



**PATIENT**

Tony Seyler

**PRESENTING CLINICAL SIGNS**

Colitis & weight loss. Concern for intestinal mass.

**SPECIES**

Feline

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

**BREED**

DSH

The urinary bladder is moderately 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.

**SEX**

Neutered Male

The right kidney is normal in size (3.2 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.

**AGE**

14 Years 6 Months

The left kidney is normal in size (4.0 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.

**WEIGHT**

10 Pounds

**Adrenal Glands**

The adrenal glands are unable to be well visualized in these images.

**Spleen**

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

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**

**IMAGING PERFORMED BY**

Dr. Katie Freson

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.

**HOSPITAL NAME**

Kings Vet Hospital

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**

**REFERRING VET**

Dr. Katie Freson

The visible stomach wall is normal in thickness and layering. The stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. However, given the reported history of fasting, delayed gastric emptying could be considered. Soft (cloth) fluid absorbing foreign material is considered less likely but cannot be definitively ruled out. If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

**INVOICE**

46322

**DATE**

3/30/23

One bowel loop is closely examined in multiple images and appears to be a bowel mass characterized by 0.60 cm thick wall and not complete loss of layering but decreased mural detail and emerging loss of layering. Based on location in several images, the bowel in question appears to be colon, but it can't be definitively traced and guaranteed to be colon. The remainder of the bowel is difficult to comment on based on these images.



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**Pancreas**

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

**Free Abdomen**

There is no evidence of free peritoneal effusion noted in these images.

There is a round, hypoechoic, prominent lymph node adjacent to the bowel mass described above.

**ULTRASONOGRAPHIC FINDINGS**

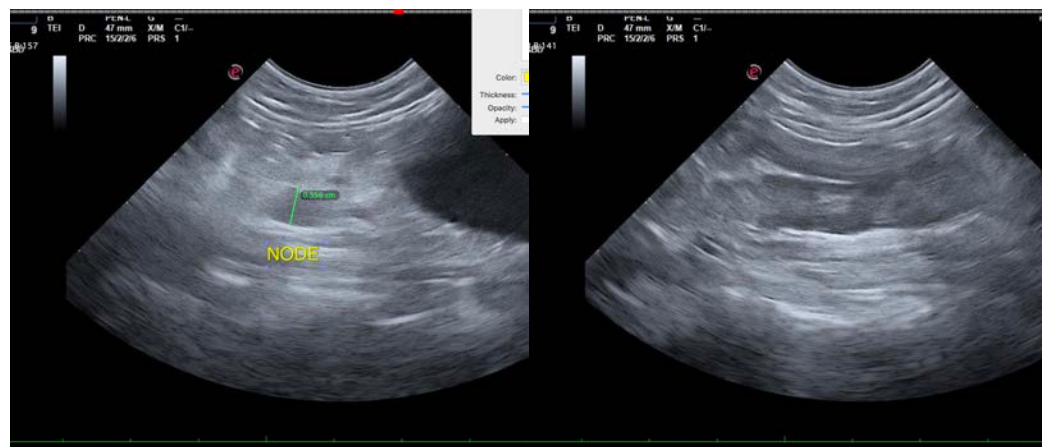
- Bowel mass – Presumed to be colonic based on location in some of these images, as well as patient’s history of colitis. However, small versus large cannot be definitively ruled out. The appearance of the mass, given the emerging loss of layering, is most concerning for infiltrative neoplasia such as lymphoma. A benign infectious, parasitic, or inflammatory disease can’t be definitively ruled out but is considered slightly less likely. Adjacent lymphadenopathy could represent a reactive lymphadenopathy or infiltrative neoplasia and can’t be determined without tissue sampling.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

A general metabolic health screen is recommended, beginning with CBC/Chem panel, electrolytes, a urinalysis and, if indicated based on urinalysis results, urine culture. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

Ultimately, tissue sampling (likely if this is colon via colonoscopy) is recommended for definitive diagnosis. Additionally, a fecal exam is recommended if not recently evaluated, as is a fecal enteropathogen PCR panel to Texas A&M GI Laboratory, and 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.

In the meantime, empirical deworming with a 5-day course of Panacur is recommended, as is a probiotic such as Visbiome or Provable, and potentially if tolerated, a transition to a colitis or fiber response diet.





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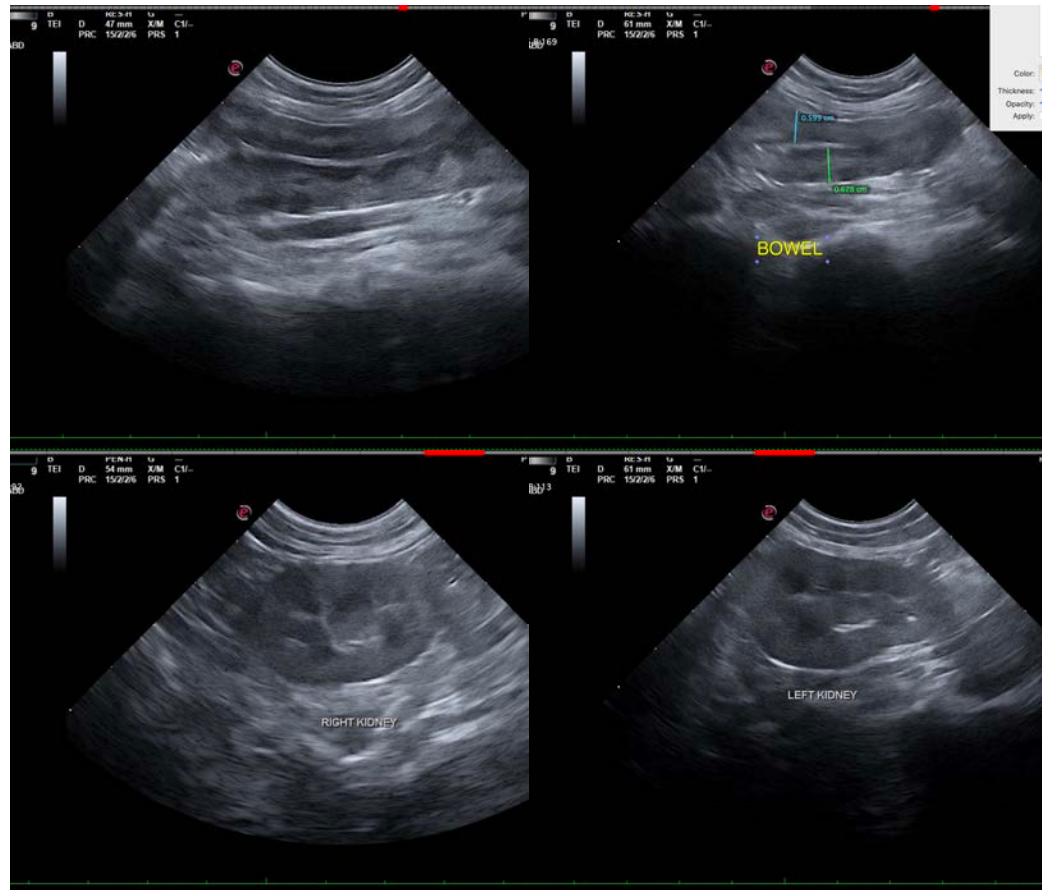
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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