PATIENT

Max Cooper

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

17 Years

WEIGHT

15 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Pamela Harrigan, RDCS, Certified Vet Sonographer

HOSPITAL NAME

Sturbridge Veterinary Hospital

REFERRING VET

Thomas Hamilton, DVM

INVOICE

75079

DATE

5/12/26

PRESENTING CLINICAL SIGNS

Max is a geriatric feline presenting with an abdominal component to breathing. Previous radiographs suggest an enlarged cardiac silhouette, raising concern for cardiac disease. No cardiac murmur. There was also a concern for possible abdominal mass effect. BP: 174, 175,, 185 mmHg. *Having bi-cavity ultrasound exams.

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 small, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. No mineral is observed. Left kidney measured 3.13 cm. Right kidney measured 3.23 cm. Trace pyelectasia noted bilaterally.

Adrenal Glands

The right adrenal gland is normal in size (0.60 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.64 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The spleen has a rounded emerging mass-like appearance to the tail of it, resulting from an approximately 1.3 cm x 1.5 cm homogeneous, iso- to slightly hypoechoic mass.

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. Multifocal discrete homogeneous hyperechoic nodules/densities as well as a slightly more mixed, cystic 1.4 cm in diameter hyperechoic mass are noted throughout the parenchyma. 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 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 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.

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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.

Pancreas

Pancreas is prominent in size with swollen irregular contour. Parenchyma is heterogenous characterized by hyperechoic tissue remodeling intermixed with ill-defined hypoechoic nodules. The duct is mildly dilated at 0.22 cm. There is no evidence of active peripancreatic inflammation.

Free Abdomen

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

Mesenteric lymph nodes 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 splenomegaly/rounded emerging splenic mass is concerning for infiltrative neoplasia such as round cell neoplasia i.e., lymphoma versus mast cell tumor versus other, although a benign infiltrative process can't be ruled out without tissue sampling.
- 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.
- Suspect pancreatic nodular hyperplasia – Infiltrative neoplasia cannot be ruled out but is considered less likely. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.
- Moderately reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Suspect feline biliary cystadenomas – In a senior cat, these liver lesions are most consistent with benign biliary cystadenomas. Malignancy cannot be ruled out but is considered less likely give lack of clinical signs and/or laboratory changes.
- Moderate bilateral chronic kidney disease changes with trace bilateral pyelectasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes described above are of unknown if any contribution to patient's reported dyspnea, and is reportedly already in place, continued workup for that is recommended. Further recommendations for the abdominal changes, however, include:

If not recently evaluated, a general metabolic health screen (CBC, chemistry panel with electrolytes and urinalysis) is recommended.

Fine needle aspirates of the spleen +/- liver +/- pancreas could be considered if patient's coagulation status is appropriate.

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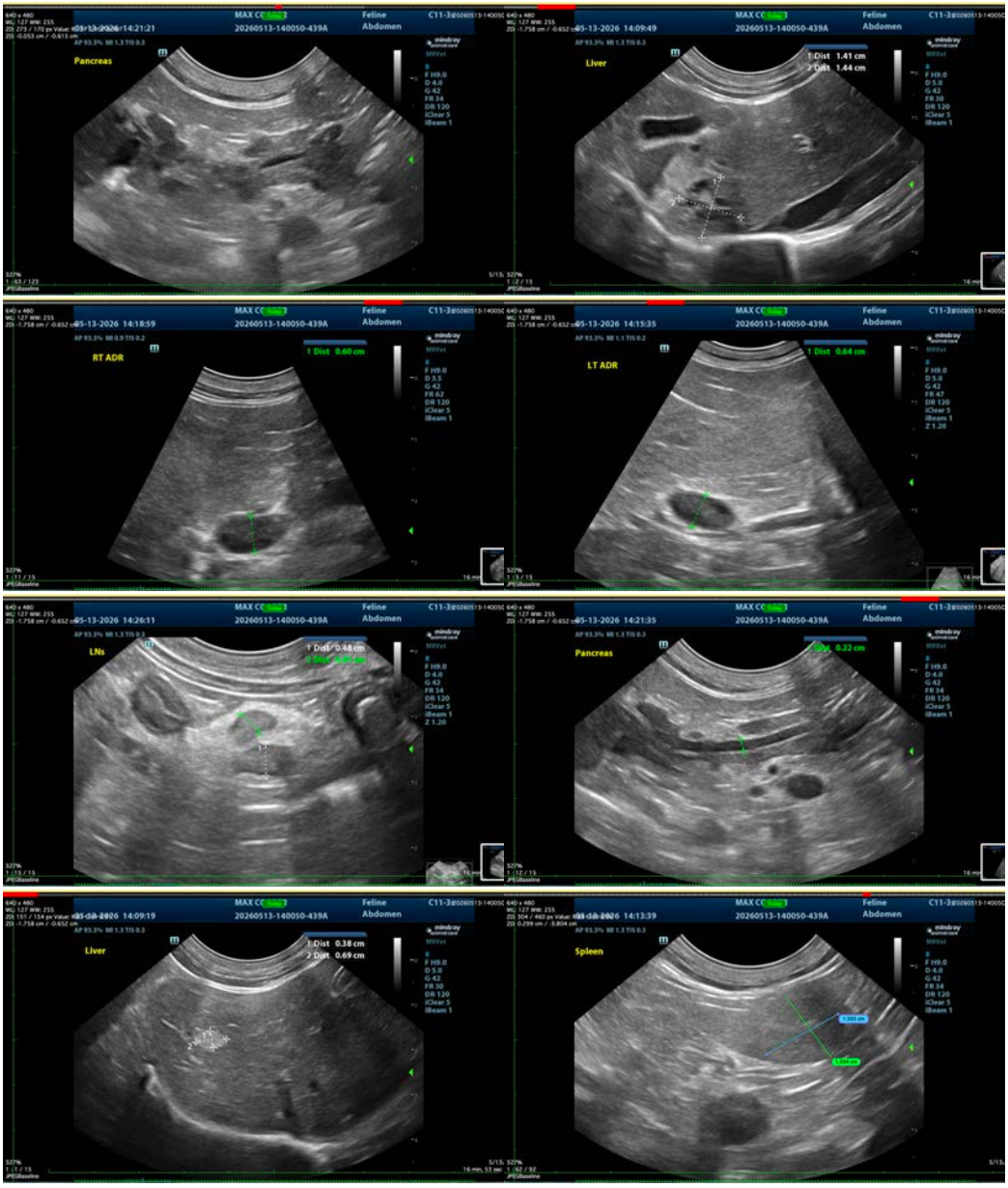
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.



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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