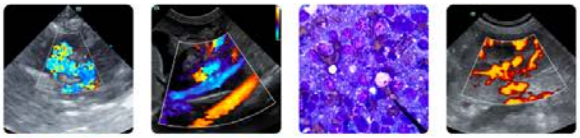


SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Bruce Kavcic

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

15 Years

WEIGHT

4.6 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Buck Animal Hospital

REFERRING VET

Dr. MacFarlane

INVOICE

73555

DATE

3/11/26

PRESENTING CLINICAL SIGNS

Presented for weight loss and decreased appetite, sudden change in activity level. Progressively declining since last week, barely eating at all now.

Current Medications: Miratаz, cerenia

Abnormal PE/Chem/CBC/UA Results: NEUT 13.58, suspect bands, mono 0.8, EOS 0.05, GLU 10.96, CREA 52, UREA 5.4, GLOB 57, ALT 173. GGT 11 Radiographic Findings na Primary Question to Be Answered in This Exam abnormal finds

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is subjectively moderately over distended. This change should be interpreted with when patient last urinated, any lower urinary tract signs, etc. The bladder has a normal uniform wall thickness. Contents include primarily anechoic fluid with a large amount of echogenic non-shadowing debris, most consistent with exfoliated cells, crystals, mucous and/or small blood clots likely combined with incidental suspended lipid. Both sterile inflammation as well as urinary tract infection can 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.

The right kidney is normal is size (4.6 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.

The left kidney is normal is size (4.5 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), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.44 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

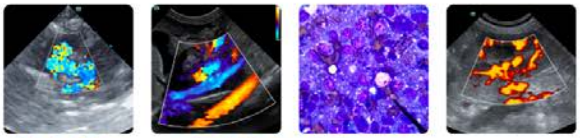
Spleen

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.



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Gastrointestinal

In the cranial abdomen, in what I believe is the pylorus into the proximal duodenum is an approximately 2.1 cm x 3.0 cm hypoechoic bowel mass. It is difficult to definitively determine the exact location of the bowel mass, however, with stomach, proximal small bowel, or less likely but unable to be definitively ruled out, Ileocecocolic junction all being possibilities.

Other than described above, the visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

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 small amount of anechoic free fluid, primarily in the caudal abdomen adjacent to the urinary bladder.

Additionally, in the area of the aortic trifurcation, is an approximately 0.50 cm x 0.90 cm ovoid echogenic density that in some views appears to potentially be within a vessel. Differentials include a thrombus versus a lymph node adjacent to the vessels versus other. This finding should be interpreted in combination with any clinical or physical exam findings consistent with possible saddle thrombus.

ULTRASONOGRAPHIC FINDINGS

- Large amount of echogenic urinary bladder debris.
- Cranial abdominal bowel mass/suspect possible proximal duodenal mass – Most 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. As described above, definitive location is difficult to say, but my top differential is proximal small bowel/proximal duodenum potentially extending into the pyloric area. Having said that, Ileocecocolic junction, while thought less likely can't be definitively ruled out.
- The trace 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.
- The liver changes are non-specific but similarly concerning for an infiltrative process with infiltrative round cell neoplasia such as lymphoma being one differential, but a benign process such as bacterial or lymphoplasmacytic cholangiohepatitis, hepatic lipidosis, other benign infectious or inflammatory hepatopathy, etc. can't be ruled out without tissue sampling.

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- As described above, possible saddle thrombus versus mildly reactive medial iliac lymphadenopathy is difficult to fully differentiate.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

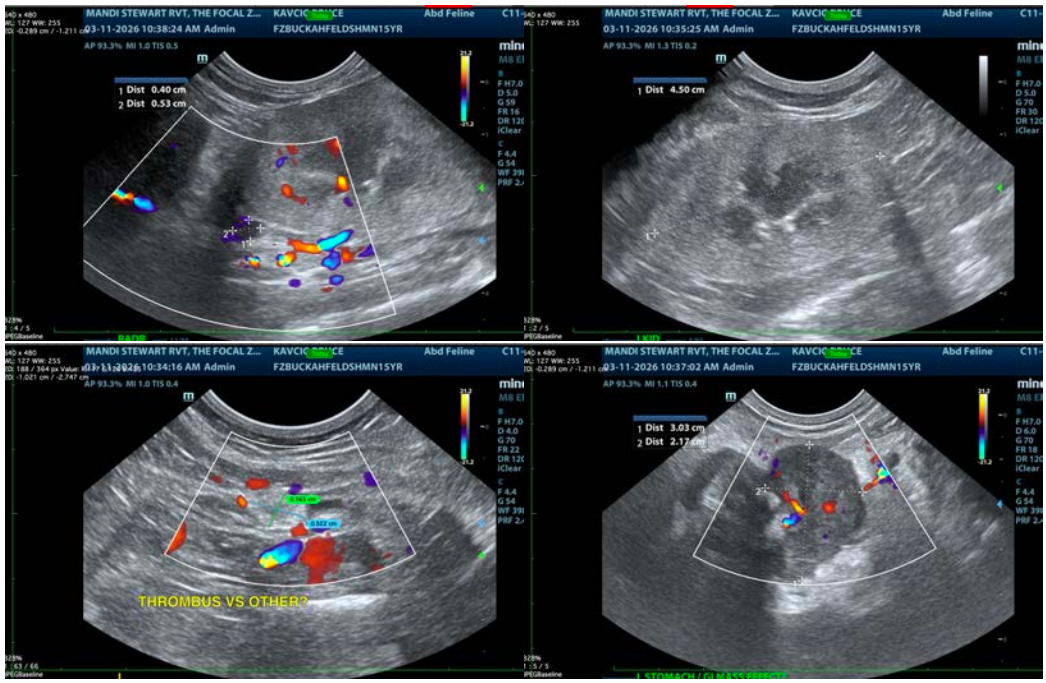
Fine needle aspirates of the bowel mass +/- liver are recommended if patient's coagulation status is appropriate.

Urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended.

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.

Based on geographic differences in case submission, for laboratory results to be utilized in recommendations please provide units, reference ranges, or at least a high or low indication after the value if lab work is not directly attached.

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



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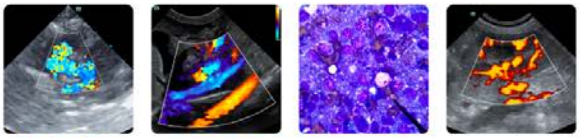

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Educational Teleconsultation Services™

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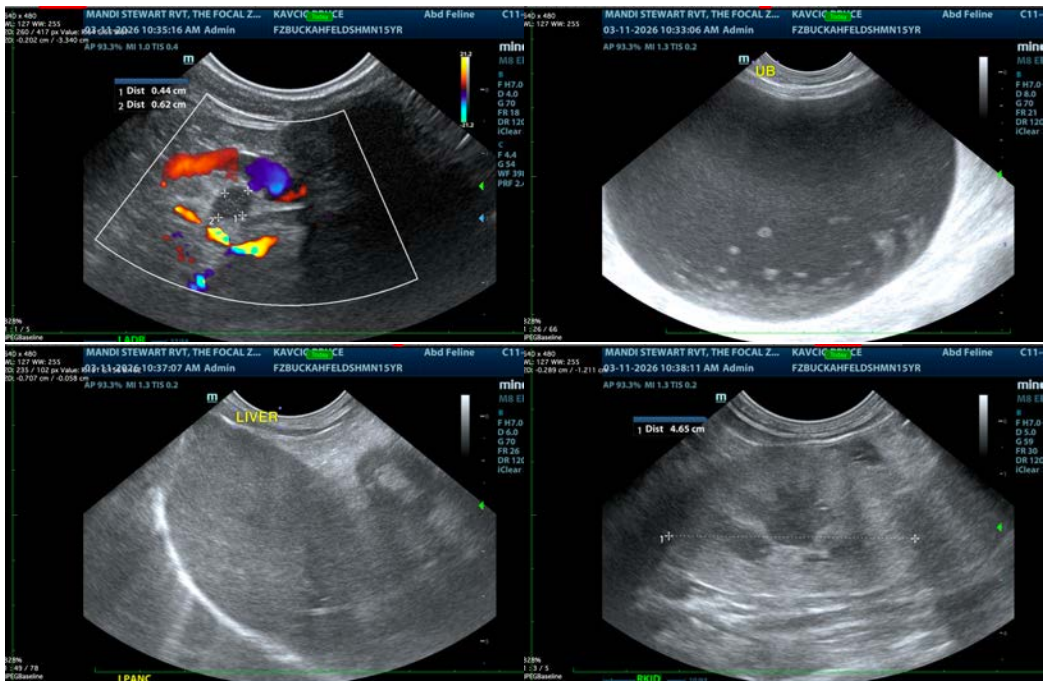

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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