



PATIENT

Clarice Ryan

SPECIES

Feline

BREED

DLH

SEX

FS

AGE

13Y

WEIGHT

9.5lbs

INTERPRETED BY

Beth Johnson, DVM,
DACVIM (SAIM)

IMAGING PERFORMED BY

Jessica Milligan DVM

HOSPITAL NAME

Dockside Veterinary
Imaging

REFERRING VET

Lindsay Bennett DVM

INVOICE

74300

DATE

3-23-26

PRESENTING CLINICAL SIGNS

- Decreased appetite, lethargy, Radiology Report states possible abdominal mass/IBD/Lymphoma

Abnormal PE/Chem/CBC/UA Results: Radiograph review attached.

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.

The right kidney is normal is size (4.24 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 (3.87 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 area of the right adrenal gland is examined without evident adrenal gland pathology but is difficult to fully visualize/isolate for measurement.

The left adrenal gland is normal in size (0.59 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. In the area of the hilus, there is an approximately 0.4 x 0.8 cm homogeneous isoechoic bulge. Suspect accessory spleen but an infiltrative neoplastic nodule cannot be definitively ruled out. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). Splenic vasculature appears normal.

Liver

The 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.

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



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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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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, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

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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

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.

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Free Abdomen

There is a scant/trace amount of anechoic free fluid noted in the mid abdomen as well as an approximately 5.6 x 4.0-4.5 cm in size heterogeneous hypoechoic mesenteric root/suspect lymph node mass.

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ULTRASONOGRAPHIC FINDINGS

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Beth Johnson, DVM,
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- The mesenteric root/lymph node mass is concerning for infiltrative neoplasia such as round cell neoplasia i.e. lymphoma vs other. A benign inflammatory process is possible but considered less likely.
- Trace 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.
- Marked 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.
- The splenic changes described above trends in appearance toward a benign incidental accessory spleen although infiltrative neoplastic process cannot be ruled out without tissue sampling.
- Mild amount of echogenic urinary bladder debris.
- Concurrent mild chronic low grade smoldering pancreatitis cannot be ruled out.

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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.

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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.

As is reportedly already pending, FNA of the enlarged mesenteric lymph node and spleen could be considered if the patient's coagulation status is appropriate. If a cytologic diagnosis is not able to be



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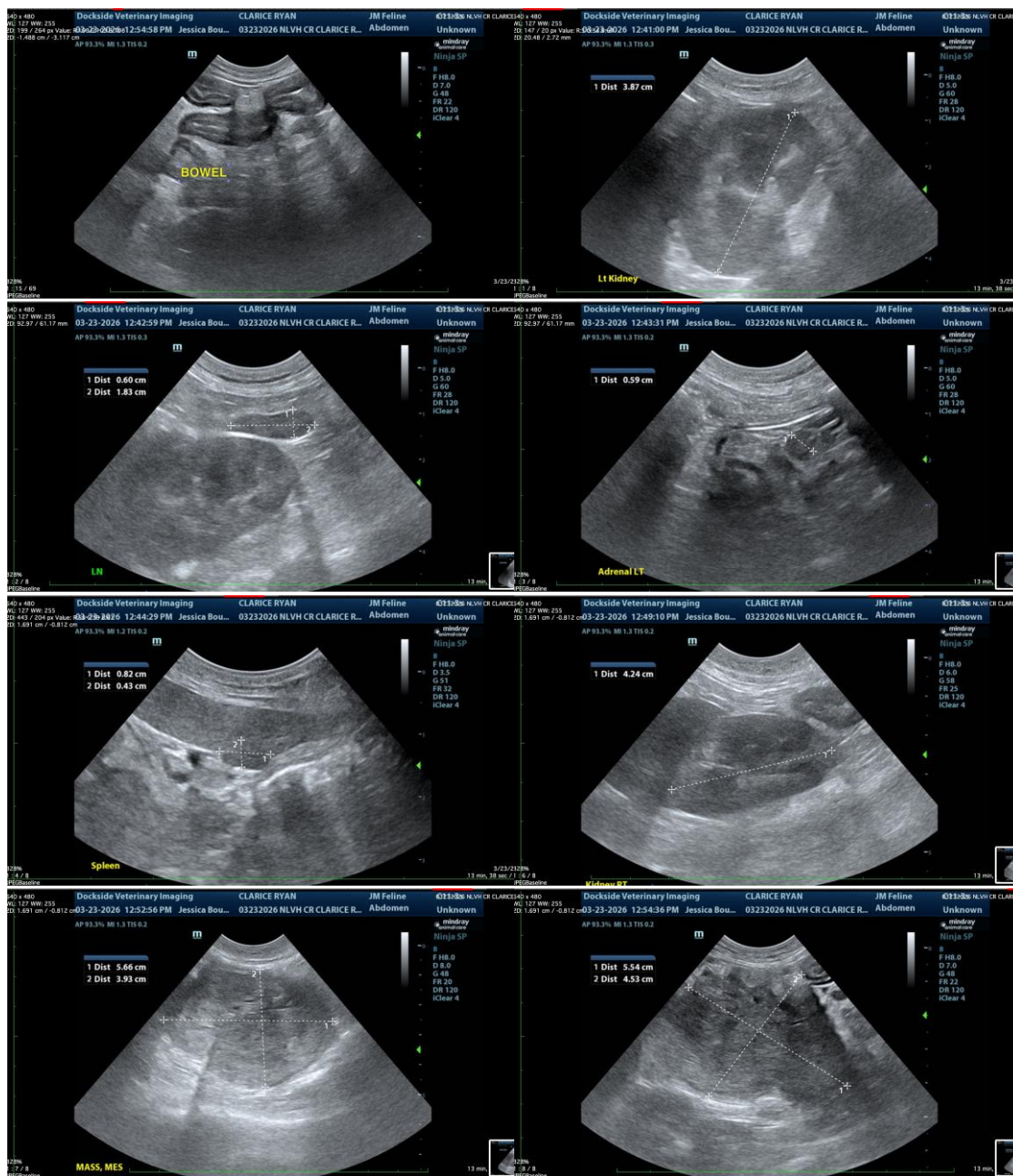
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obtained, ultimately biopsies of the GI tract may be necessary for a definitive diagnosis and therefore to further guide medical management.

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





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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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