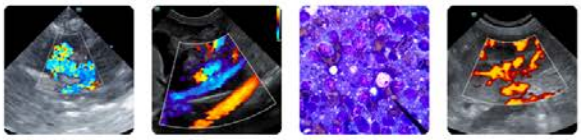


DATE

5/21/26

PATIENT

Wally Holt

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

10/2/05

WEIGHT

8.9 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Pleasantville Animal Hospital

REFERRING VET

Dr. Gounaris

INVOICE

75247

PRESENTING CLINICAL SIGNS

Patient History: Owner reports Wally, an indoor-only senior cat, has had increasingly frequent episodes of blood in the stool, with the blood now appearing darker in color. Stool quality has varied from constipation in the past to current loose stools. Despite a good appetite, owner reports noticeable weight loss. Intermittent vomiting episodes have also occurred, including foamy vomit and vomit containing partially digested cat food. Additional concerns include chronic inappropriate urination outside the litter box (often near the front door), abnormal vocalization/crying especially at night, and intermittent sniffly nasal sounds. Diet has recently changed from Tiki Cat back to Fancy Feast, which he prefers. He is not currently receiving any medications, and full BW/thyroid testing performed in February was reportedly normal.

Current Medications: Proviable capsules and paste.
Labwork Results: Labwork not attached, reported as: 3/06/2026 - Amy 1741, K+ 3.7, all else WNL. 2/16/2026 - T4 WNL
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Declined at this time.
Imaging Performed by: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or definitive cystoliths are observed. The 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 is small normal at 3.69 cm. Right kidney is small normal at 3.58 cm. Mild pyelectasia is noted bilaterally. Additionally, in the left cranial pole there isd an approximately 0.50 cm in diameter hypo- to anechoic density.

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 (0.29 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size (1.2 cm thick at the hilus) 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

The liver is subjectively mildly large in size and rounded in appearance with multifocal some mildly heterogeneous, some more solidly hypoechoic nodules/masses throughout with several representative lesions measuring approximately 3.0 cm x 3.5 cm in size and 1.7 cm x 2.7 cm in size.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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.

In one view there is an approximately 0.80 cm x 0.90 cm irregular, hypoechoic density right at the Ileocecocolic junction that could represent normal tissue fold, potentially cecum, although tissue growth in that area cannot be ruled out.

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 a trace amount of anechoic free fluid 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 multifocal liver nodules/masses could represent a benign infectious or inflammatory reactive change, feline biliary cystadenomas, other, although infiltrative neoplasia including round cell neoplasia, metastatic disease, other cannot be ruled out without tissue sampling.

- 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.

- 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.

- Concurrent chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.

- The density at the Ileocecocolic junction could represent normal tissue fold versus benign inflammatory process or emerging infiltrative neoplasia, which can't be ruled out.

- Moderately reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

- The trace 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.

- Mild gallbladder debris – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness, however, it can also be associated with hepatobiliary disease in cats and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

- Bilateral chronic kidney disease changes with a possible nodule in the cranial pole of the left kidney although a cyst cannot be ruled out. Both benign and neoplastic differentials are possible.

- Mild amount of echogenic urinary bladder debris.

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.

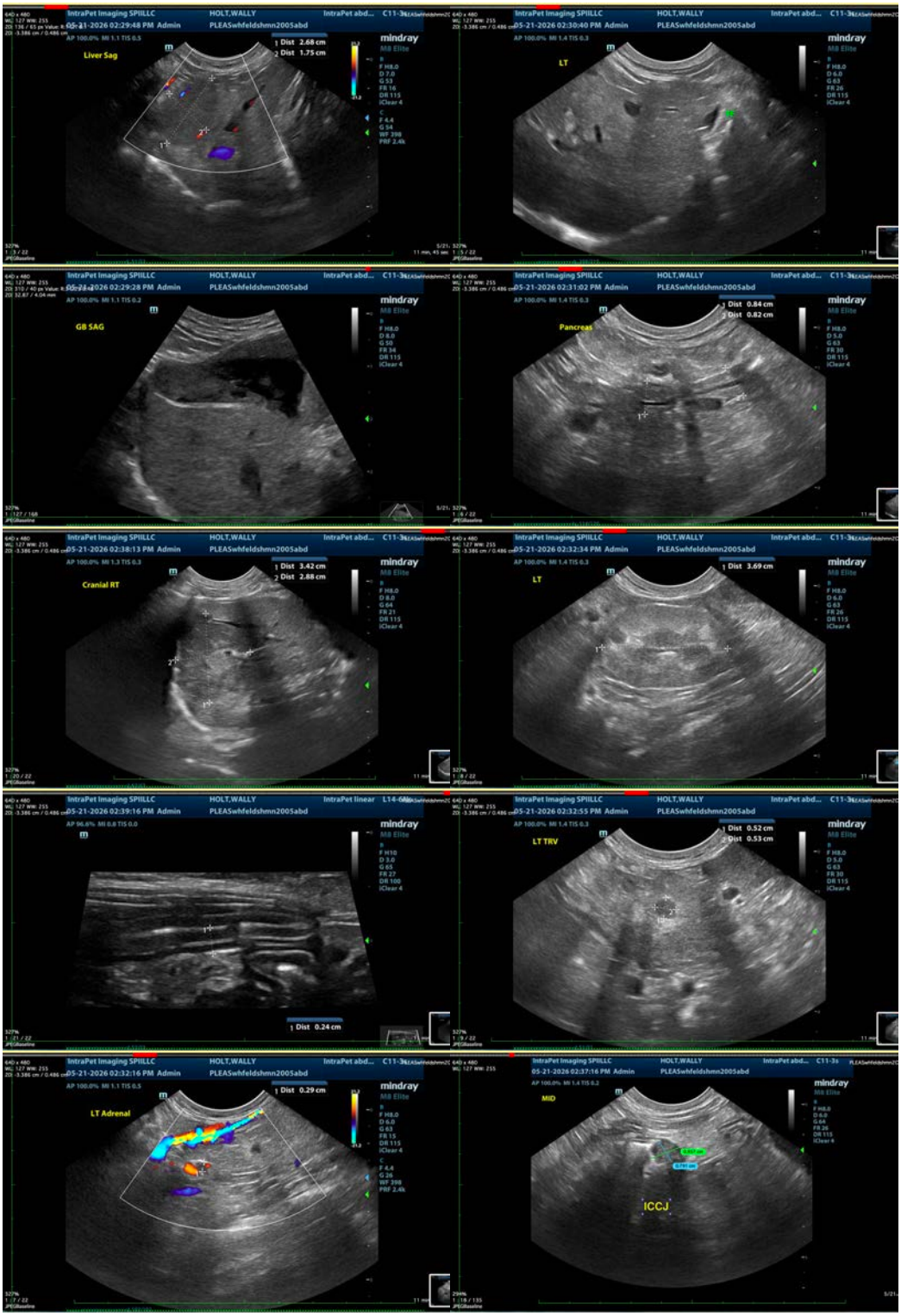
Tissue sampling is recommended if patient's coagulation status is appropriate to further investigate benign inflammatory changes versus infiltrative neoplasia. Therefore, fine needle aspirates of the liver masses, the spleen, potentially the left kidney nodule +/- the enlarged mesenteric lymph nodes and/or even fluid sampling could all be considered.

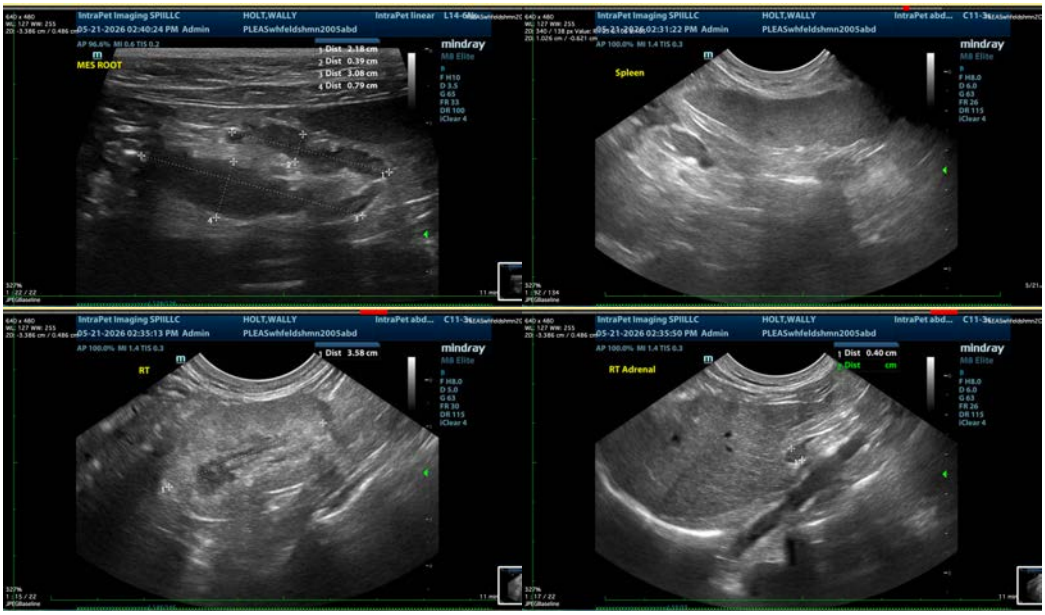
In the meantime, given reported clinical history of hematochezia, a routine fecal/giardia exam is recommended.

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.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

If a diagnosis is not obtained, biopsies of the variety of changes described above may be necessary.


Liver Sag
LT
GB SAG
Pancreas
Cranial RT
LT
LT TRV
LT Adrenal
MID
ICCJ



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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