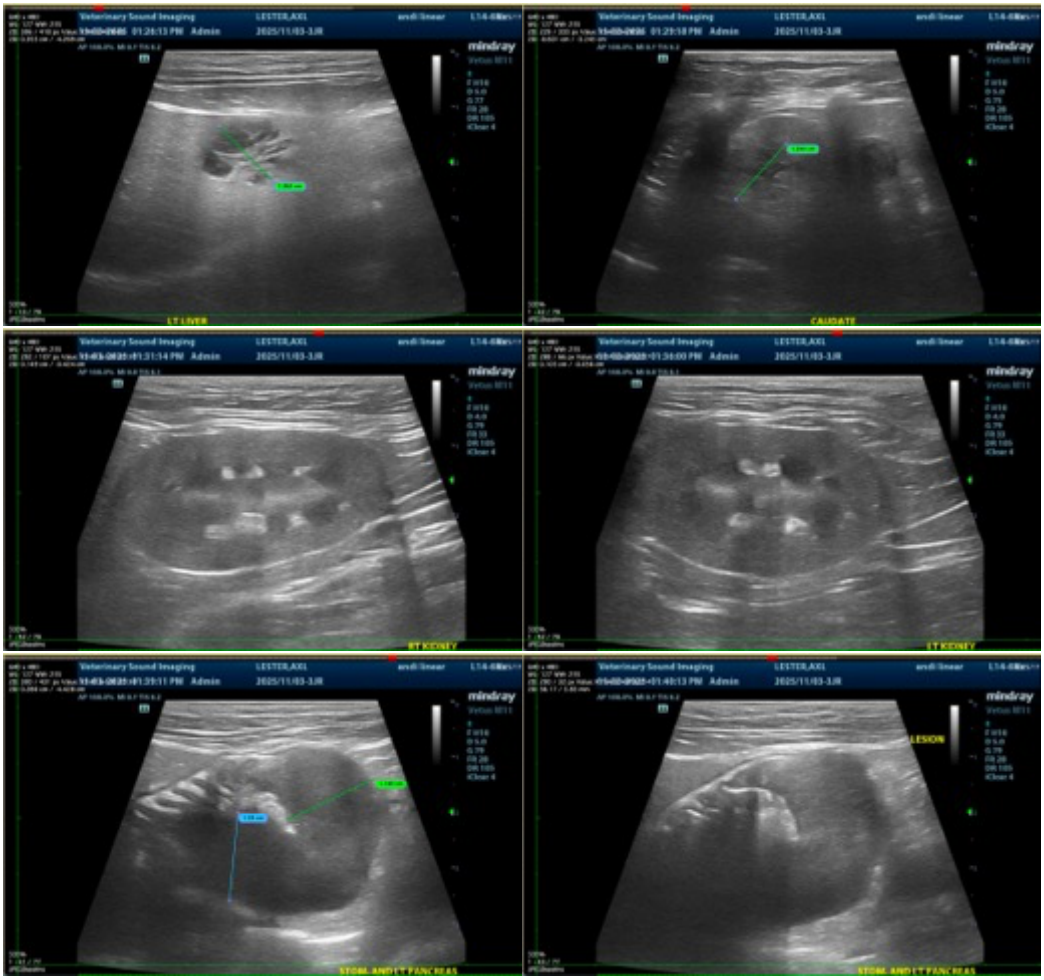
Fine needle aspirates of the gastric wall mass +/- liver are recommended if patient's coagulation status is appropriate.

In the meantime, a T4 +/- Free T4 is recommended if not recently evaluated, as is a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory for further evaluation of GI and pancreatic function.

Pending results of above, bile acids could also be considered if patient's total bilirubin is not increased.

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



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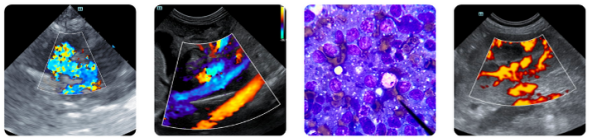

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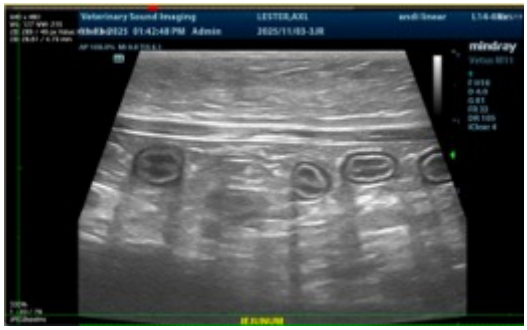

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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