



## PATIENT

Lilly Allen

## SPECIES

Feline

## BREED

Maine Coon

## SEX

FS

## AGE

14 years

## WEIGHT

8 lbs

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Dr. Julia Bakker

## HOSPITAL NAME

Orange Blossom  
Veterinary Imaging

## REFERRING VET

Dr. Gabriella Sanchez

## INVOICE

11604

## DATE

4/1/2026

## PRESENTING CLINICAL SIGNS

Pet presented for hematuria, reduced appetite. Screening for abdominal neoplasia. Survey radiographs suspicious of abdominal mass effect and pulmonary nodule. CBC/Chem/T4 unremarkable. Ulcerated mass on lip. Patient takes methimazole for hyperthyroidism and is well controlled.

## 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 pyelectasia, mineral or infarcts observed. Left kidney measures 3.36 cm and the right kidney measures 4.1 cm.

### Adrenal Glands

The right adrenal gland is normal in size (0.39 cm at cranial pole and 0.38 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.29 cm at cranial pole and 0.25 cm at caudal pole), 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. 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

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted. Pyloric outflow tract appears patent.

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



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irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted.

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 (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. \*See Free Abdomen\*

### **Free Abdomen**

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

There is definitive distinct lymphadenopathy noted in these images. However, in the left cranial abdomen, there's an approximately 1.5 cm x 2.0 cm homogenous, hypoechoic density that is closely associated to the left pancreas and could represent a pancreatic nodule/mass or adjacent lymphadenopathy.

### **PRIMARY FINDINGS**

- 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.
- Hypoechoic hepatomegaly – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.
- Concurrent chronic low grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- A pancreatic nodule/mass versus adjacent lymphadenopathy can't be differentiated, as described above.

### **SECONDARY FINDINGS**

- Mild age-related kidney changes.
- A very mild amount of echogenic urinary bladder debris.

### **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

Especially given the reported appearance of a possible pulmonary nodule, tissue sampling to look for infiltrative neoplasia is recommended. Therefore, fine needle aspirates of the liver, as well as the left



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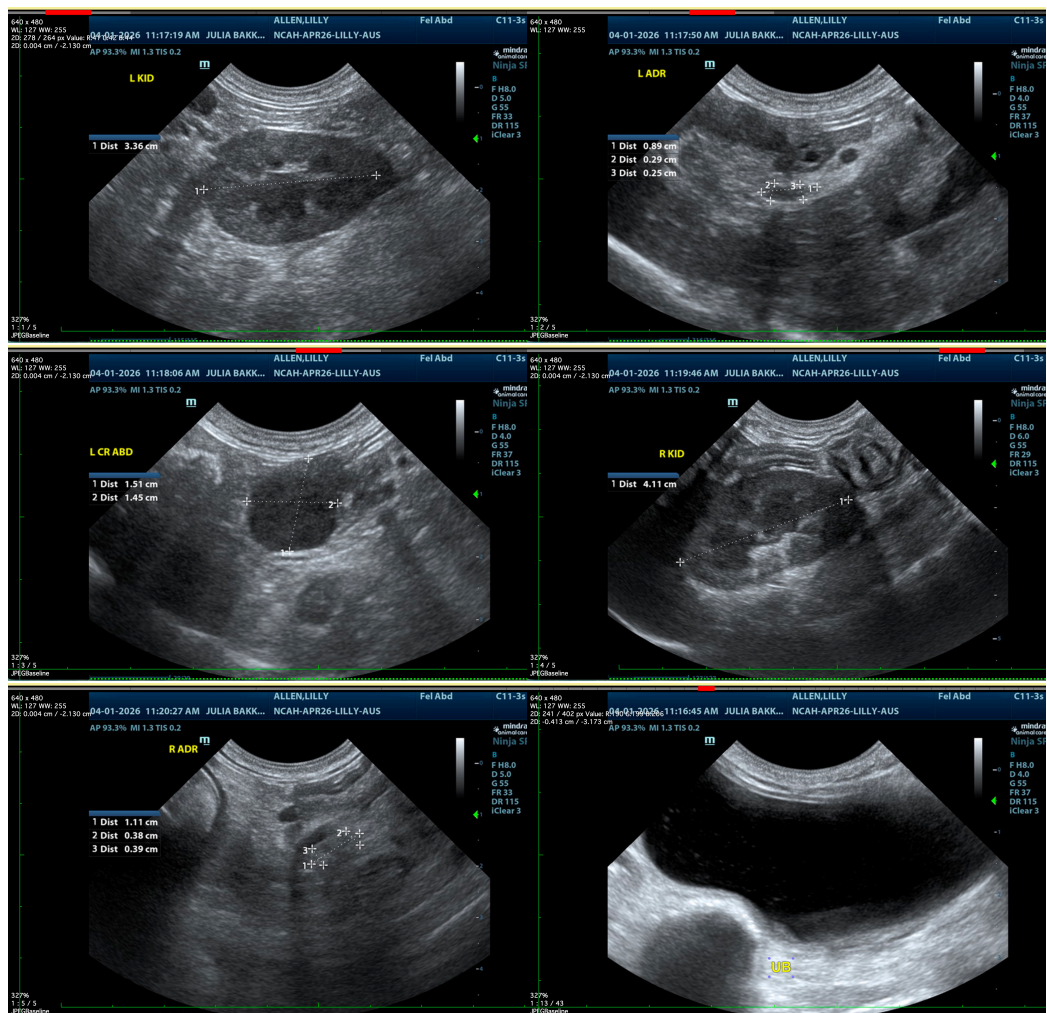
cranial hypoechoic density, if it can safely be reached, are recommended if patient's coagulation status is appropriate.

In the meantime, additionally, 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.

If a diagnosis is not obtained, cytologically, ultimately biopsies of the GI tract being sure to include ileum, if possible, as well as biopsies of the left cranial abdominal structure could be considered.

Given the reported radiograph suspicions, advanced imaging of the thorax i.e. CT or sampling of the possible pulmonary nodule, could also be considered if patient's coagulation status is appropriate.

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





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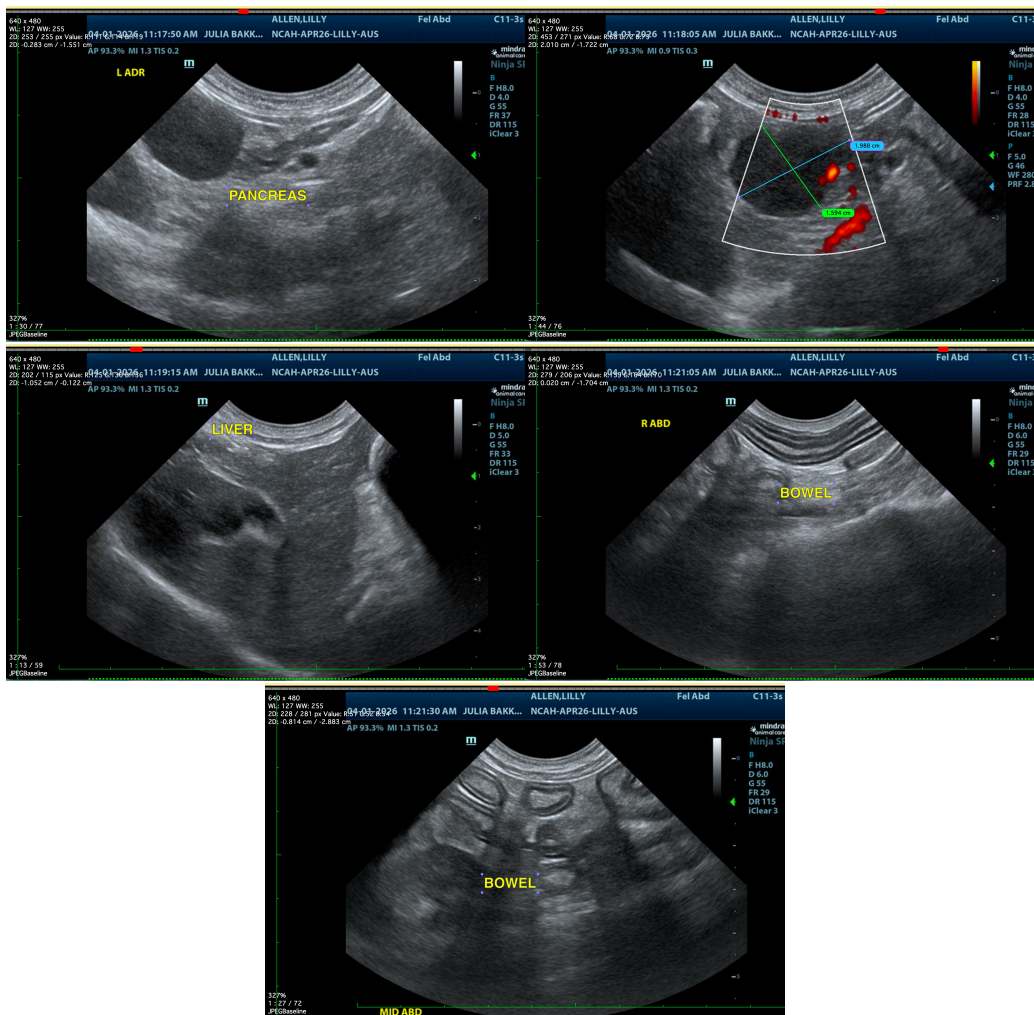
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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