



## PATIENT

Marigold Wynekoop

## SPECIES

Feline

## BREED

DSH

## SEX

Spayed Female

## AGE

11 Years

## WEIGHT

7.6 lbs

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Julia Bakker, DVM

## HOSPITAL NAME

Orange Blossom  
Veterinary Imaging

## REFERRING VET

Donna Allen, DVM

## INVOICE

73285

## DATE

2/25/26

## PRESENTING CLINICAL SIGNS

Several episodes of vomiting, fluctuating bowel movements between mucoid diarrhea and normal stools, weight loss, extreme elevation of WBC's mainly Lymphocytes. DDX Lymphoma/ IBD

Abnormal PE/Chem/CBC/UA Results: Lymphocytosis

## 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 (3.89 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 (3.71 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 right adrenal gland is normal in size (0.40 cm at cranial pole and 0.30 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.30 cm at cranial pole and 0.20 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

### Spleen

Spleen is subjectively large in size with a swollen and scalloped/undulating capsular contour. Multifocal coalescing nodules are noted throughout the parenchyma. Splenic vasculature appears normal. Enhanced hyperechoic surrounding fat is noted.

### Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions 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 mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.



<b>PATIENT</b>	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. Multifocal bowel loops demonstrate “hazy” wall thickness with loss of layering. The lumen is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is no evidence of obstruction, foreign material or infiltrative disease.
Marigold Wynekoop	
<b>SPECIES</b>	The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.
Feline	
<b>BREED</b>	<b><i>Pancreas</i></b>
DSH	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.
<b>SEX</b>	<b><i>Free Abdomen</i></b>
Spayed Female	There is no visible free peritoneal effusion noted in these images.
<b>AGE</b>	Mesenteric 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.
11 Years	
<b>WEIGHT</b>	<b>ULTRASONOGRAPHIC FINDINGS</b>
7.6 lbs	<ul style="list-style-type: none"><li>• Honeycomb Spleen – This finding is strongly suggestive of infiltrative disease such as round cell neoplasia. Benign disease cannot be ruled out but is considered less likely.</li><li>• Gastrointestinal lymphoma (suspect) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. Given the concurrent pathology noted, infiltrative neoplasia is considered more likely, but benign IBD cannot be ruled out without tissue sampling.</li><li>• 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.</li></ul>
<b>INTERPRETED BY</b>	<b>INTERPRETATION OF THE FINDINGS &amp; FURTHER RECOMMENDATIONS</b>
Beth Johnson, DVM DACVIM	Further evaluation of the peripheral lymphocytosis, beginning with a pathology review, could be considered.
<b>IMAGING PERFORMED BY</b>	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.
Julia Bakker, DVM	If a diagnosis is not obtained, tissue sampling is recommended, beginning with fine needle aspirates of the spleen and the enlarged mesenteric lymph nodes if patient’s coagulation status is appropriate.
<b>HOSPITAL NAME</b>	If a diagnosis is unable to be obtained cytologically, ultimately biopsies of the GI tract, being sure to include ileum, if possible, as well as the areas with loss of layering, if possible, may be necessary for a definitive diagnosis and therefore to further guide medical management.
Orange Blossom Veterinary Imaging	
<b>REFERRING VET</b>	
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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