

**PATIENT**

Cliff Bowsher

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

15 Years

WEIGHT

3.3 kg

INTERPRETED BYBeth Johnson, DVM
DACVIM**IMAGING
PERFORMED BY**

Dr. Goeres

HOSPITAL NAMEKelowna Veterinary
Hospital**REFERRING VET**

Dr. Forwood

INVOICE

74331

DATE

4/9/26

PRESENTING CLINICAL SIGNS

Chronic diarrhea for past 6 months. Otherwise e/d/u - normal. Has also started vomiting clear fluid occasionally. BW in October 2025 showed possible stage I CKD otherwise unremarkable, T4 WNL, FIV/FelV negative. No recent BW

Abnormal PE/Chem/CBC/UA Results: Cachexic pale MM tense on abdominal palp

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 or infarcts observed. Punctate non-obstructive nephroliths are noted in the left kidney. Left kidney measured 4.5 cm. Right kidney measured 4.3 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

Spleen is subjectively large/ "plump" appearing in size with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. 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 mildly subjectively thick, irregular, and hyperechoic. 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 a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.



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The bowel is diffusely normal in thickness, but multifocally has a subtly less distinct than normal submucosa layer separating a mildly prominent muscularis layer from mucosa. The lumen is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is 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

Free fluid is noted in these images.

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.

PRIMARY FINDINGS

- The bowel changes are subtle and could indicate a benign infiltrative inflammatory bowel disease, or infiltrative neoplasia such as lymphoma, which can't be ruled out especially given the concern for some early or emerging loss of layering in some layers.
- Hypoechoic hepatomegaly – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.
- Splenomegaly – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, amyloidosis as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- Aggressive mesenteric lymph nodes – concerning for infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.
- The mild amount of 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.
- Concurrent chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.

SECONDARY FINDINGS

- Moderate age related kidney changes with punctate non-obstructive nephroliths in the left kidney.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A recheck full general metabolic health screen is recommended to include CBC, Chemistry panel, electrolytes, T4 +/- free T4, a 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 ratio is recommended.

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.

As is reportedly already pending, fine needle aspirates of the enlarged lymph nodes are recommended if patient's coagulation status is appropriate. If a cytologic diagnosis is unable to be obtained, additional sampling of the liver and/or spleen could be considered. Ultimately, however, biopsies of the GI tract, being sure to include ileum, if possible, may be necessary for a definitive diagnosis and therefore to further guide medical management.





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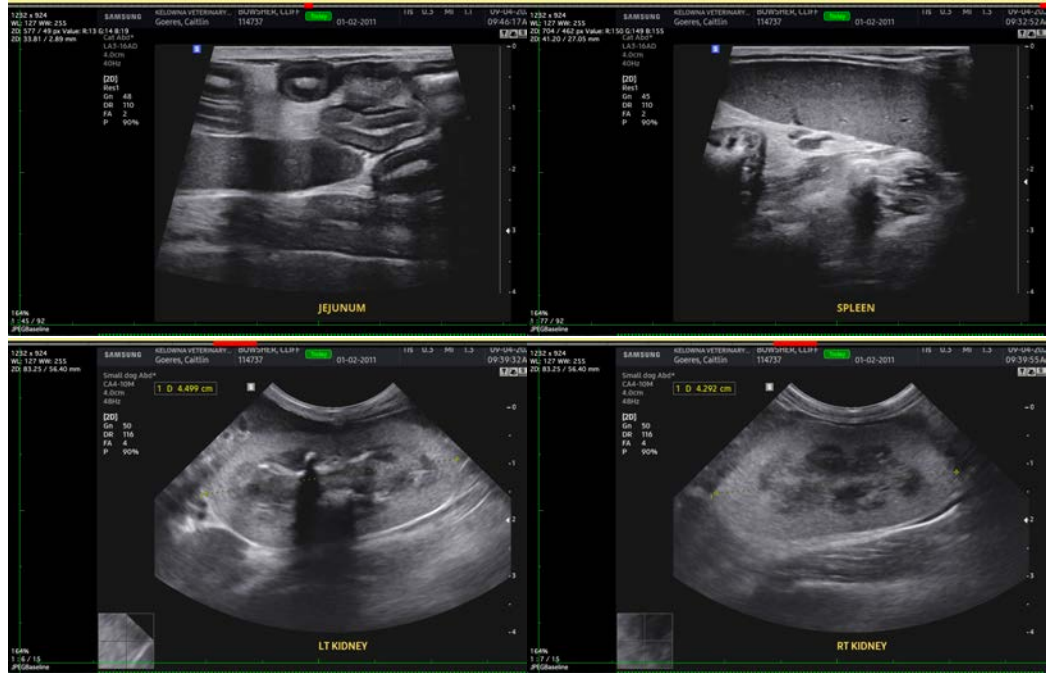
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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