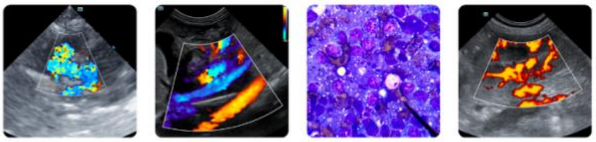


PATIENT

Zoey- Whitney Alexander

SPECIES

Feline

BREED

Persian

SEX

Neutered Male

AGE

18 Years 10 Months

WEIGHT

4.03 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Jessie Evoniuk

HOSPITAL NAME

State Avenue Vet Clinic

REFERRING VET

Dr. Jessie Evoniuk

INVOICE

14443

DATE

03/19/26

PRESENTING CLINICAL SIGNS

- Presents for ongoing management of soft stool and appetite concerns.
- - History of soft stool; improved after discontinuing prednisone—still soft, less frequent, using litter box.
- - Previously on prednisolone TD and metronidazole, on and off
- - Appetite stimulation required, assisted feeding; currently receiving Mirataz.
- - Gabapentin administered this morning as calming med

Abnormal PE/Chem/CBC/UA Results: 3/12/26: RBC 7.35, HCT 31.82, ALT 132; SDMA and T4- WNL
Consideration of GI panel (TLI, PLI, Cobalamin and Folate), pending US

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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. The left kidney measures 4.0 cm. The right kidney measures 3.9 cm.

Adrenal Glands

The area of the adrenal glands are examined without evident adrenal gland pathology.

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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature appears normal.

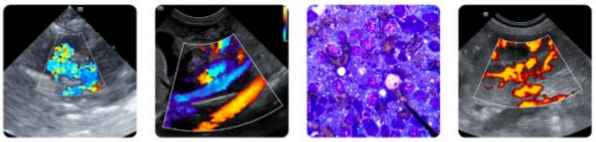
Liver

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.

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.



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The visible small intestine 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.

The visible colon is thickened in wall thickness (0.46 cm) with loss of wall layering for at least 2.1 cm beyond the ileocecocolic junction. The lumen is empty.

Pancreas

Pancreas is prominent in size with swollen irregular contour. Parenchyma is heterogenous characterized by hyperechoic tissue remodeling intermixed with ill-defined hypoechoic nodules. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is a small to moderate amount of free fluid 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.

ULTRASONOGRAPHIC FINDINGS

- The ascending and possible transverse and potentially longer colon changes are concerning for infiltrative neoplasia such as round cell neoplasia, i.e. lymphoma versus carcinoma versus other. Having said that, benign, infectious, parasitic, other inflammatory process cannot be ruled out without tissue sampling.
- Mesenteric lymphadenopathy- concerning for infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.
- A small to moderate amount of free fluid- 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.
- Pancreatic nodular hyperplasia- Infiltrative neoplasia cannot be ruled out but is considered less likely. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.
- Hyperechoic splenic nodules- most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.
- Age-related kidneys changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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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.

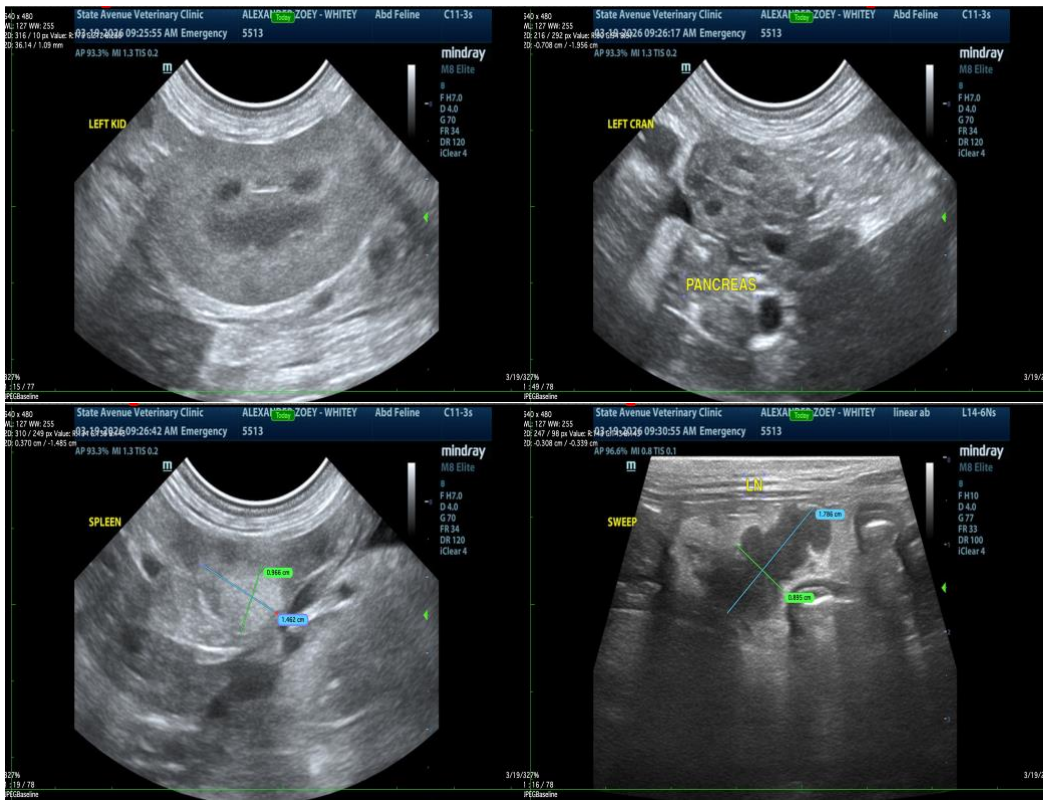
Fine needle aspirates of the enlarged lymph nodes +/- spleen +/- pancreas could be considered if patient's coagulation status is appropriate, as could sampling of the free abdominal fluid.

Ultimately, sampling of the colon is likely necessary for a definitive diagnosis and to further guide medical management, potentially via colonoscopy.

However, in the meantime, if not recently evaluated, a routine fecal/Giardia exam is recommended, as is 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.

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



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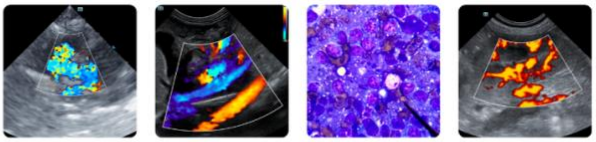

Clinical Sonography & Telecytology
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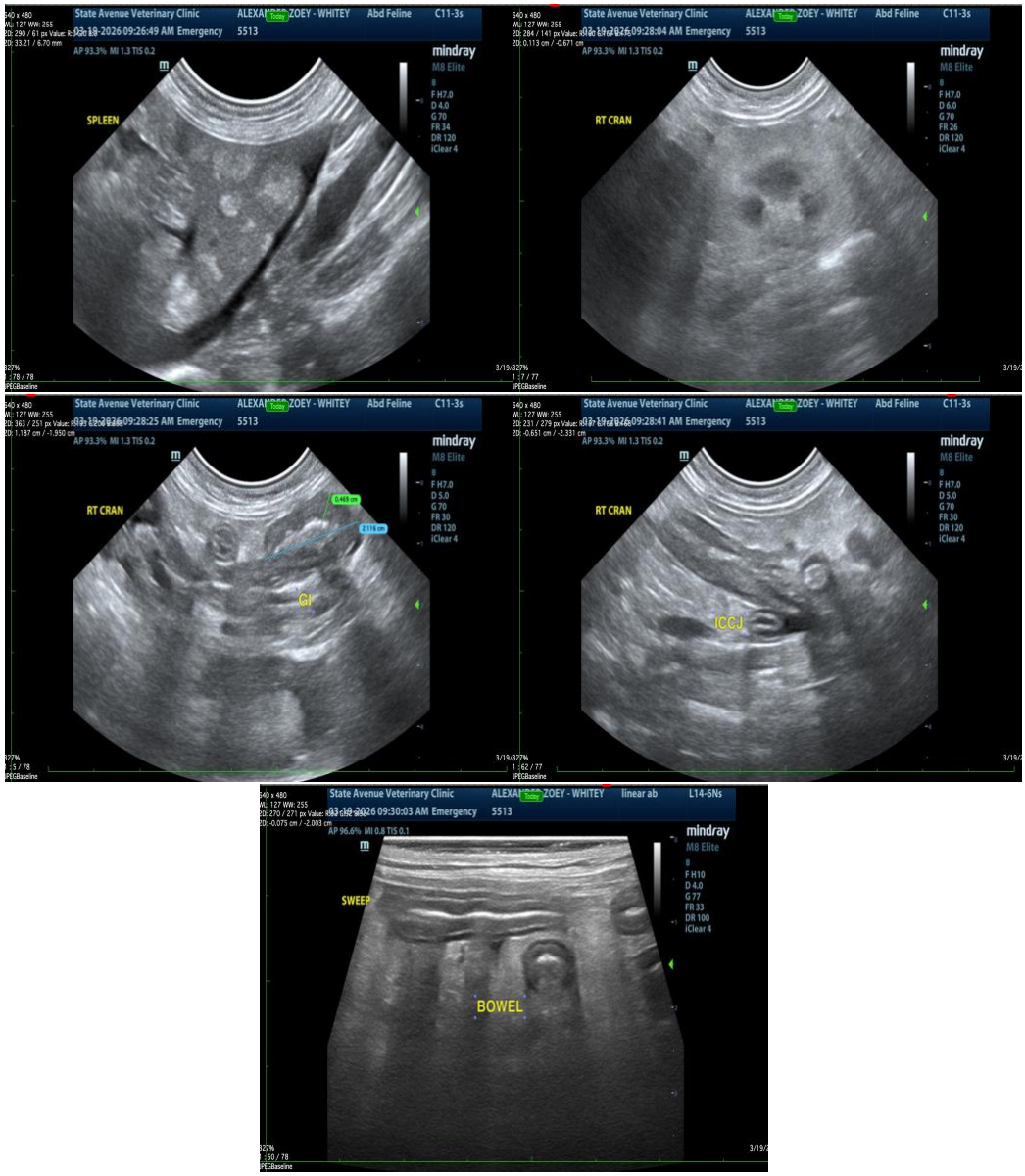

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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