



**PATIENT**

Boris Harris

**SPECIES**

Feline

**BREED**

Maine Coon

**SEX**

Neutered Male

**AGE**

10 Years

**WEIGHT**

8.7 Pounds

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Diane McFadden, RVT

**HOSPITAL NAME**

Advanced Vet Care

**REFERRING VET**

Dr. Farrell

**INVOICE**

46647

**DATE**

4/13/23

**PRESENTING CLINICAL SIGNS**

Diarrhea and not eating much for 4-5 days. weight loss. Possible abdominal mass. On felimazole 2.5 mg x 2 tabs am and 1 tab pm.

Abnormal PE/Chem/CBC/UA Results: wnl

**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.

The right kidney is normal in size (4.37 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 in 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.

**Adrenal Glands**

The right adrenal gland is normal in size (0.43 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.52 cm), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

**Spleen**

Spleen is subjectively large in size with a swollen and scalloped/undulating capsular contour. Multifocal coalescing nodules are noted throughout the parenchyma. Splenic vasculature appears normal. Enhanced hyperechoic surrounding fat is noted.

**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 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.

Diffusely, the visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). However, in the caudal abdomen, there is a small



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bowel mass characterized by hypoechoic, heterogeneous thick wall and complete loss of normal layering. Additionally, in the area of the ileocecolic junction, there is a 4+ cm in diameter heterogeneous, partially cavitated cecal mass. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

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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 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.

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**Free Abdomen**

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

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Mesenteric lymph nodes are enlarged with swollen irregular capsular contour and loss of normal length to width ratio (rounded in shape). Nodes are hypoechoic with loss of normal parenchymal detail.

Hepatic lymphadenopathy is also present.

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**PRIMARY FINDINGS**

- **Large, heterogeneous cecal mass and a second suspected small bowel mass** – Most concerning for multifocal infiltrative neoplasia such as round cell neoplasia (i.e., lymphoma).
- **Honeycomb Spleen** – This finding is strongly suggestive of infiltrative disease such as round cell neoplasia. Benign disease cannot be ruled out but is considered less likely.
- **Hypoechoic hepatomegaly** – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.
- **Aggressive mesenteric lymph nodes** – most consistent with infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.
- **Hepatic lymphadenopathy** – This could represent reactive lymph node or also infiltrative or metastatic neoplasia.

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**SECONDARY FINDINGS**

- Urinary bladder debris

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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This patient's ultrasound is most concerning for multifocal infiltrative neoplasia such as lymphoma. Therefore, recommendations include fine needle aspirates of the cecal mass, enlarged lymph nodes, spleen, and/or liver if patient's coagulation status is appropriate. Alternatively, or if a diagnosis cannot be obtained cytologically, an exploratory laparotomy could be considered for excisional biopsies. However, given the multifocal nature of the disease, full surgical resection is not likely possible.



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To help further guide medical management while awaiting a diagnosis or after obtaining a diagnosis, 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.

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Additionally, if not recently evaluated, a urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended.

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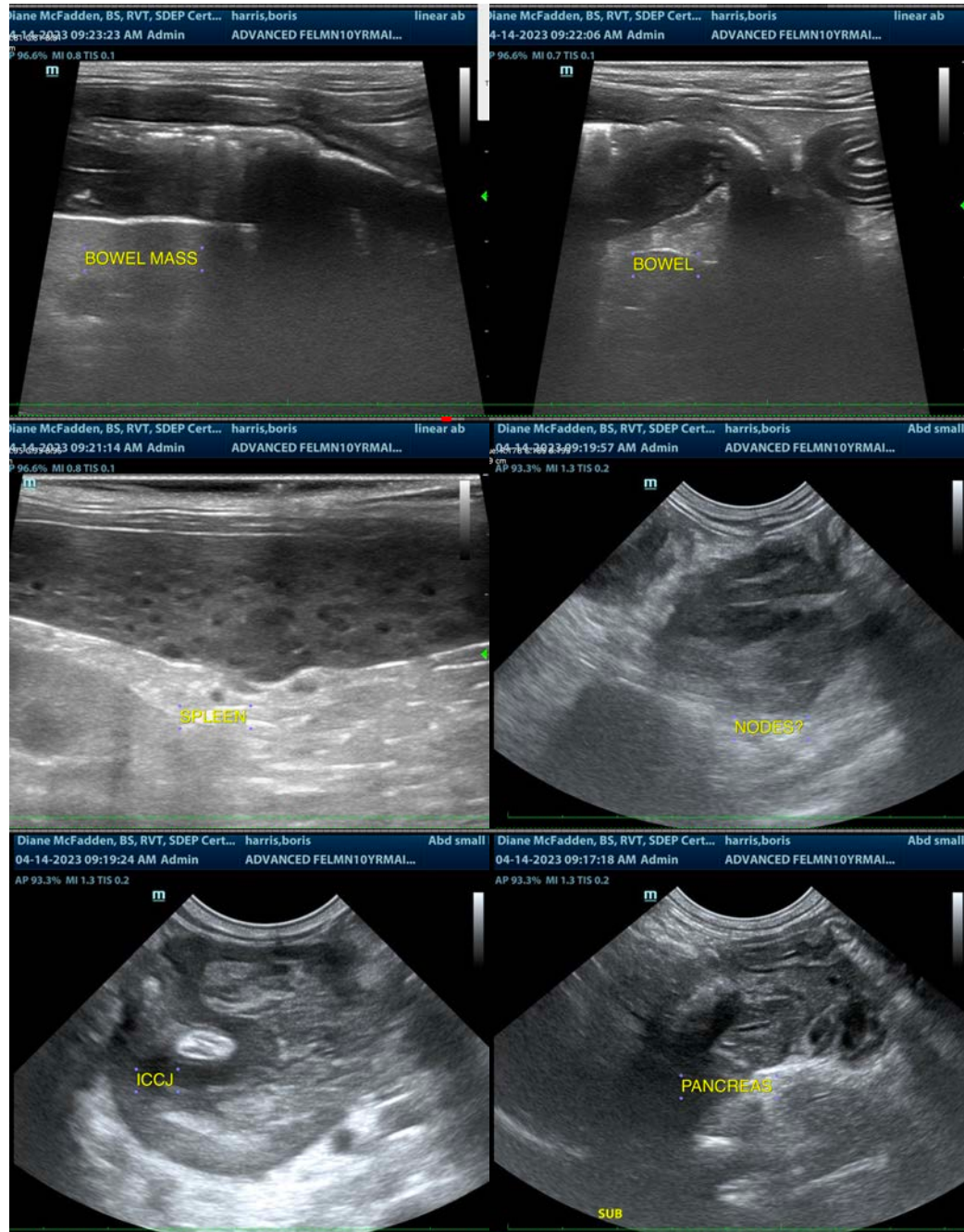
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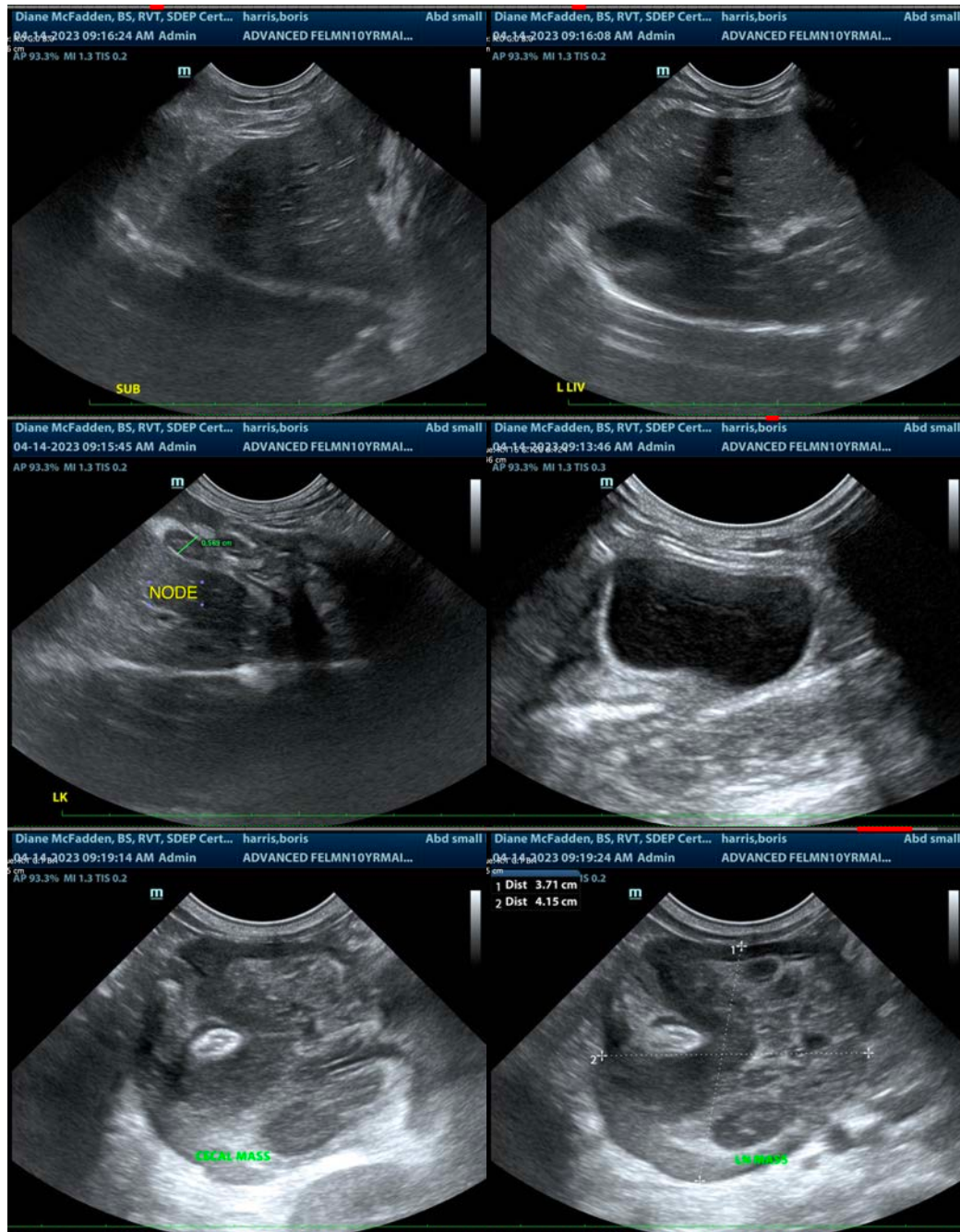
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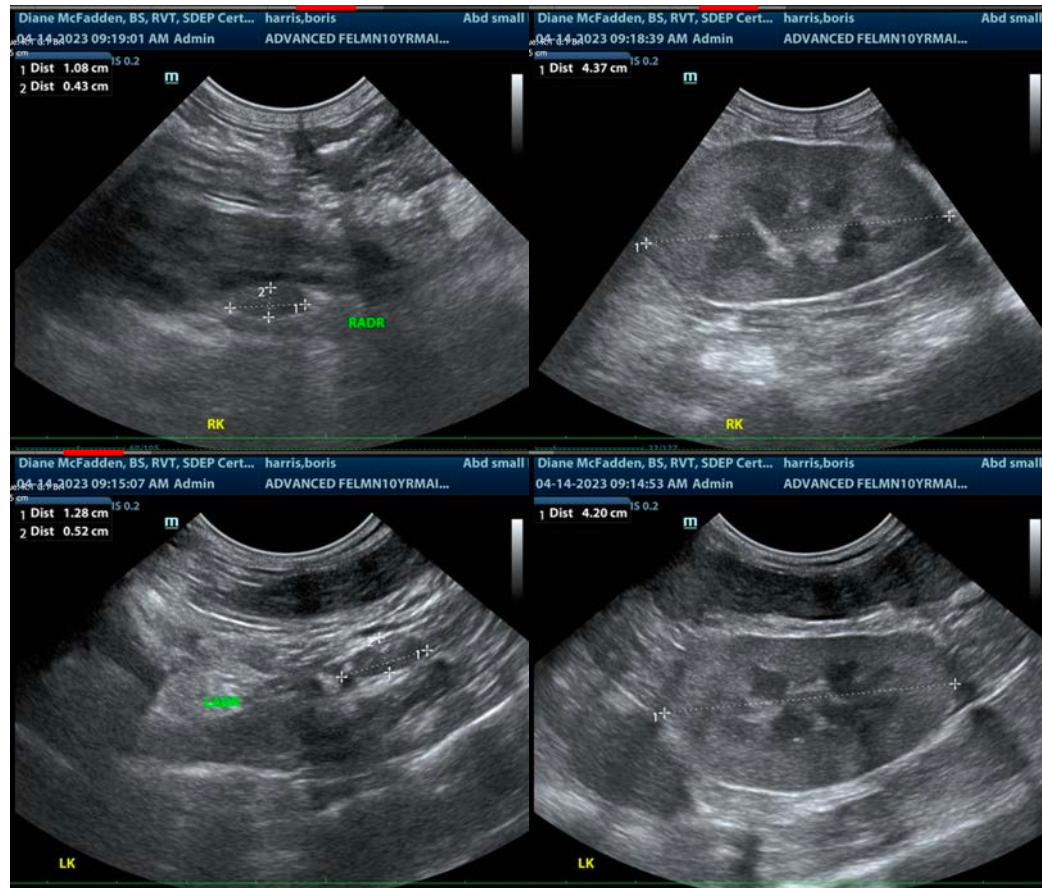
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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