



**PATIENT**

OC Karabec

**SPECIES**

Feline

**BREED**

Domesti Medium Hair

**SEX**

Neutered Male

**AGE**

14 Years

**WEIGHT**

10.1 lbs

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Meghan Morse, LVT,  
CVT

**HOSPITAL NAME**

Kingston Animal  
Hospital

**REFERRING VET**

Dr. Rosen

**INVOICE**

74109

**DATE**

4/1/26

**PRESENTING CLINICAL SIGNS**

Wt loss (1lb in 2 weeks), decreased appetite, Hx of diabetes, recent diabetic remission, V+/D+ (small soft stools). Elevated CardioBNP (111), unable to appreciate heart/lung sounds, purring

Current meds: Mirataz

Abnormal PE/Chem/CBC/UA Results: Mild monocytosis and basophilia, rest WNL

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is adequately 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.

The right kidney is normal is size (4.2 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.

The left kidney is normal is size (4.07 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 right adrenal gland is normal in size (0.41 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.44 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. 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**

The liver is subjectively mildly to moderately large with rounded, scalloped margins as a result of multifocal discrete homogeneous hypoechoic nodules/masses of varying sizes. The largest in the mid liver measures approximately 3.4 cm x 3.2 cm in size. A smaller more caudal, similar appearing mass measures 1.5 cm x 1.8 cm. \*See other.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

**Gastrointestinal**

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 mildly 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. \*See other.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

**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.

**Other**

A trace amount of anechoic free fluid is present in these images.

No definitive lymphadenopathy noted, but in the mid to cranial abdomen there is an approximately 1.6 cm x 1.8 cm homogeneous, hypoechoic density/mass similar in appearance to the liver masses described above, which does not appear to originate from the liver, although caudal liver can't be ruled out. Other differentials include an enlarged lymph node, or in one view it almost appears to be originating from bowel wall.

**PRIMARY FINDINGS**

- The nodular liver is concerning for infiltrative neoplasia such as round cell neoplasia i.e., lymphoma versus other. Having said that, a benign process including benign inflammatory disease, feline biliary cystadenoma(s) versus other can't be ruled out without tissue sampling.
- Mild/emerging 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. This finding could be in part normal patient variant in a senior cat but warrants further investigation, especially given patient's reported clinical history.
- As stated above, a bowel mass or adjacent mesenteric lymph node can't be ruled out.
- The trace 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 FINDINGS**

- Mild gallbladder debris – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness, however, it can also be associated with hepatobiliary disease in cats and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.



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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

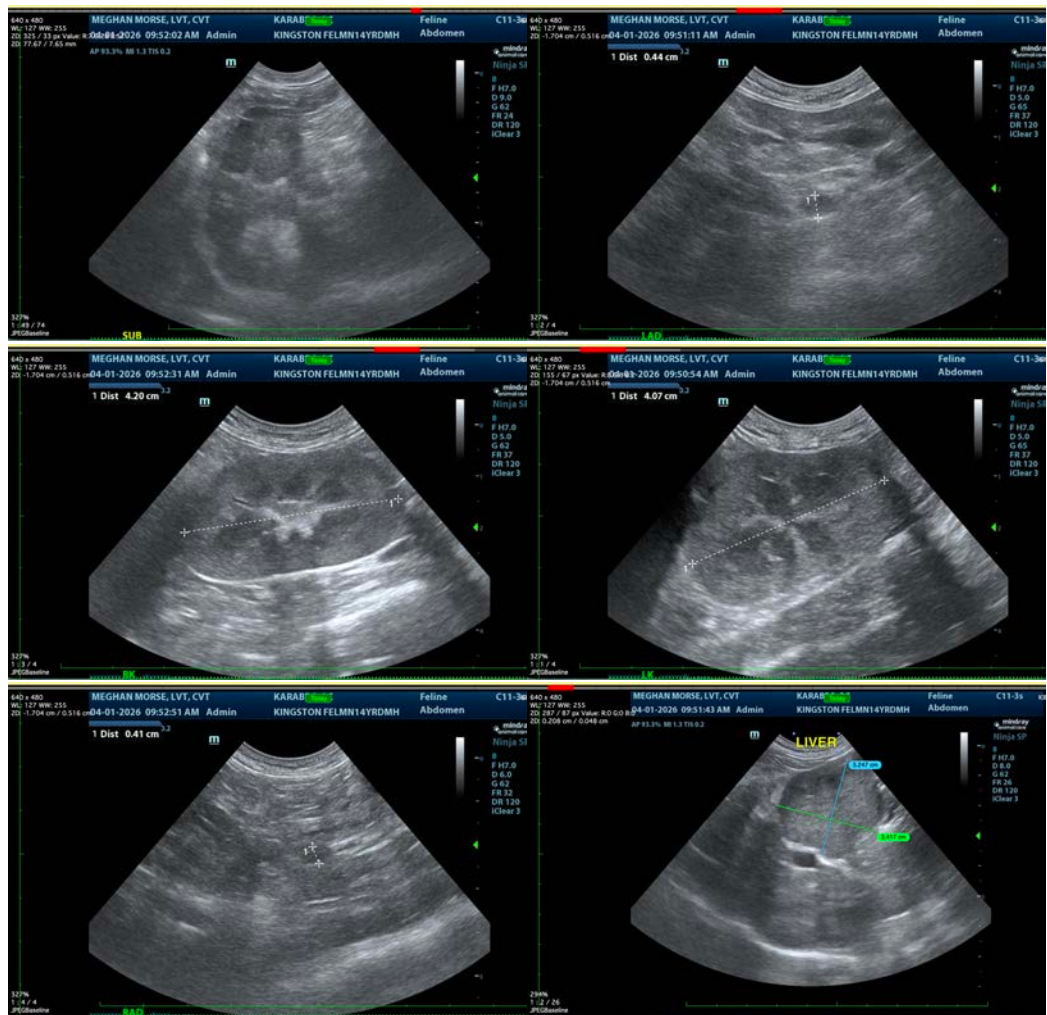
Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

A T4 +/- free T4 is recommended 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 liver as well as the similar appearing nodule in the mid to cranial abdomen/potentially lymph node or bowel mass are recommended if patient's coagulation status is appropriate. Additionally, as is reportedly already in progress, cardiac evaluation in the form of an echocardiogram is recommended.

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





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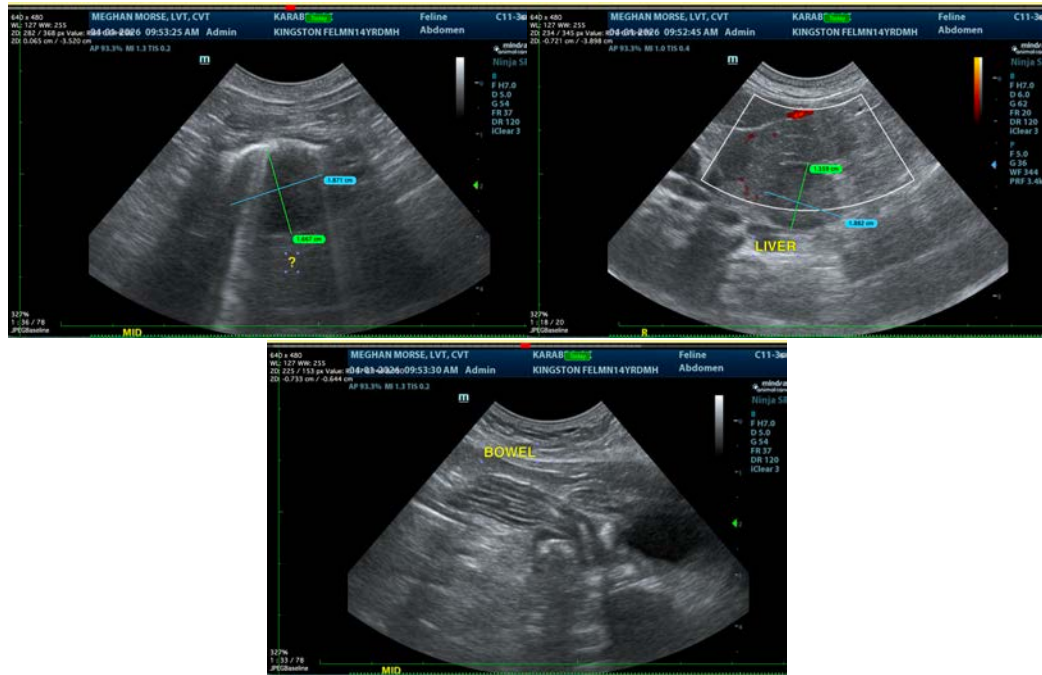
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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**  
 info@sonopath.com