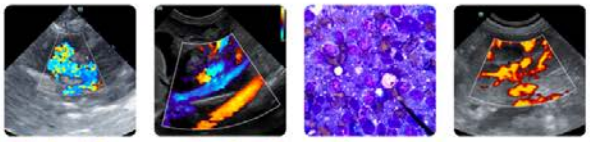


PATIENT

Salem Graybiel

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

17 Years

WEIGHT

4.8 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Michelle DeMelo, RVT

HOSPITAL NAME

Woodstock Veterinary Hospital

REFERRING VET

Dr. Esther Duschinsky

INVOICE

74711

DATE

4/22/26

PRESENTING CLINICAL SIGNS

Salem is a 17 year old cat with a previous hx of chronic vomiting and an acute flare in November 2024 when he was vomiting and anorexic. At that time Vitamin B12 and folate levels were normal. There was also evidence of some early renal disease with a dilute USG in normally hydrated cat on dry food diet. The suspected IBD was managed with Prednisolone at tapering doses and hypo/renal diet. In recent months, the Prednisolone dose has been reduced to 0.6 mg/kg given every 72 hours.
In the past 48 hours clinical signs of vomiting, anorexia and dehydration have reoccurred. CBC shows evidence of a stress leukogram (vs mild monocytosis), 17 chemistries are normal other than mildly high cholesterol and urinalysis shows only dilute USG in the face of clinical dehydration, electrolytes showed low normal potassium.

Treatment has been started with fluids with potassium supplementation, cerenia and buprenorphine. AUS recommended to assess for possible neoplasia vs IBD, cholestasis etc..

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.

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 3.5 cm. Right kidney measures 3.8 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.40 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.40 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

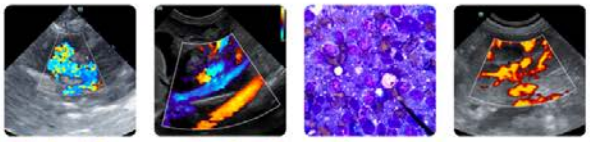
Spleen

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 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. In the right cranial abdomen, I believe originating from the liver, is an approximately 3.5 cm in diameter mixed, largely cystic, primarily hyperechoic mass. 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.



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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.

The visible small intestines are normal in wall thickness and layering. 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.

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.

Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- Suspect cystic liver mass that likely represents a benign biliary cystadenoma in a senior cat. Malignancy, while less common, cannot be ruled out without tissue sampling.
- Chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs. Infiltrative disease affecting the pancreas including pancreatic nodular hyperplasia and/or less likely infiltrative neoplasia can't be ruled out but is considered less likely.

SECONDARY FINDINGS

- Mild age related kidney changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a T4 +/- free T4 is recommended.

A recheck 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.

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 suspected liver mass +/- pancreas could be considered if patient's coagulation status is appropriate.

In the meantime, in addition to supportive/symptomatic medical management of clinical signs, if tolerated, a transition in diet is recommended, based on trial-and-error response.

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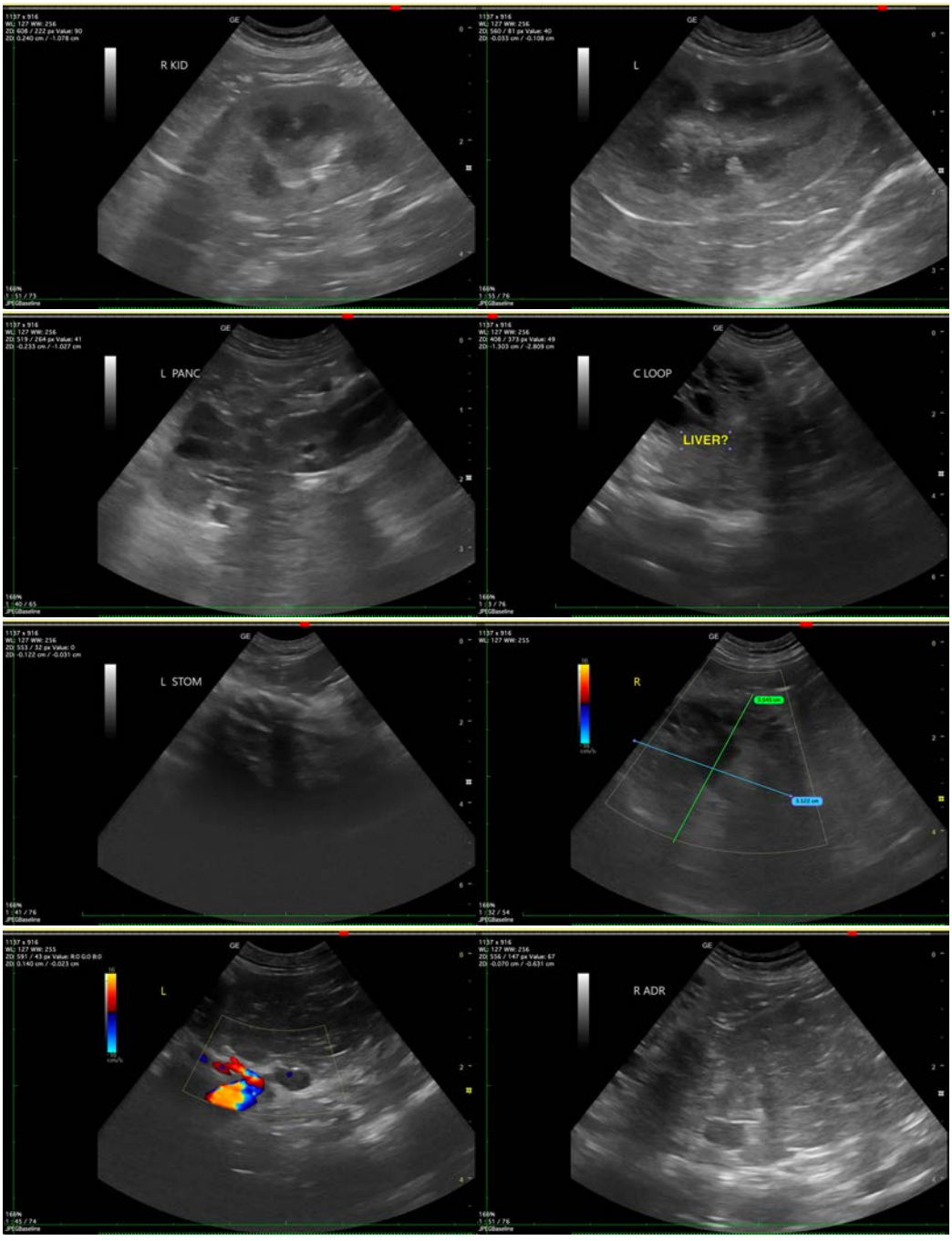
Some options to consider include a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs a fiber response/colitis diet vs a bland, easy to digest or low-fat diet vs other.



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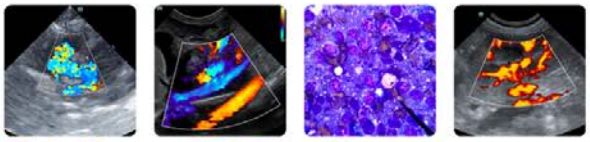

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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