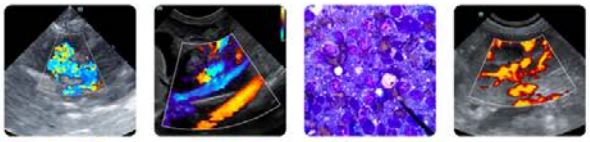


PATIENT

Zoey Henderson

SPECIES

Feline

BREED

Abyssinian

SEX

Spayed Female

AGE

11 Years

WEIGHT

8.9 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Julia Bakker, DVM

HOSPITAL NAME

Orange Blossom Veterinary Imaging

REFERRING VET

Jonathan Shivers, DVM

INVOICE

72736

DATE

2/4/26

PRESENTING CLINICAL SIGNS

Pt presents for vomiting for 1 week. O states that Pt has been vomiting brown fluid for 1 week and there are no clumps in it and it is pure liquid. O also mentioned that Pt had a small bm 3 days ago and fecal material seemed hard and Pt has not had a bm for 2 days and seems lethargic for past 2 days as well.

Abnormal PE/Chem/CBC/UA Results: Neutrophilia and liver enzyme elevations (see attached) FNA of pancreatic mass and lymph nodes taken today to send for cytology

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 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 3.56 cm. Right kidney measures 3.26 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.48 cm at cranial pole and 0.25 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.26 cm at cranial pole and 0.28 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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

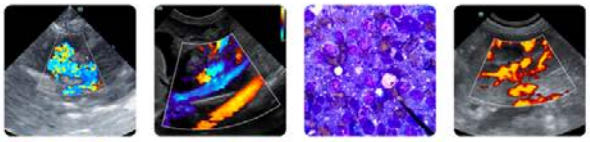
Liver is subjectively enlarged (swollen contour). Mild parenchymal remodeling with diffusely mildly coarse architecture and increased portal markings is present. No focal nodules or masses are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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 moderately thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular,



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

Pancreas

Throughout the cranial abdomen, extending from the left limb of the pancreas caudal to the stomach all the way to the right cranial abdomen are multiple discrete hypoechoic nodules/masses that appear to originate from the pancreas, on the left measuring approximately 2.0 cm x 1.3, and on the right measuring 3.0 cm x 4.6 cm. Other smaller hypoechoic densities are noted throughout the area and may represent additional pancreatic nodules/masses or adjacent lymph nodes.

Free Abdomen

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

With the exception of the possible lymph nodes adjacent to the pancreatic masses described above, no lymphadenopathy is noted.

PRIMARY FINDINGS

- The pancreatic masses/nodules are concerning for infiltrative neoplasia such as round cell neoplasia i.e., lymphoma versus carcinoma versus other. A benign inflammatory process is possible but considered less likely.
- 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.

SECONDARY FINDINGS

- Age related kidney changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

As is reportedly already pending, fine needle aspirates of the pancreatic masses +/- the adjacent lymph nodes are recommended if patient's coagulation status is appropriate.

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.

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.

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

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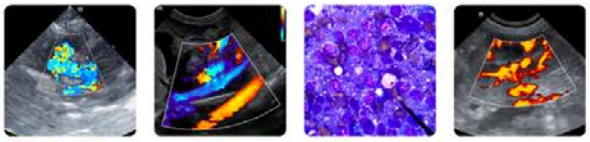

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SonoPath.com | info@sonopath.com | 1.800.838.4268

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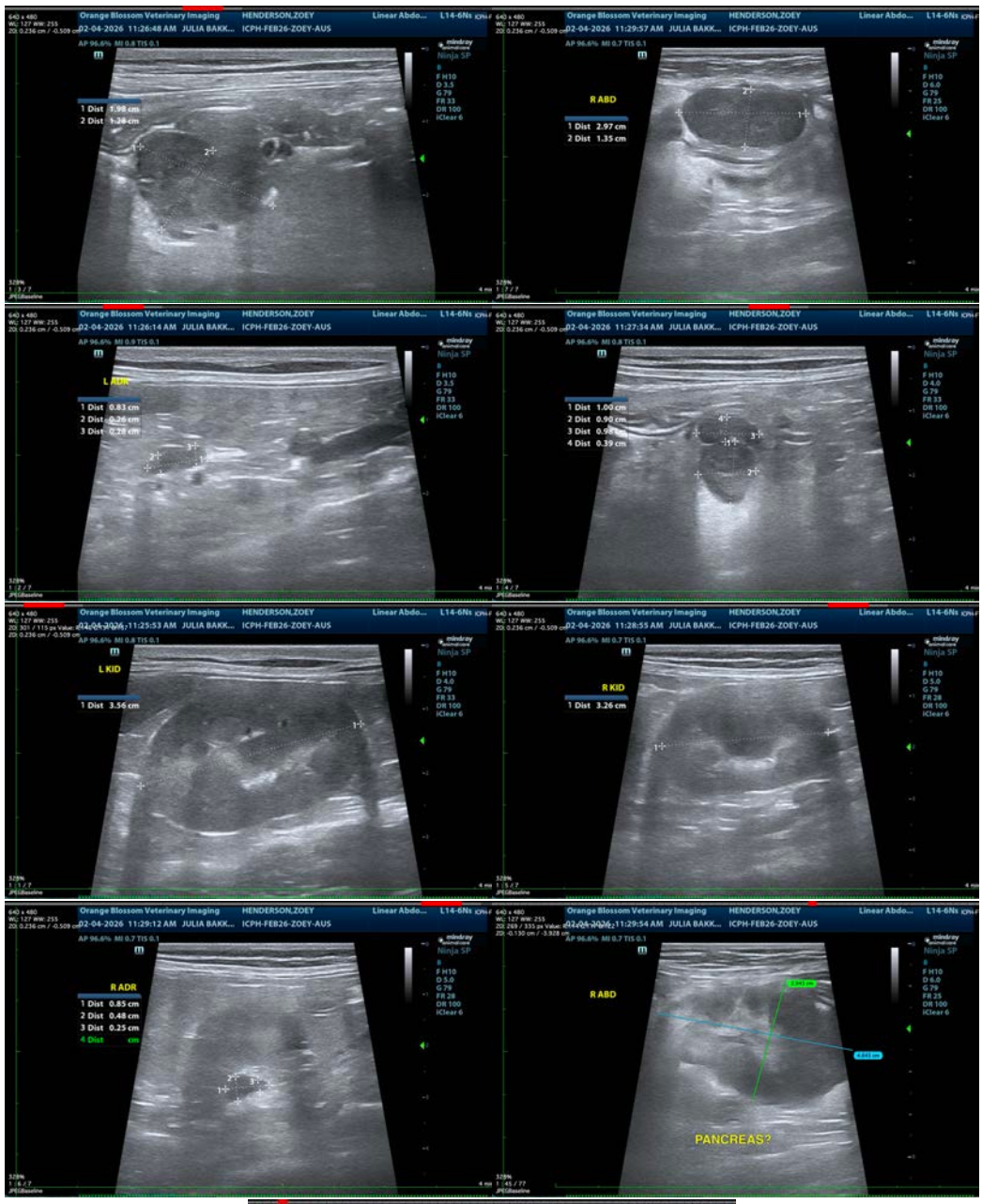

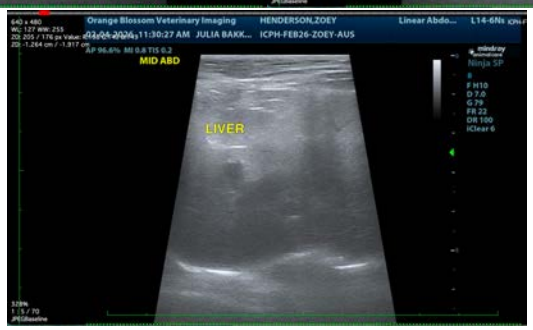

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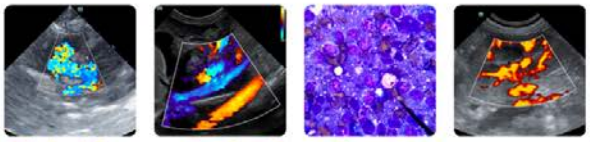

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@sonopath.com