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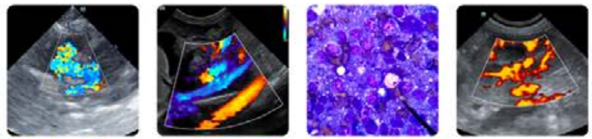


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT
Rusty Keene

SPECIES
Feline

BREED
DSH

SEX
Neutered Male

AGE
14 Years

WEIGHT
8 lbs

INTERPRETED BY
Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY
Julia Bakker, DVM

HOSPITAL NAME
Orange Blossom Veterinary Imaging

REFERRING VET
Tom Mullins, DVM

INVOICE
73283

DATE
2/25/26

PRESENTING CLINICAL SIGNS

Increased Bilirubin and Alk Phos on initial and recheck labwork, decreased appetite and weight loss. FNA of mesenteric lymph nodes taken today during scan.

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 occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also 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.

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 3.66 cm. Right kidney measures 3.55 cm.

Adrenal Glands

The right adrenal gland is unable to be well visualized in these images. The structure labeled “right adrenal gland” I believe is part of other right cranial abdominal pathology such as a lymph node versus other.

The left adrenal gland is normal in size (0.23 cm at cranial pole and 0.26 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The spleen has a focally mildly thick area from an approximately 1.2 cm x 1.6 cm expansive but not disruptive, homogeneous, iso- to slightly hypoechoic nodule/mass.

Liver

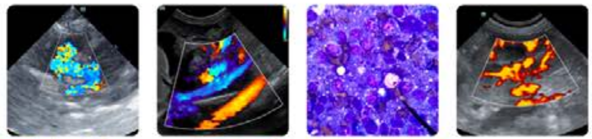
The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal 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 empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

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. In the mid abdomen there is one loop of small bowel (suspect jejunum)



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of undeterminable length that demonstrates a thick wall and loss of layering. The wall measures 0.42 cm thick. 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.

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.

PRIMARY FINDINGS

- 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 loss of layering noted, infiltrative neoplasia is considered more likely, but benign IBD cannot be ruled out without tissue sampling.

- 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.

- Concurrent chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.

- 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.

SECONDARY FINDINGS

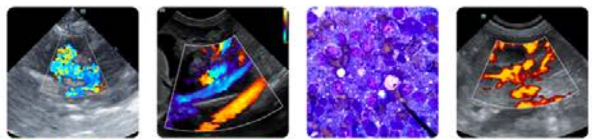
- Age related kidney changes.

- Mild amount of echogenic urinary bladder debris.

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.

Tissue sampling is recommended. Fine needle aspirates of the spleen, the liver, the lymph nodes, and/or even the focally thick small bowel could all be considered if patient's coagulation status is appropriate.



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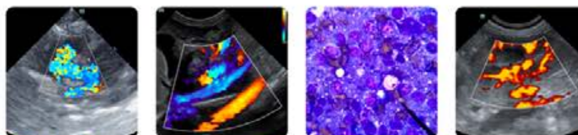
Alternatively, or if a cytologic diagnosis is unable to be obtained, however, biopsies, including biopsies of those organs, resection and anastomosis of the focally thick bowel, and biopsies of the ileum, if possible, may be necessary for a definitive diagnosis and therefore to further guide medical 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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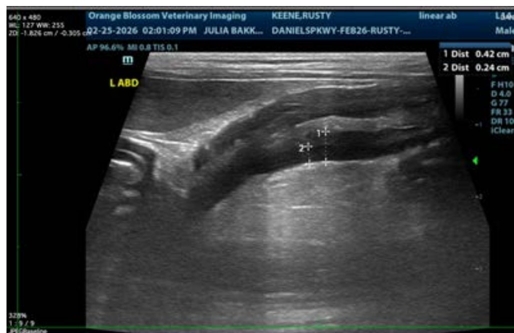

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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