



PATIENT	PRESENTING CLINICAL SIGNS
LittleMan Gangemi	4 lbs weight loss, diarrhea for 5 days, grade 3 cardiac murmur, mass effect palpable caudal abdomen
SPECIES	Current meds: Provable, Flagyl, Panacur, Epakitin
Feline	Abnormal PE/Chem/CBC/UA Results: WBC 26.3, increased neutrophils, calcium 7.6, Tp 4.8, Alb 1.8 UPC 0.1
BREED	ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN
Domestic Shorthair	<i>Urinary System</i>
SEX	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.
Neutered Male	Kidneys are bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. Left kidney is small-normal at 3.6 cm. Right kidney is normal in size at 3.89 cm.
AGE	<i>Adrenal Glands</i>
9 Years	The right adrenal gland is normal in size (0.42 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.
WEIGHT	The left adrenal gland is normal in size (0.32 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.
9.4 lbs	<i>Spleen</i>
INTERPRETED BY	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.
Beth Johnson, DVM DACVIM	<i>Liver</i>
IMAGING PERFORMED BY	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.
Meghan Morse, LVT, CVT	<i>Gastrointestinal</i>
HOSPITAL NAME	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.
Walden Animal Clinic	<i>Gastrointestinal</i>
REFERRING VET	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.
Dr. Kelly	The visible small intestine demonstrates areas of moderately 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.
INVOICE	
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DATE	
4/2/26	



PATIENT

LittleMan Gangemi

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered Male

AGE

9 Years

WEIGHT

9.4 lbs

INTERPRETED BY

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DACVIM

IMAGING PERFORMED BY

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In the right cranial abdomen, appearing to involve the colon just beyond the ileocecolic junction is an approximately 1.8 cm x 2.8 cm homogeneous, hypoechoic bowel mass. The remaining colon is normal.

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.

Free Abdomen

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

Lymph nodes adjacent to the bowel mass 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 ileocecolic junction/colonic mass is most concerning for infiltrative neoplasia such as round cell neoplasia i.e., lymphoma versus carcinoma versus other. A benign inflammatory process, however, cannot be definitively ruled out without tissue sampling.
- Adjacent moderately reactive lymphadenopathy – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Concurrent 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.
- Moderate bilateral chronic kidney disease changes.

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.

Fine needle aspirates of the bowel mass +/- adjacent lymphadenopathy are recommended if patient's coagulation status is appropriate.

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.

Pending results of above, additionally a routine fecal/giardia exam could be considered.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.



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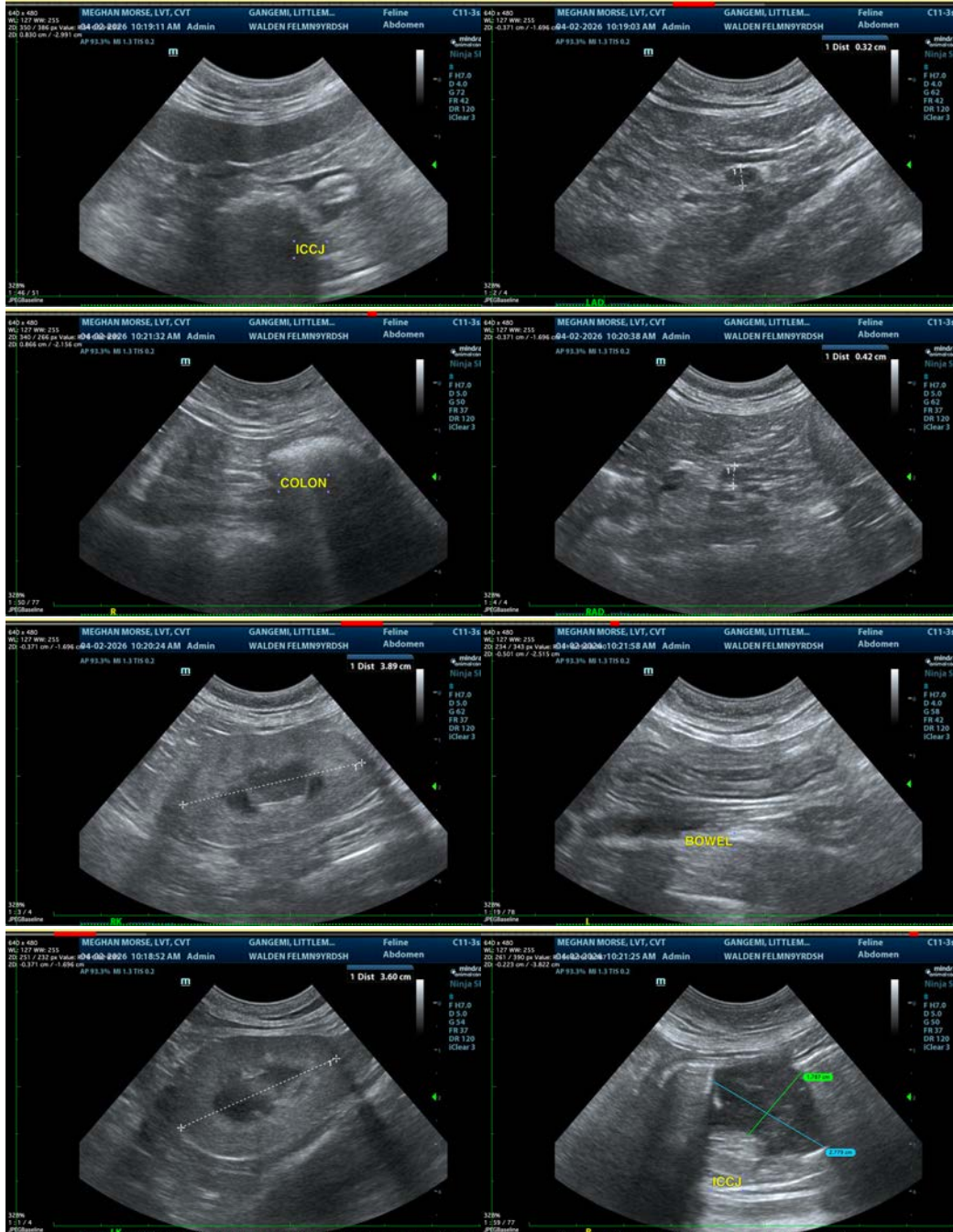
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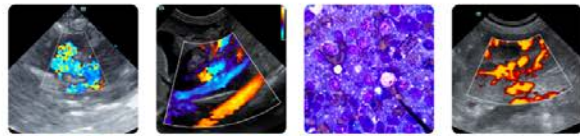
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Ultimately, however, if a cytologic diagnosis is unable to be obtained, an exploratory laparotomy for biopsies of the mass as well as the diffuse small bowel changes may be necessary for definitive diagnosis and therefore to further guide medical management.

Given location of the mass, if surgery is necessary and pursued, consultation with a veterinary surgeon is recommended.





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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