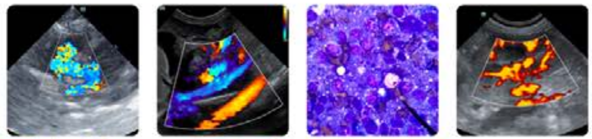


PATIENT
Bull Breen

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
15 Years 9 Months

WEIGHT
7.6 lbs

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
A Murhphy, CVT

HOSPITAL NAME
Wauwatosa Veterinary Clinic

REFERRING VET
Dr. Ericka Haynes

INVOICE
73276

DATE
2/25/26

PRESENTING CLINICAL SIGNS

Patient presented for examination on 2/23/26 due to 6 week history of weight loss, lethargy, and decreased appetite. Blood panel abnormalities noted below. Screening for triaditis, neoplasia (ie-GI lymphoma)

Abnormal PE/Chem/CBC/UA Results: Nonregenerative anemia Elevated SDMA Elevated BUN Elevated liver enzymes (ALT, ALP, GGT, Bili) Elevated Lipase

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 bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted. The left kidney is small at 2.8 cm. The right kidney is small-normal at 3.26 cm. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted bilaterally.

Adrenal Glands

The adrenal glands are unable to be well visualized in these images.

Spleen

Spleen is subjectively large in size (1.2 cm thick at the hilus) with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and 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.

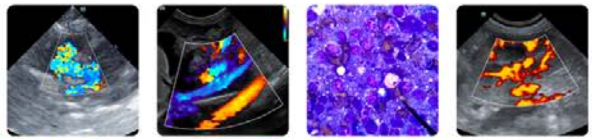
The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

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 colon is diffusely mildly thick, measuring 0.36 cm thick with some concern for early or emerging hazy loss of layering in some areas. 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.

Free Abdomen

There is a mild amount of anechoic free fluid in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Splenomegaly– can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

- 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 or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.

- Similarly, differentials for the mildly thick colon include both benign infiltrative as well as neoplastic infiltrative disease, with infiltrative neoplasia potentially being slightly more concerning, given the suspected emerging loss of layering.

- Concurrent mild or emerging acute, potentially acute on chronic low-grade smoldering pancreatitis is suspected.

- The mild 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.

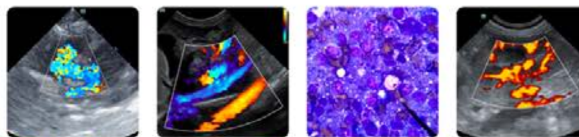
- Significant bilateral chronic kidney disease changes with non-obstructive dystrophic mineralization noted bilaterally.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

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.

Tissue sampling is recommended. Fine needle aspirates of the spleen and liver could be considered if patient's coagulation status is appropriate, but if a cytologic diagnosis is unable to be obtained,



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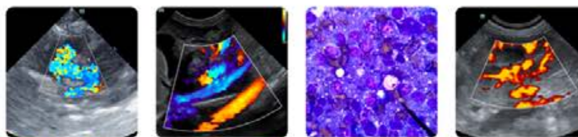
ultimately biopsies of those organs as well as biopsies of the bowel, being sure to include colon and ileum, if possible, may be necessary for definitive diagnosis and therefore to further guide medical management. A blood pressure is recommended if not recently evaluated.

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



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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