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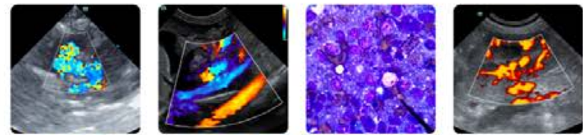


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Dasher Paulsen

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

10 Years

WEIGHT

9 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Rebecca Hamilton

HOSPITAL NAME

The Veterinary Hospital

REFERRING VET

Dr. Johnson

INVOICE

72249

DATE

12/2/25

PRESENTING CLINICAL SIGNS

Presented 12/1 for inappetance, dasher was depressed, dehydrated, and very jaundiced, abdominal palpation suggested enlarged spleen. Meds: was on metacam- have stopped as of yesterday, hospitalized on IV fluids

Abnormal PE/Chem/CBC/UA Results: CBC- anemic HCT 29, RBC 5.4- slide review NSF. Chem" low TP (5.2) elevated ALKP 277, Tbil 12.5, GGT 16- (possible artifact due to jaudiced serum) AST 64, SDMA 21, T4 1.0, Urine: 3+ blood, 3+ bili

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is subjectively mildly over distended with anechoic contents. This finding should be interpreted in combination with any clinical history of lower urinary tract signs or obstruction, as it is likely secondary to the reported fluid therapy and reluctance to use litter box in hospital. 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 (X4.54 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 mineral or infarcts observed. Mild to moderate pyelectasia is present.

The left kidney is normal is size (4.38 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 mineral or infarcts observed. Mild to moderate pyelectasia is present.

Adrenal Glands

The right adrenal gland is normal in size (0.35 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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

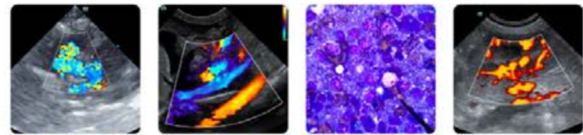
Spleen

Spleen is subjectively large in size (1.4 cm thick at the hilus) 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 (swollen contour). Mild parenchymal remodeling with diffusely mildly coarse architecture and increased portal markings is present. No focal nodules or masses 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.



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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 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 is diffusely prominent, irregular, coarse, and hypoechoic in appearance. Additionally, in the right cranial abdomen in the area of the pancreas in an ill-defined mixed, approximately 2.5 cm x 2.8 cm, partially cystic density. In that same area are several round, homogeneous, hypoechoic densities.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

Medial iliac lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

ULTRASONOGRAPHIC FINDINGS

- The cranial abdominal/suspect pancreatic changes could indicate chronic smoldering pancreatitis with an acute active flare up surrounded by inflammatory changes, edema, etc., with the homogeneous hypoechoic densities representing enlarged lymph nodes, although a pancreatic mass or masses can't be definitively ruled out.

- 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.

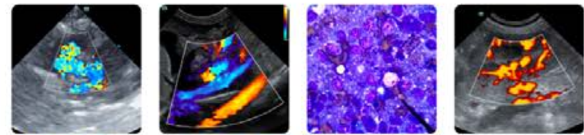
- Hypoechoic hepatomegaly – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.

- 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.

- Moderately reactive medial iliac lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Based on appearance, a top differential in my opinion is infiltrative round cell neoplasia such as lymphoma potentially affecting the spleen, lymph node, +/- pancreas and resulting in lymphadenopathy,



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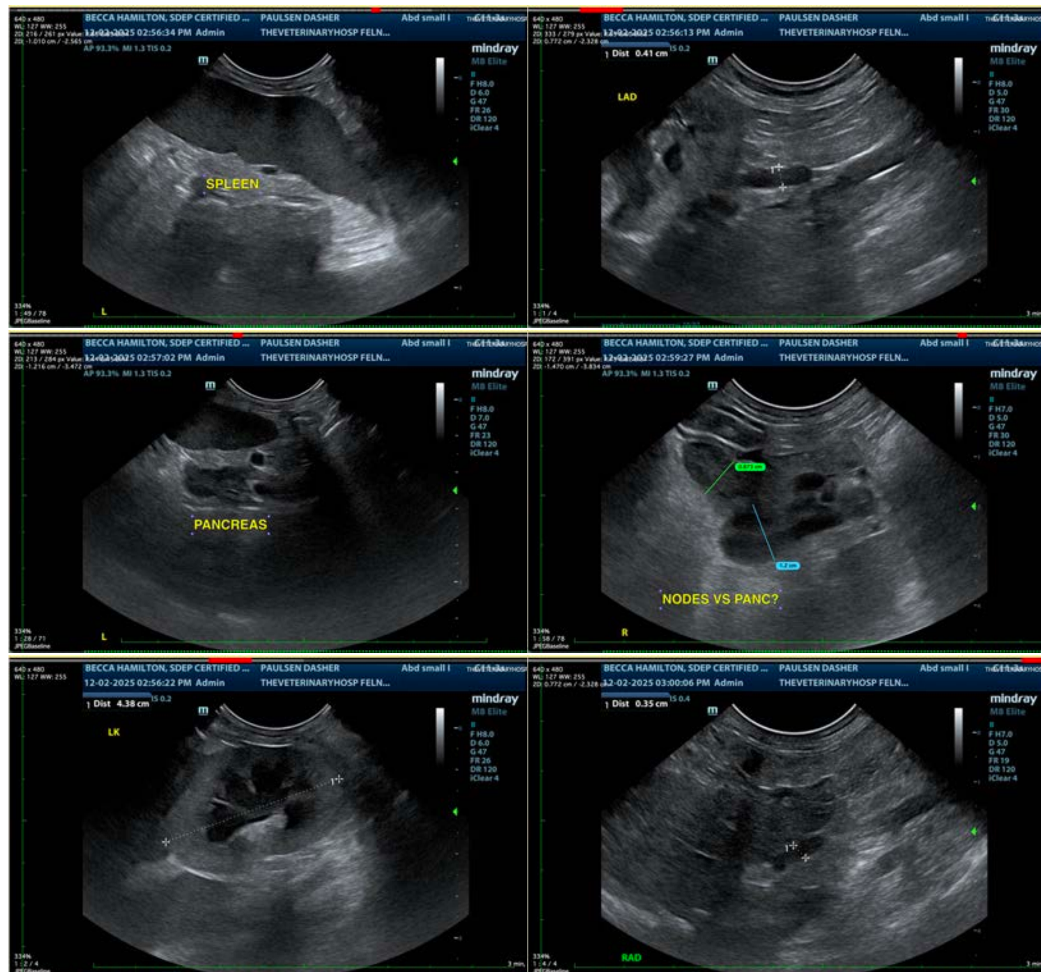
both medial iliac and the densities in the area of the pancreas.

Having said that, benign inflammatory processes including potential infectious disease versus other can't be ruled out. Therefore, tissue sampling is recommended, beginning with fine needle aspirates of the spleen and liver as well as the suspected lymph nodes in the cranial abdomen if patient's coagulation status is appropriate.

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

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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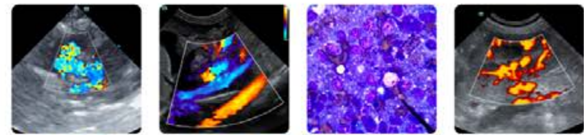

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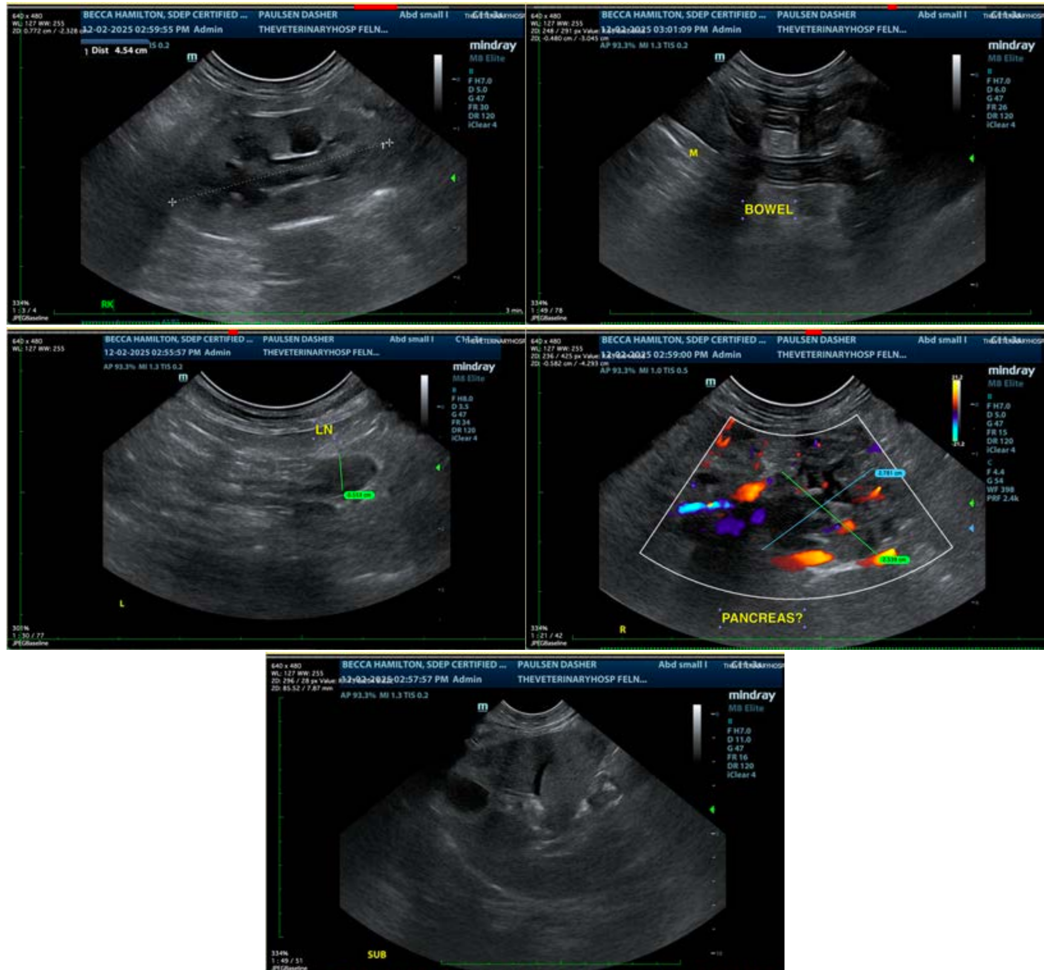

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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