



## PATIENT

Mame Fukasawa

## SPECIES

Feline

## BREED

DSH

## SEX

MN

## AGE

17 years

## WEIGHT

13.8

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Dr. Hesham Akbawy

## HOSPITAL NAME

Lincoln Avenue Cat  
and Dog Hospital

## REFERRING VET

Dr. Hesham Akbawy

## INVOICE

11541

## DATE

3/23/2026

## PRESENTING CLINICAL SIGNS

- Mame 17 years old MN DSH feline. Has been having hyperthyroid for 6 weeks.
- On methimazole 2.5 mg BID. Came for checking T4 after 5 weeks treatment.
- Icteric. Decreased appetite.
- Blood test show: elevated total bilirubin, subjugated and conjugated as well
- Controlled T4.
- On IV NaCl, antibiotics and supportive treatment

## 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.

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 mineral or infarcts observed. What I believe is the left kidney, measures 4.3 cm. The kidneys are not labeled, and I'm not sure when I'm seeing the left kidney versus the right kidney from the otherwise but based on positioning, what I know is the right kidney measures 4.4 cm. Both kidneys demonstrate trace pyelectasia.

### Adrenal Glands

The area of the right adrenal gland is examined without evident adrenal gland pathology.

The left adrenal gland is unable to be visualized.

### Spleen

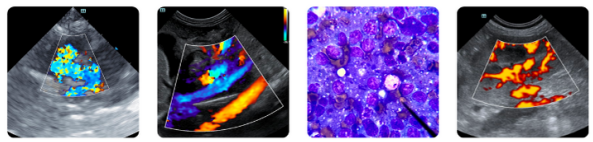
The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

### 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



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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 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*

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. \*See other\*

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### *Free Abdomen*

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

There is no apparent pathologic lymphadenopathy noted in these images.

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In the cranial to mid abdomen, there's an approximately a 5.6 cm x 2.8 cm ill-defined, heterogenous, partially cystic, density that's unable to be attached to a specific organ or have origination identified. It could represent a lymph node, pancreas, although bowel, liver, other can't be ruled out. Additionally, dorsal to the urinary bladder, is an approximately 1.0 cm in diameter hypo- to anechoic density that could represent an enlarged lymph node. Although cysts, hematoma, abscess, other, can't be ruled out.

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Some subtly enhanced hyperechoic tissue, mesenteric fat, omentum, etc., is noted adjacent to the cystic heterogenous mass.

### **PRIMARY FINDINGS**

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- Cranial to mid abdominal mass is of unknown origin. As stated above, it could represent pancreas in which case severe but benign pancreatitis versus infiltrative neoplasia affecting the pancreas are possibilities. An enlarged lymph node, in which cause infiltrative neoplasia is a concern as a differential, although other etiologies including bowel mass, liver mass, can't be ruled out. Similarly, benign differentials such as hematoma, abscess, other, can't be ruled out without tissue sampling.

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- Suspect medial iliac lymphadenopathy, but as described above, the density in that area could represent cyst, hematoma, abscess, other.

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- 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.



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- Hypochoic hepatomegaly – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.

**SECONDARY FINDINGS**

- Trace bilateral pyelectasia.
- Mild to moderate amount of echogenic urinary bladder debris.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

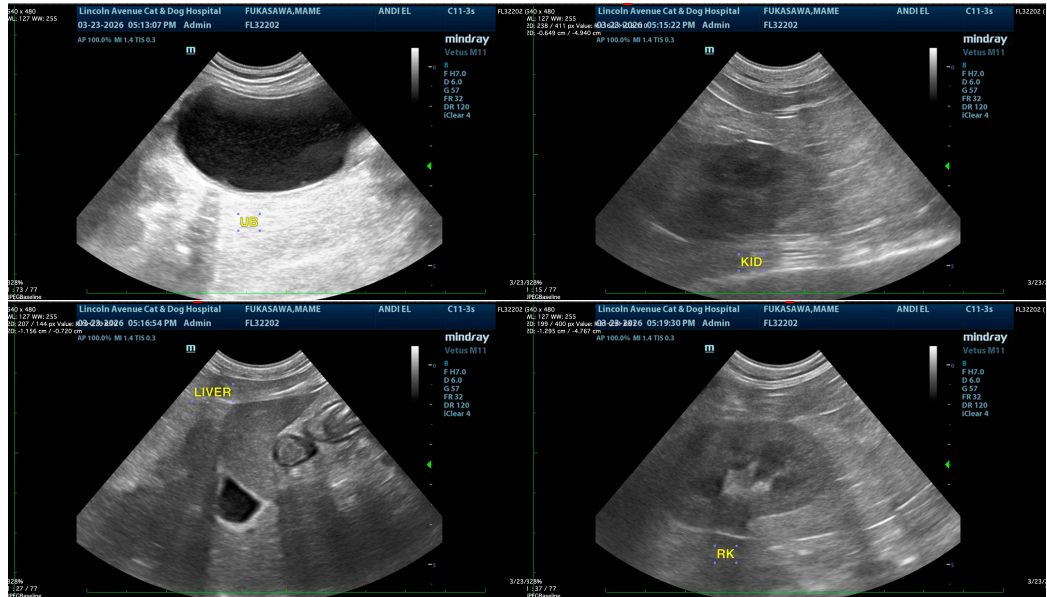
Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

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.

Fine needle aspirates of the mid to cranial abdominal structure as well as the liver, and potentially the suspected lymph node adjacent to the urinary bladder if it can safely be reached, could all be considered if patient's coagulation status is appropriate.

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

While quite rare, severe hepato toxicity can be the result of methimazole therapy, and while based on the pathology visible above, I don't think that's the primary problem. Temporary discontinuation of methimazole or transition to an alternative therapy could also be considered.





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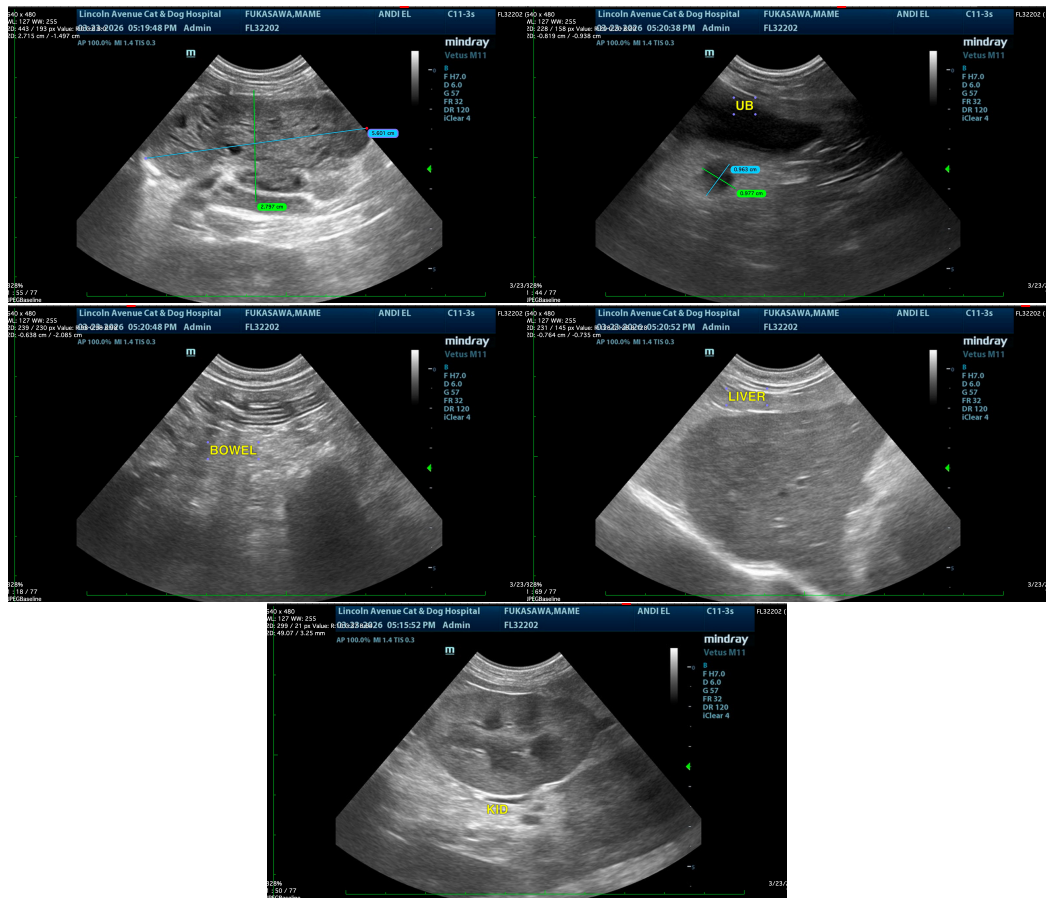
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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