

**PATIENT**

Shadow Hatley

**SPECIES**

Feline

**BREED**

DSH

**SEX**

MN

**AGE**

2009

**WEIGHT**

7.2

**INTERPRETED BY**

Beth Johnson, DVM  
 DACVIM

**IMAGING PERFORMED BY**

Rebekah Jakum, CVT  
 ARDMS/RVT

**HOSPITAL NAME**

Mt Airy Animal Hospital

**REFERRING VET**

Riley

**INVOICE**

24146

**DATE**

03/09/2026

**PRESENTING CLINICAL SIGNS**

- 5.7# weight loss in 18 months
- History of progressive weight loss, ataxia, increased liver values
- Medication: Cerenia, ondansetron PRN

**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 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 pyelectasia, mineral or infarcts observed. The left kidney measured 4.1 cm, the right kidney measured 4.1 cm.

**Adrenal Glands**

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

**Spleen**

The spleen is normal except for a subjective mid-medial bulge, homogenous and isoechoic in appearance, measuring 0.7 by 0.8 cm in size.

**Liver**

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mottled by multifocal discrete hypoechoic nodules of varying sizes "moth-eaten". 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**

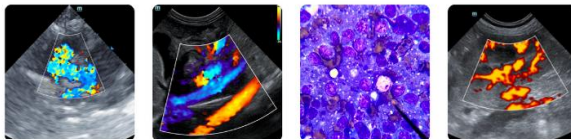
The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestine demonstrates areas of moderate 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.

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 in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. Pancreatic duct dilation is noted.



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### Free Abdomen

A trace amount of free fluid is noted in these images. Cranial abdomen lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

### ULTRASONOGRAPHIC FINDINGS

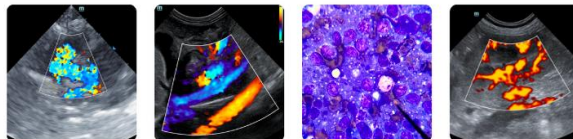
- The appearance of the liver is concerning for infiltrative neoplasia such as round cell neoplasia vs metastatic neoplasia vs other. A benign inflammatory process is possible but considered less likely.
- Possible concurrent splenomegaly can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- Moderate 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.
- Concurrent chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs
- 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.

### Secondary

- Age-related kidney changes
- Mild amount of echogenic urinary bladder debris

### INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. 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.
2. FNA of the liver +/- spleen as well as free fluid sampling could all be considered if patient's coagulation status is appropriate.
3. 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.
4. Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.



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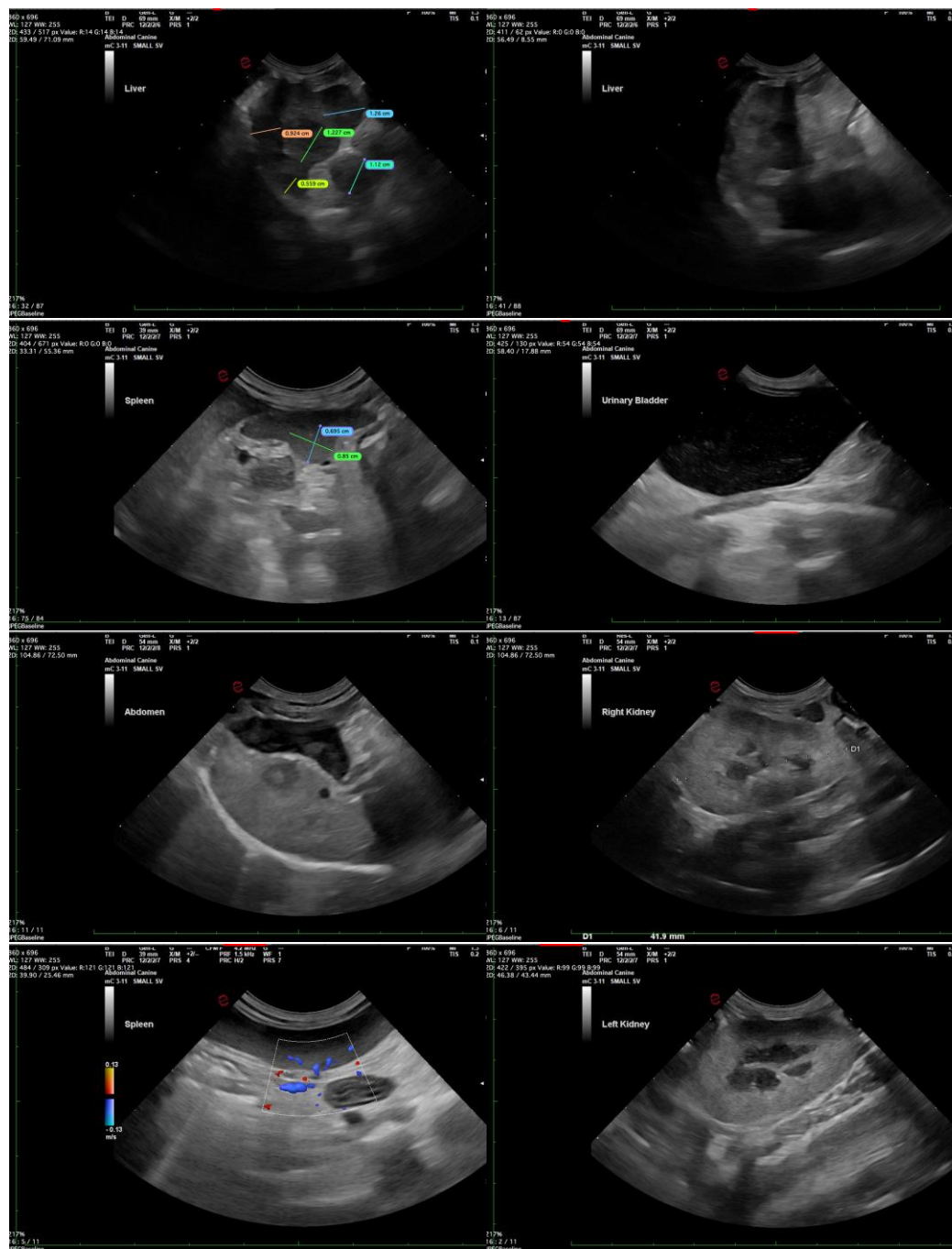
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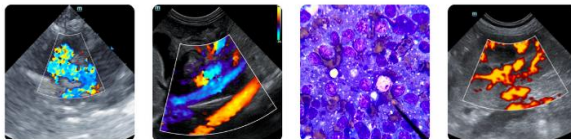
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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