



PATIENT

Ginger MacDonald

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

16 Years

WEIGHT

4.7 kg

INTERPRETED BY

Beth Johnson, DVM
 DACVIM

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

East Credit Veterinary
 Hospital

REFERRING VET

Dr. Gardiner

INVOICE

74324

DATE

4/9/26

PRESENTING CLINICAL SIGNS

Presented for progressive weight loss despite good appetite. BW/US in Sept revealed renal disease and large course spleen with enlarged LNs. FN of Spleen at that time and LNs revealed reactive lymphoid hyperplasia. Chronic history of intermittent vomiting of bile. Voracious appetite with weight and muscle loss. Drinking more. Has slowed down but seems more affectionate. Has been on Vit B12 inj, Restoralax, Glucosamine supplement, Omega 3 and Provable.

Today on presentation was weak, cold, wobbly(ataxia started at 11am) jumped off ottoman earlier, hypothermic, menace response absent, very pale MMs, unable to get doppler.

Abnormal PE/Chem/CBC/UA Results: See attached previous US report as well as lab results including todays most recent BW

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 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. Both kidneys have large cortical cysts on the cranial pole. The left kidney cyst measures 1.6 cm x 2.5 cm. The right measures 1.5 cm x 2.3 cm. The left kidney is small-normal at 3.53 cm. The right kidney is small-normal at 3.66 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.42 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 has an overall irregular scalloped shape as a result of at least two mildly heterogeneous, largely isoechoic, expansive but non-disruptive nodules/masses, one measuring 1.2 cm x 1.5 cm, the other measuring 1.6 cm x 1.8 cm.

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. No focal lesions 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.



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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 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.

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.

Free Abdomen

There is a mild amount of free fluid noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Moderate bilateral chronic kidney disease changes with bilateral cortical cysts.
- The splenic nodules/masses could still represent a benign infiltrative disease such as lymphoid hyperplasia, amyloidosis, or even extramedullary hematopoiesis, although infiltrative neoplasia such as round cell neoplasia versus other, especially given the change in the appearance of the pathology, can't be ruled out.
- 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.
- 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.

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.

Given the change in the appearance of the spleen, recheck fine needle aspirates of the splenic nodules as well as sampling of the free abdominal fluid could be considered if patient's coagulation status is appropriate.



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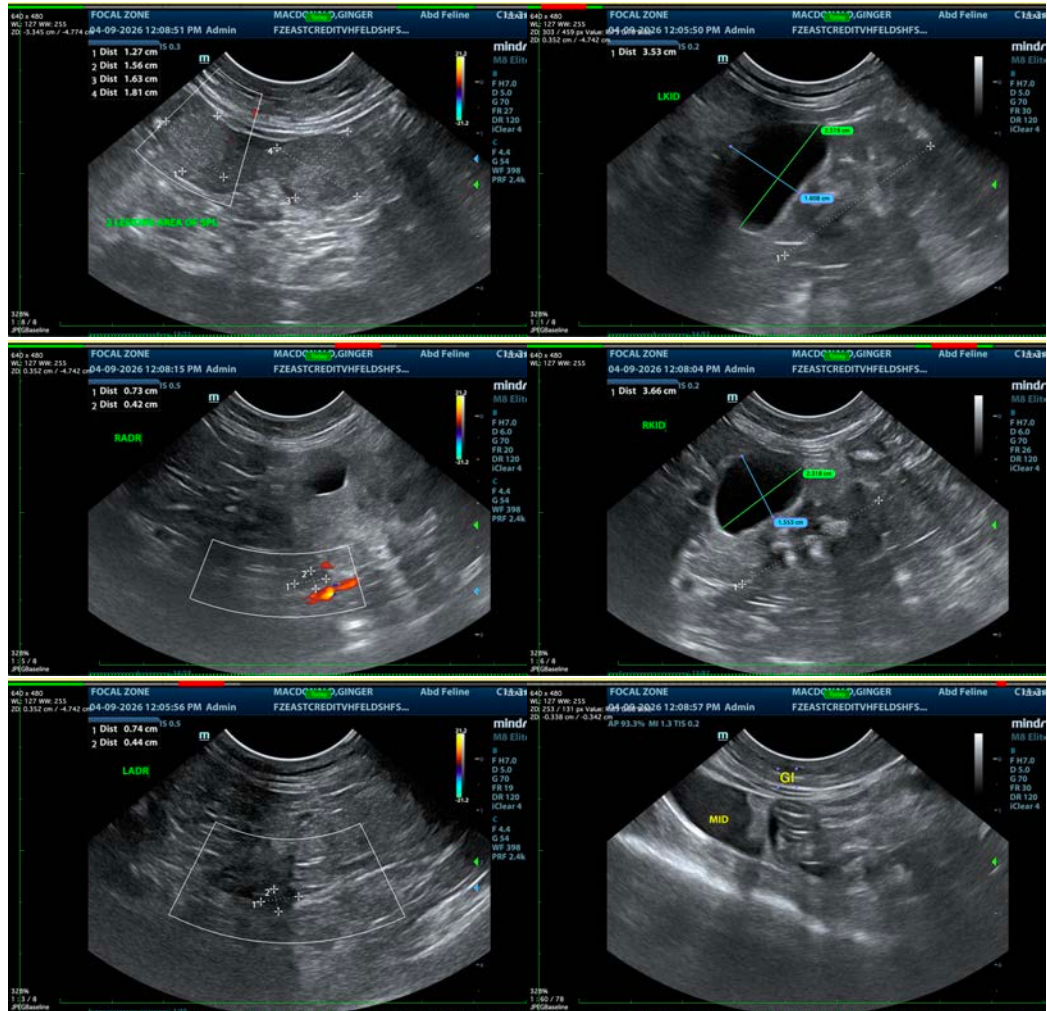
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A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Ultimately, however, patient's most recent presenting complaint could be secondary to newly diagnosed diabetes mellitus if that fits the clinical history and is not an already medically managed condition, in which case supportive/symptomatic medical management of clinical signs, electrolyte abnormalities, hydration as well as hyperglycemia, etc. may help alleviate the clinical signs. If not, further neurologic evaluation or workup may also be indicated.





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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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