



PATIENT

Daisy Lewis

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

17 years old

WEIGHT

5.5 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Jill Rankin

HOSPITAL NAME

Banded Peak
Veterinary Hospital

REFERRING VET

Dr. Jordan

INVOICE

10954

DATE

12/17/2025

PRESENTING CLINICAL SIGNS

See attached also. Daisy came in today for an examination for decreased appetite over the last few days. Noticing decrease stool in the litter box. No recent blood work. Not on any medications. She always loves her food thus this a concern. Owners wanted to make sure it was nothing serious based on her age. Have since done BW.

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 a large amount of echogenic non-shadowing debris, most consistent with exfoliated cells, crystals, mucous and/or small blood clots likely combined with incidental suspended lipid. Both sterile inflammation as well as urinary tract infection can 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. In some images, there appears to be an approximately 0.2 cm x 0.4 cm echogenic density settled along the dependent inner wall, but with agitation that area gets smaller, indicative of some settled debris versus tissue. Having said that, a small tissue density can't be ruled out.

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 3.9 cm, and the right kidney measures 4.0 cm.

Adrenal Glands

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

Spleen

Spleen is subjectively large in size with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a mildly coarse/heterogenous echotexture. No 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.



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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

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.

There is some enhanced hyperechoic fat in the cranial abdomen surrounding the stomach and some enlarged lymph nodes, and pancreas, indicative of some possible focal inflammation in that area.

Mesenteric and cranial abdominal 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.
- 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.
- The liver changes are non-specific but indicate a microscopic hepatopathy with differentials including a benign infectious or inflammatory bacterial or lymphoplasmacytic cholangiohepatitis, hepatic lipidosis, other infectious or reactive hepatopathy, or infiltrative neoplasia 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 or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.
- Concurrent chronic low grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.

SECONDARY FINDINGS

- Age related kidney changes.



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- A moderate amount of echogenic urinary bladder debris.

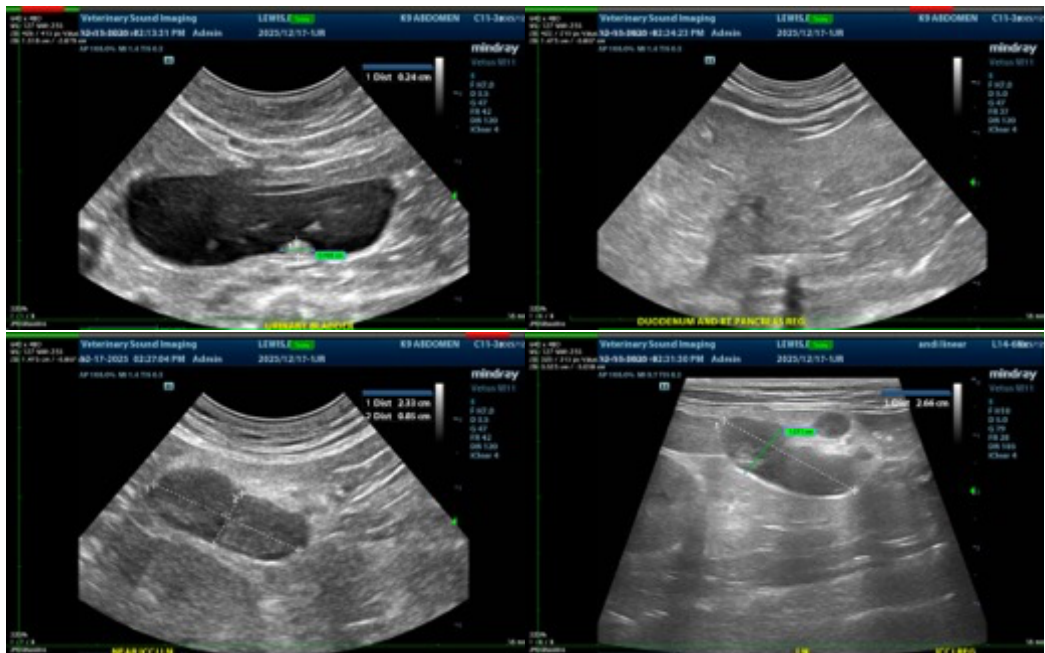
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The attached record or lab work was unable to be opened. If not recently evaluated, a full general metabolic health screen is recommended to include CBC, chemistry panel, and electrolytes, as well as 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.

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.

Tissue sampling is recommended. Fine needle aspirates of the enlarged lymph nodes, spleen and liver could be considered if patient's coagulation status is appropriate. If a cytologic diagnosis is unable to be obtained, ultimately, biopsies of the GI tract being sure to include ileum, may be necessary for a definitive diagnosis and therefore to further guide medical management.

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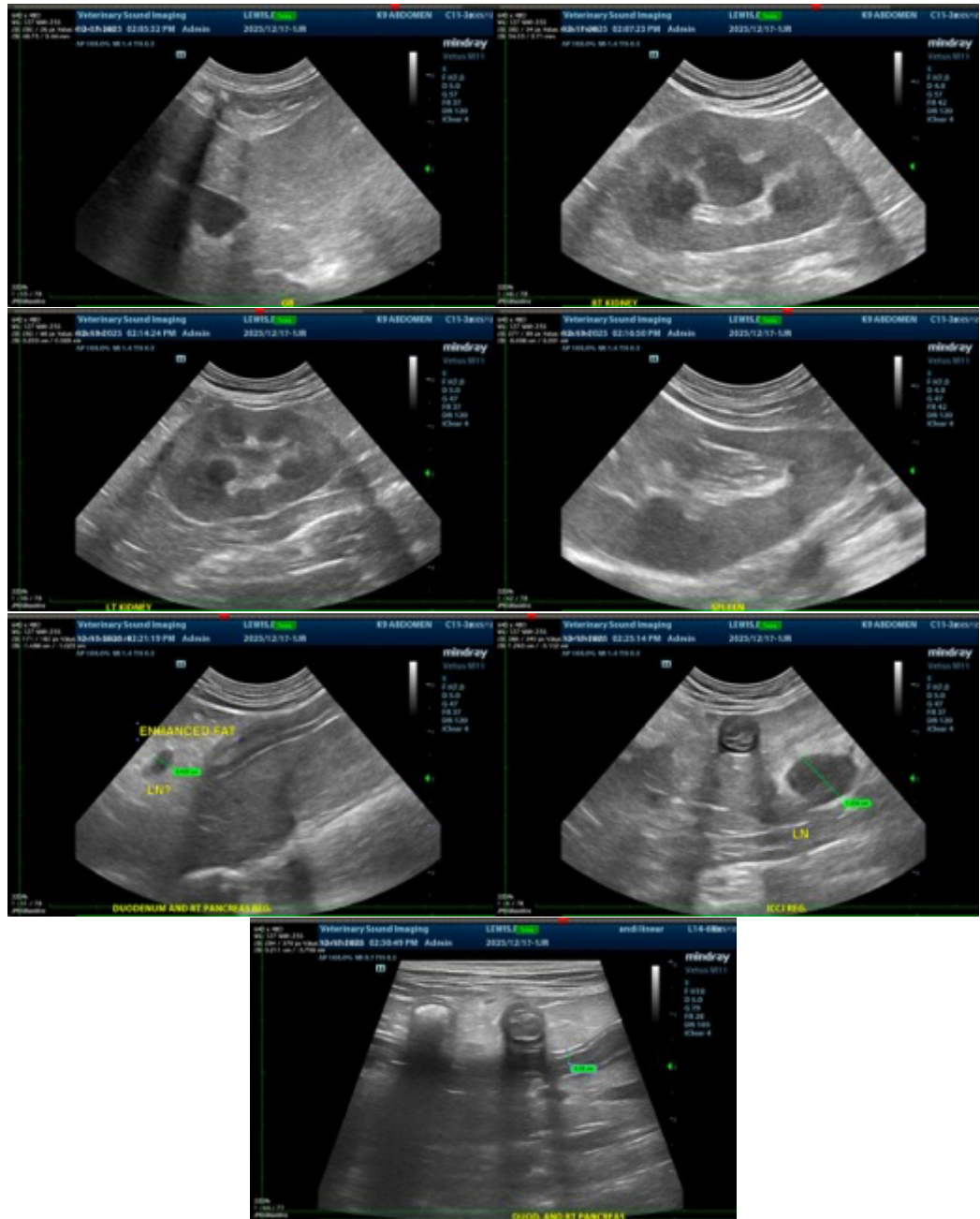
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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