



## PATIENT

Princess Walsh

## SPECIES

Feline

## BREED

DLH

## SEX

Spayed Female

## AGE

8

## WEIGHT

14.4

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Dr. Kathy Cronin

## HOSPITAL NAME

Ark Animal Homecare

## REFERRING VET

Dr. Kathy Cronin

## INVOICE

13839

## DATE

02/17/26

## PRESENTING CLINICAL SIGNS

- Has been vomiting for about a month. Radiographs/BW on 1/27/26 unremarkable. Not eating much, even on mirtazapine. Currently vomiting every 2-3 days (liquid). Has developed diarrhea within the last week or so. Weight loss of 3# in the past year, 1# weight loss since 1/27/26
- she had a 104.4-degree fever on exam today.

Abnormal PE/Chem/CBC/UA Results: Painful on deep abdominal palpation, weight loss. CBC/chem/T4 1/27/26 - eosinopenia 0.14, BUN low (15), ALT low 13.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

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 irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. The left kidney is normal in size measuring 3.7 cm in length. The right kidney is normal in size measuring 3.6 cm in length.

*The kidneys aren't labeled in these images and the only view of what I believe is two separate kidneys is at the beginning of the study, so I cannot definitively say that what I am calling is the right kidney at 3.6 cm is truly the right kidney.*

### *Adrenal Glands*

The area of the adrenal glands are examined without evident adrenal gland pathology but they are unable to be well visualized/definitively isolated for measurement.

### *Spleen*

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) 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.

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 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 markedly/significantly 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.

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The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

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### *Pancreas*

The observed pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Pancreatic duct dilation is noted. Enhanced hyperechoic ill-defined surrounding fat is noted.

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### *Free Abdomen*

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

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In the mid abdomen, there is an approximately 6.1 cm x 4.3 cm irregular coarse hypoechoic density/mass that I believe is a mesenteric lymph node root mass or other including bowel, however while thought less likely cannot be definitively ruled out.

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Cranial abdominal lymphadenopathy 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.

## ULTRASONOGRAPHIC FINDINGS

### IMAGING PERFORMED BY

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- Suspect aggressive mesenteric lymphadenopathy- concerning for infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture. As described above, however, while this mesenteric mass appears to be lymph node bowel, while thought less likely, cannot be definitively ruled out.

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- Concurrent marked/significant inflammatory bowel disease pattern.

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- Concurrent mild to moderate acute pancreatitis is suspected.

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

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- Mild to moderate chronic kidney disease changes are noted bilaterally.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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- Recheck general metabolic health screen is recommended to include CBC, chemistry panel, electrolytes and urinalysis, given the acute change in the clinical signs and fever.

- 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.



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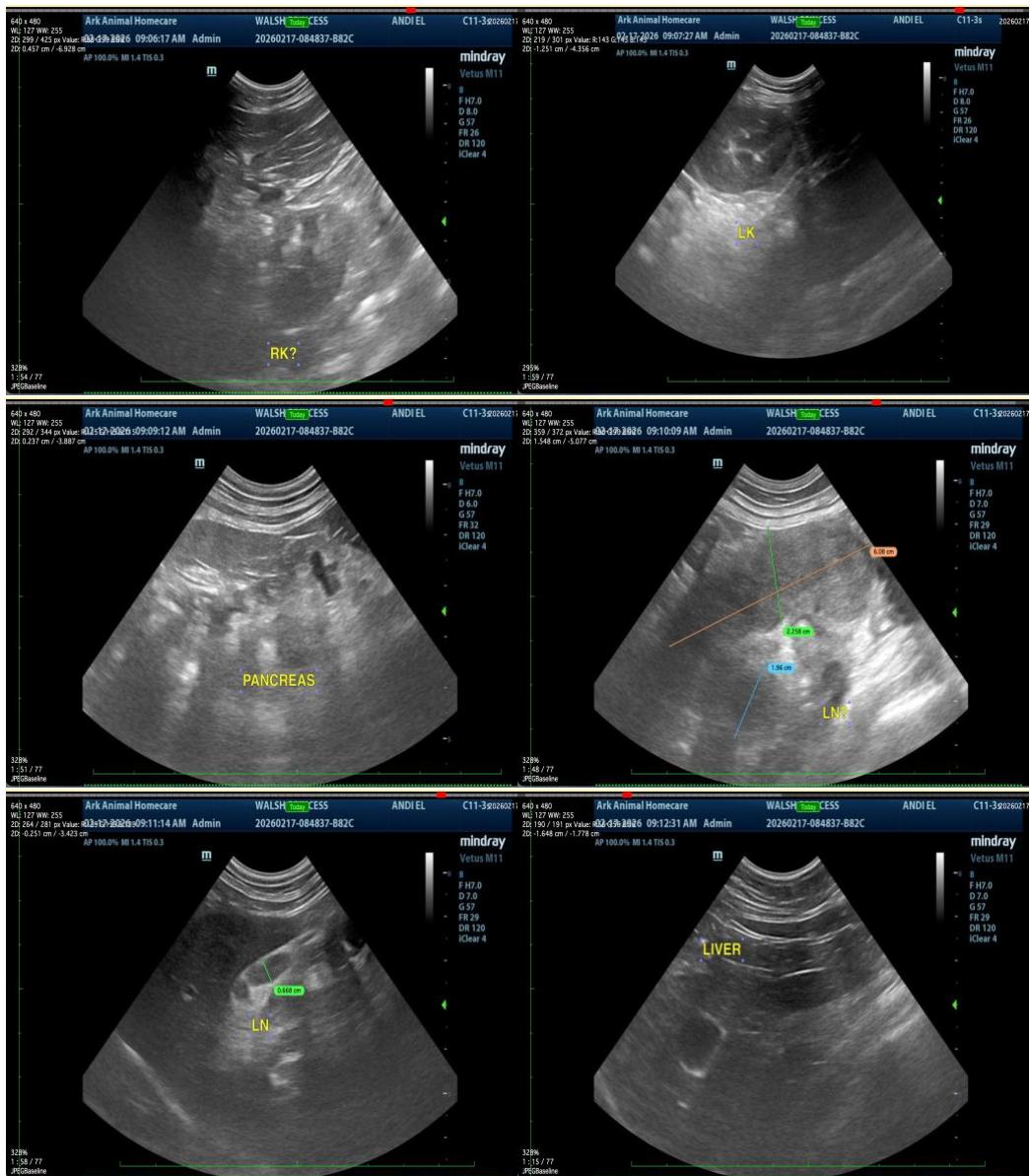
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- Tissue sampling is recommended.
- Fine needle aspirates of the mesenteric root/suspect lymph node +/- liver can be considered if patient's coagulation status is appropriate. If a cytologic diagnosis is unable to be obtained, however, ultimately biopsies of the GI tract, being sure to include ileum as well as biopsies of the suspected lymph node may be necessary for a definitive diagnosis and therefore to further guide medical management.
- Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.





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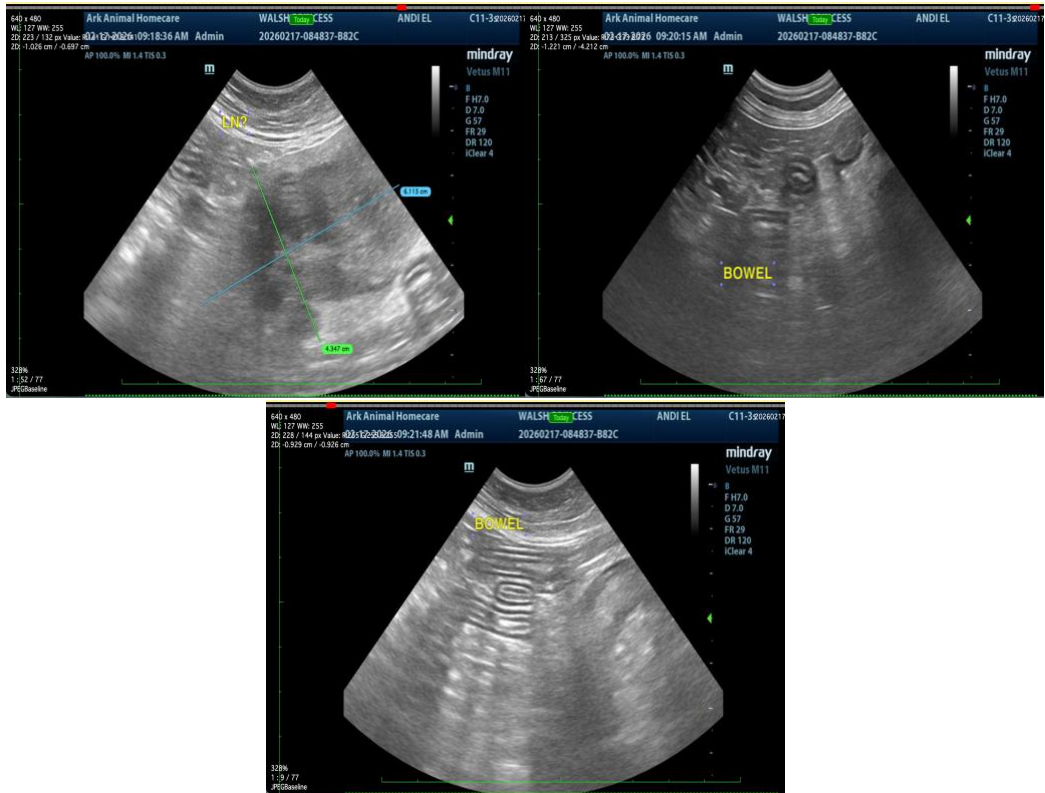
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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**

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