



PATIENT

Ollie Law

SPECIES

Feline

BREED

DLH

SEX

Neutered Male

AGE

10 Years

WEIGHT

9.4 Pounds

INTERPRETED BY

Beth Johnson, DVM,
DACVIM (SAIM)

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

Echo Hollow VH

REFERRING VET

Dr. Kenna

INVOICE

36779

DATE

2/9/26

PRESENTING CLINICAL SIGNS

- Mid abdomen – Three, 1-inch, irregular firm masses noted in mid abdomen
- Heart murmur
- Ultrasound guided FNA
- Current Medications: Gabapentin 50mg/mL -SubQ Fluids

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.

Left kidney is normal in size (3.99 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.

Right kidney is normal in size (4.14 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

Left adrenal gland is normal in size (0.4 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.37 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

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 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.



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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.

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Gastrointestinal

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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.

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In the right cranial abdomen, there is a loop of small bowel that is thick, measuring between 0.44 cm thick and 0.71 cm thick, with a hypoechoic wall and loss of layering noted. This loop of bowel could represent ileum, although definitive location is difficult to say. Remaining small bowel demonstrates areas of moderate to severely 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.

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

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Pancreas

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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.

INTERPRETED BY

Free Abdomen

Beth Johnson, DVM,
DACVIM (SAIM)

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

IMAGING PERFORMED BY

The mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

Sara Hansen

ULTRASONOGRAPHIC FINDINGS

HOSPITAL NAME

Primary Findings

Echo Hollow VH

- The focally thick loop of small bowel with suspected loss of layering could represent emerging infiltrative round cell neoplasia, such as lymphoma, or a benign inflammatory process that can't be fully differentiated without tissue sampling.
- Moderately reactive mesenteric lymphadenopathy- infiltrative neoplastic disease cannot be ruled out but is considered less likely.

REFERRING VET

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Secondary Findings

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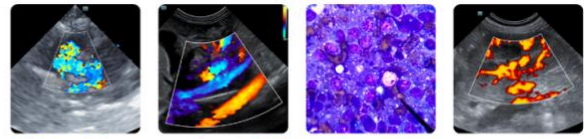
- A mild amount of echogenic urinary bladder debris

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Further recommendations depend in part on patient's clinical signs. Having said that, assuming a



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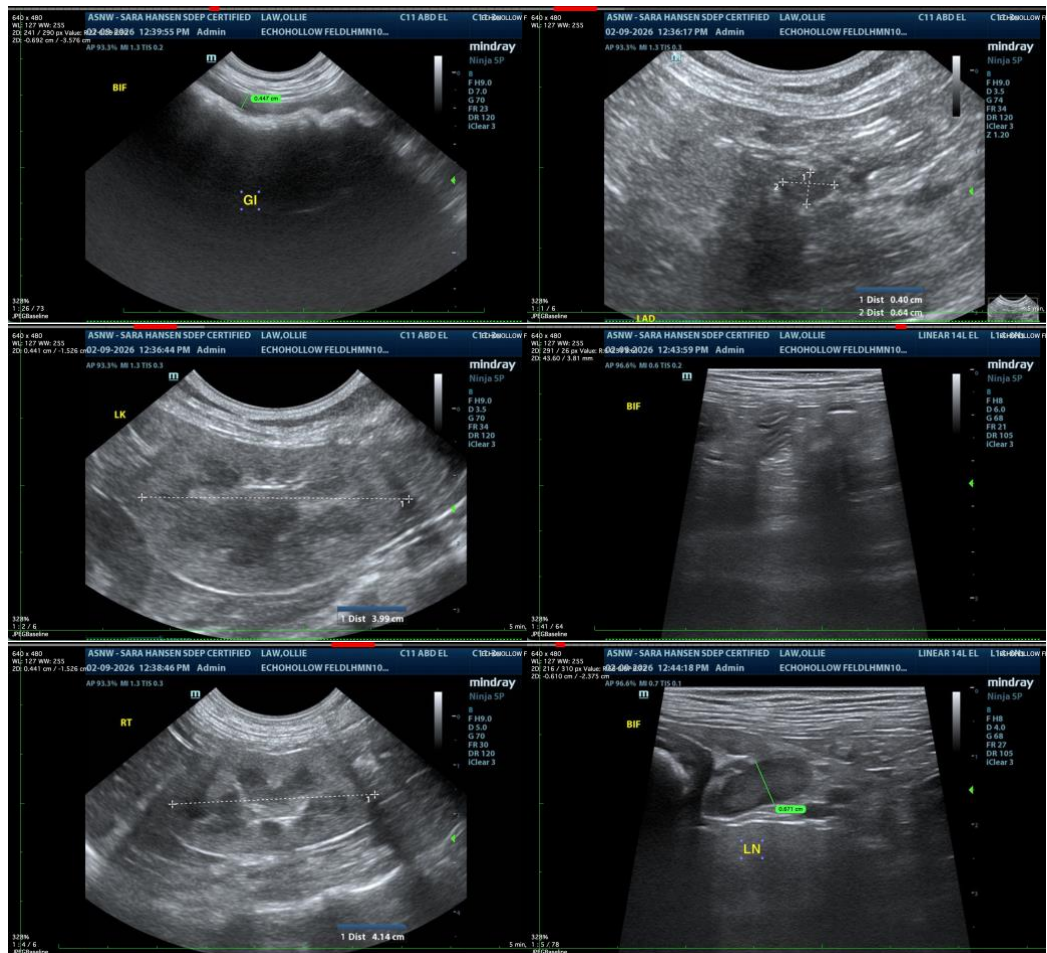
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gastrointestinal presentation, a routine fecal/Giardia exam is recommended if not recently evaluated. A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function. A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

Ultimately, however, given the changes described above, tissue sampling is recommended. Fine needle aspirates of the enlarged lymph nodes +/- the focally thick bowel could be considered if patient's coagulation status is appropriate, or if a cytologic diagnosis is unable to be obtained, biopsies of the GI tract, being sure to include the focally thicker area, may be necessary for a definitive diagnosis, and therefore to further guide therapy.





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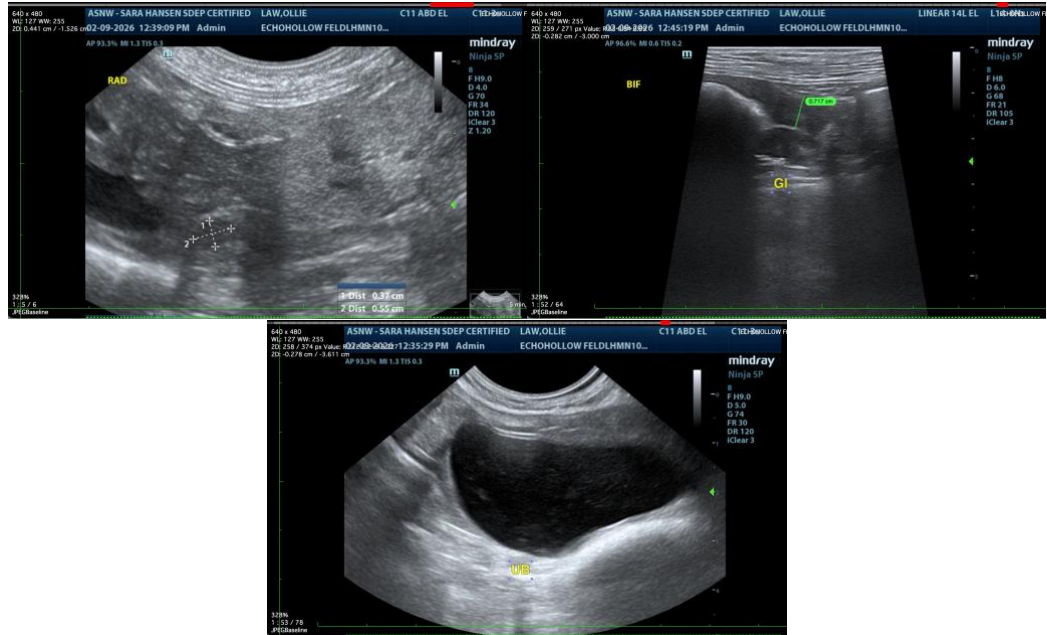
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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