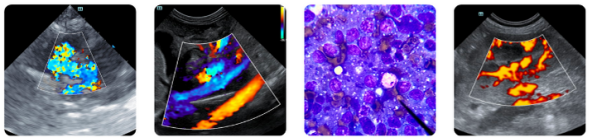


PATIENT

Thelma Dickinson

SPECIES

Feline

BREED

DSH

SEX

SF

AGE

14 years 7 months

WEIGHT

6.6 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Jill Rankin

HOSPITAL NAME

Fish Creek Pet Hospital

REFERRING VET

Dr. Dani

INVOICE

11360

DATE

2/24/2026

PRESENTING CLINICAL SIGNS

- Presented for evaluation of newly diagnosed abdominal effusion with a concurrent heart murmur. A focus ultrasound confirmed moderate ab effusion but no obvious mass. A fluid sample was collected
- Path Report INTERP: Atypical round cell proliferation - suspect neoplastic effusion. Please see comments.
- COMMENTS: The morphology of the cell population noted here are not typical for lymphoma however this is a consideration. Other conditions (myelomonocytic proliferations, undifferentiated leukemia/lymphoma) poorly cohesive carcinomas, histiocytic tumor or plasma cell tumors may have a similar cytologic appearance. As solid lesions could not be found on ultrasound you may consider PARR to help identify lymphoid origin. PARR assay (PCR for Antigen Receptor Rearrangement) uses the already submitted and stained slides to assess for lymphocyte genetic clonality. It can further confirm the presence of lymphoma and provides a B-cell versus T-cell distinction; it does not determine lymphoma subtype classification or behavior. The PARR test performed through IDEXX has an overall 93% sensitivity and 94% specificity for detecting lymphoma in dogs, while an overall 91% sensitivity and more than 90% specificity in cats (CSU Clinical Hematopathology Laboratory, 2022). Test code 1933 in US, LYMPCR in Canada. Other options would be re ultrasound or MRI to help define.
- PARR A2 A4.
- Also has grade 2 out of 6 cardiac murmur. Thoracic rads show mild heart enlargement but were otherwise clear.

Abnormal PE/Chem/CBC/UA Results: Thoracic POCUS: No pericardial or pleural effusion. No B-lines bilaterally. Subjective LA:Ao ratio of 1:1. - Ab POCUS: Moderate free fluid was identified in all four abdominal quadrants. A quick scan of the liver, spleen, kidneys, GI tract, and bladder revealed no obvious mass effect. - Thoracic Rads: Vertebral heart score (VHS) of 8.79, consistent with mild cardiac enlargement. The pulmonary pattern was normal, with no obvious mass effects or signs of metastasis. Poor abdominal serosal detail was noted, consistent with effusion. Incidental bilateral elbow osteophytes and degenerative joint disease were also seen. - ProBNP: Normal. Cytology Source: ABDOMINAL_FLUID Appearance pink/very cloudy Protein (Refractometer) 35 g/L RBC 0.06 x10E12/L Nucleated Cell Count 315.67 x10E9/L.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

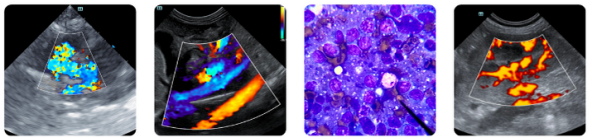
Urinary System

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 (3.7 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 (3.6 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



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

Spleen

The 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). 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 very prominently 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's a focal loop of small bowel suspect jejunum, that's mildly thicker than the remaining bowel and demonstrates loss of mural detail/loss of layering. 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 a moderate amount of free fluid present in these images, as well as diffusely enhanced hyperechoic, almost clumped/nodular mesentery.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- The bowel changes described above have been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. However, given the loss of layering as described above, infiltrative neoplasia is considered slightly more probable.

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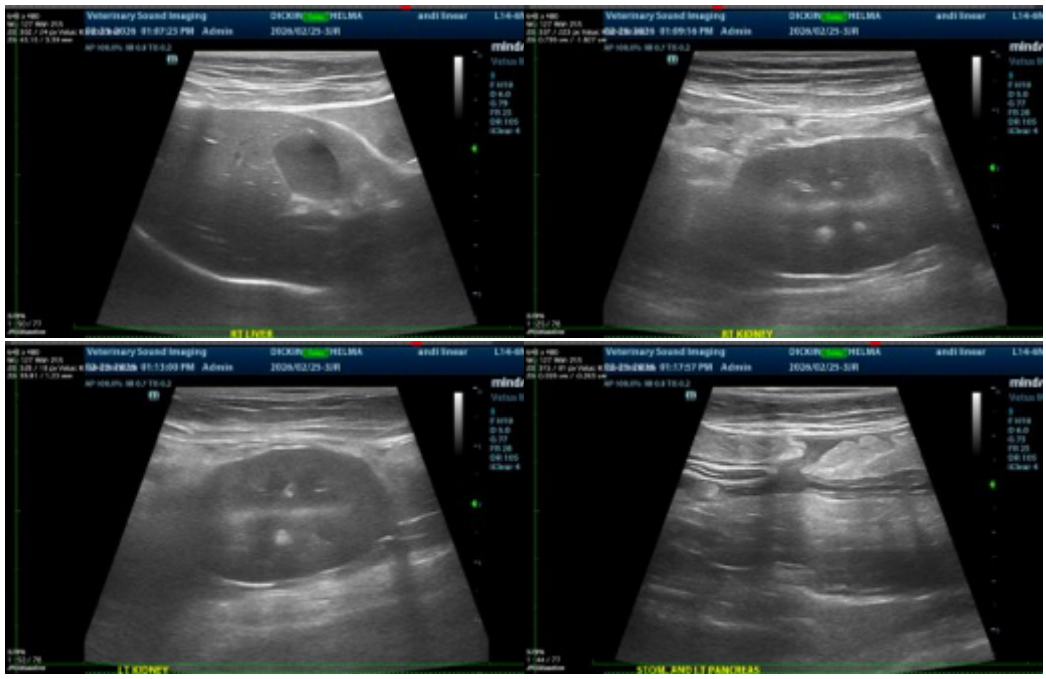
- Hypoechoic hepatomegaly – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.
- Concurrent chronic low grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- A moderate amount of 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.

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.

If histopathology is necessary for a diagnosis, biopsies of the GI tract being sure to include, if possible, may be necessary for a definitive diagnosis and therefore to further guide medical management. However, less invasively, prior to that fine needle aspirates of the liver could be considered if patient's coagulation status is appropriate or additional testing such as the previously mentioned PARR could be considered on the free fluid.

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



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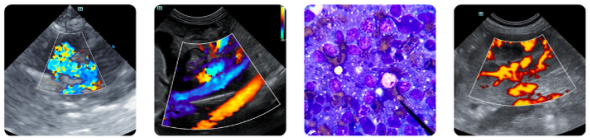

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

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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