



PATIENT

Sunkissed Borden

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

16 Years 7 Months

WEIGHT

6.1 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Rebecca Hamilton

HOSPITAL NAME

Packanack Animal
Hospital

REFERRING VET

Dr. Gonzaga

INVOICE

75070

DATE

5/12/26

PRESENTING CLINICAL SIGNS

Recurring UTI/ hematuria, bacteriuria, New mass R cranial neck, grade 4/6 heart murmur. R?O hyperthyroid, CKD, hypertension. Meds: PLO Methimazole 5mg BID, Amlodipine PO 0.625 mg BID, Convenia inj. given 4/25/26

Abnormal PE/Chem/CBC/UA Results: ALT 121 (10-100), T4 2.9, Urine: 2+ blood, USG 1.014

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 3.12 cm. Right kidney measures 3.3 cm. A subtle hyperechoic band parallel to the corticomedullary border is present bilaterally.

Adrenal Glands

The right adrenal gland is normal in size (0.25 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.31 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

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver 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 mildly thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular,



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thick and hyperechoic, with some loops demonstrating subtle loss of layering. 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

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.

In one still image attached to this case there is an approximately 0.5 cm in diameter coarse, hypoechoic density medial to the spleen with a question mark that upon later review with the linear probe I believe to be a prominent, hypoechoic pancreas. Having said that, pancreatic nodule, adjacent lymph node versus other can't be ruled out.

PRIMARY FINDINGS

- The diffuse bowel changes i.e., the prominent muscularis can be a normal patient variant in senior cats, although as described above, in some views there appears to be some early or emerging loss of layering that could signify infiltrative bowel disease, including potentially infiltrative neoplasia such as a lymphoma, which can't be ruled out without tissue sampling.
- Concurrent chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- The liver changes are also subtle and non-specific but could represent a microscopic hepatopathy including benign differentials such as bacterial or lymphoplasmacytic cholangiohepatitis, hepatic lipidosis versus other, although infiltrative neoplasia such as round cell neoplasia i.e., lymphoma can't be ruled out without tissue sampling.

SECONDARY FINDINGS

- Moderate age related kidney changes with bilateral medullary rim sign - This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including FIP, lymphoma, hypercalcemic nephropathy, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

If patient's reported liver enzyme changes don't improve with management/regulation of hyperthyroidism, fine needle aspirates of the liver could be considered if patient's coagulation status is appropriate.



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Ultimately, biopsies of the GI tract, being sure to include ileum as well as bowel loops with suspected loss of layering may be necessary for definitive diagnosis and to more definitively rule out infiltrative neoplasia.

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There is not a definitive ultrasonographically visible intraabdominal explanation for patient's reported urinary signs. An occult infection, even chronic low-grade smoldering pyelonephritis versus other, can't be ruled out.

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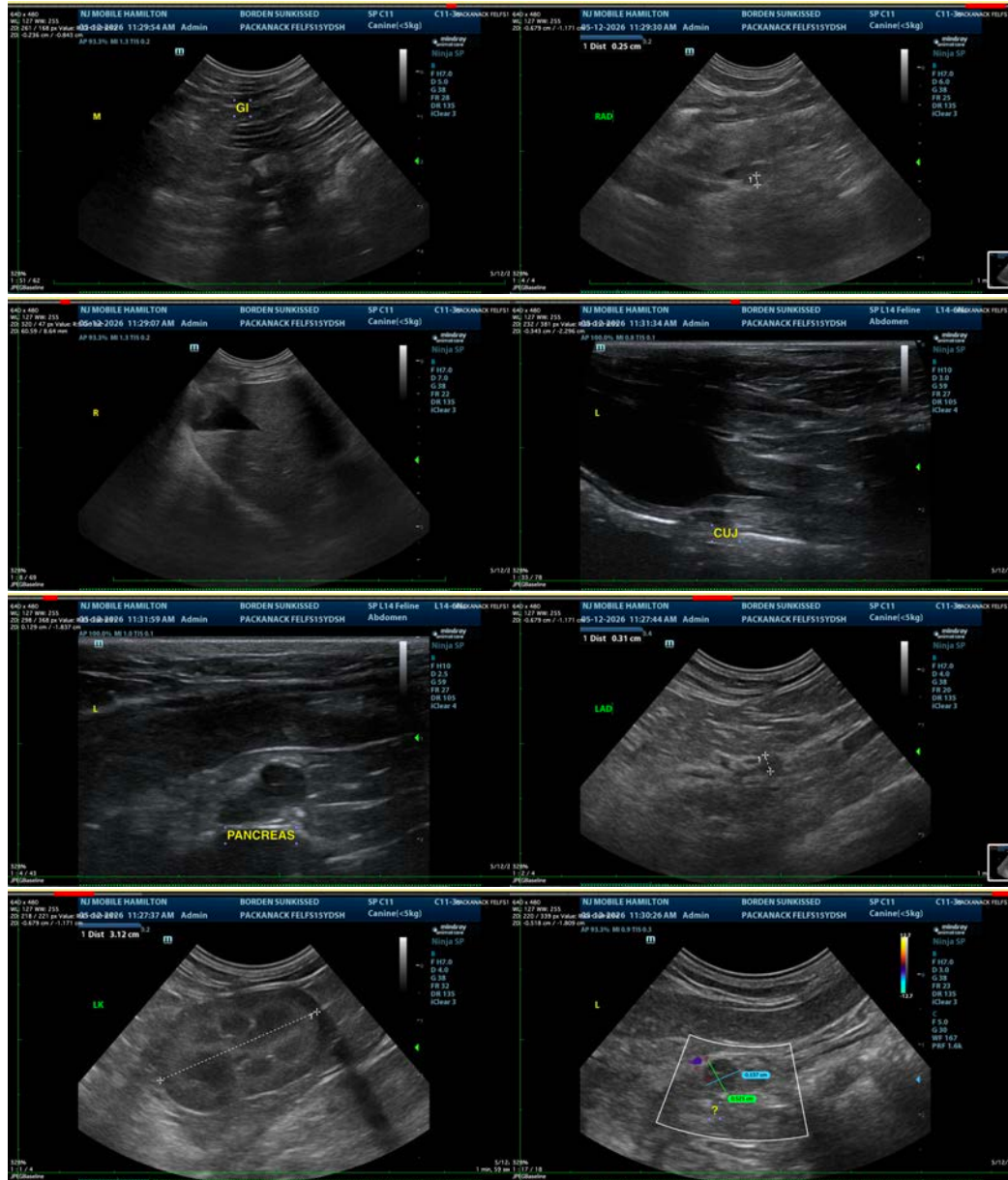
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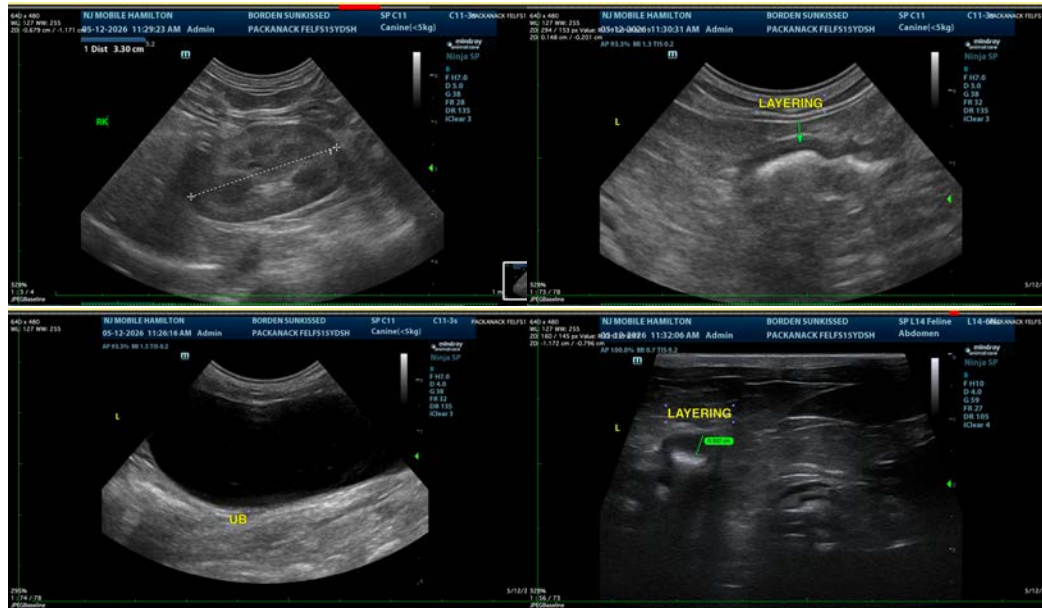
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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