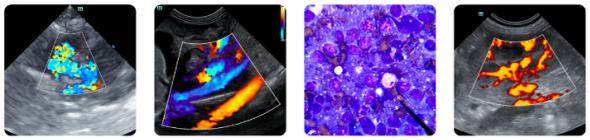


PATIENT

Yuumi Wang

SPECIES

Feline

BREED

British Shorthair

SEX

FS

AGE

8 years

WEIGHT

10.7 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Ohad Barnea

HOSPITAL NAME

Tenafly Vet Center

REFERRING VET

Dr. Amanda Buck

INVOICE

11999

DATE

5/26/2026

PRESENTING CLINICAL SIGNS

GI lymphadenopathy on AUS. Initially presented 5/5/26 for vomiting 4-day duration- hairball + food, then on day 4 undigested food and mild hematemesis. no weight loss, no appetite loss. no hx of FB ingestion. comfortable on abdominal palpation. radiographs unremarkable. creat 1.8, spec fPL 0.8, bloodwork otherwise unremarkable. Started on sucralfate, cerenia, Hill's I/d diet- no vomiting when on sucralfate, but vomiting restarted after each 5-day course of sucralfate ended. Patient currently eating Purina EN dry and wet formulation. No medication at this time. No constipation or stool abnormalities. concern for IBD vs SC LSA vs gastritis.

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.

The right kidney is normal is size (3.8 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (4.2 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (0.3 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.26 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.

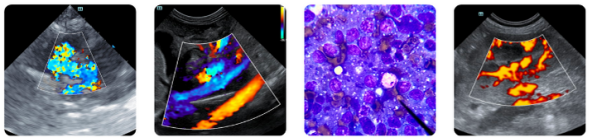
Liver

Liver is subjectively enlarged (swollen contour) with a diffusely mildly coarse architecture and subtly increased portal markings. Mildly mixed echogenic changes are noted diffusely. 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. The cystic and common bile duct are diffusely tortuous in appearance.

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.



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The visible small intestine demonstrates areas of moderate to severely 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 no visible free peritoneal effusion noted in these images.

Cranial abdominal/gastric and 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

- 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.

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

- The hepatobiliary changes are subtle/mild and nonspecific, but could represent a concurrent microscopic hepatopathy with both benign differentials such as bacterial or lymphoplasmacytic cholangiohepatitis, hepatic lipidosis, other, as well as infiltrative neoplasia such as round cell neoplasia i.e. lymphoma being differentials that cannot be fully differentiated without tissue sampling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated a T4 +/- a Free T4 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 routine fecal/giardia exam is recommended if not recently evaluated.

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.

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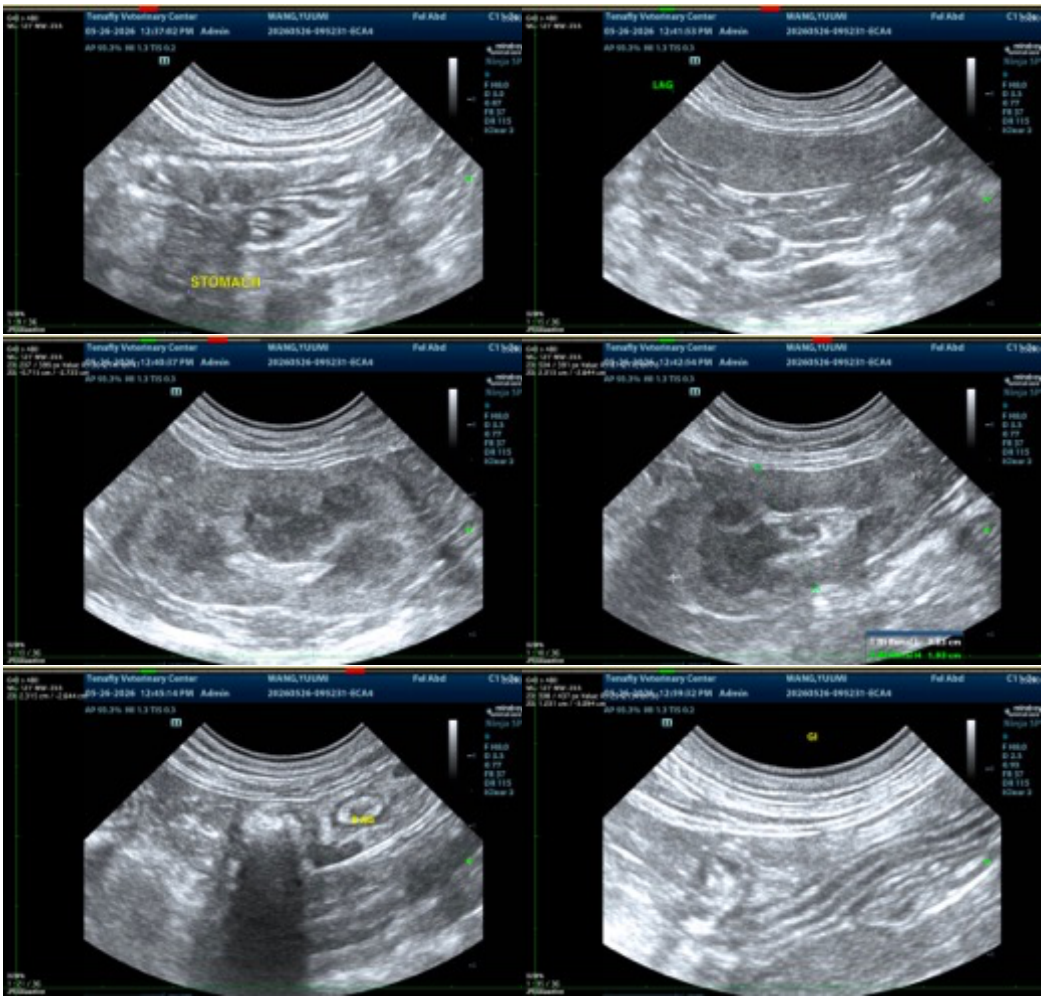
Fine needle aspirates of the enlarged lymph nodes could be considered if they can safely be reached and if patient's coagulation status is appropriate. Fine needle aspirates of the the liver could be considered at the same time.

If a diagnosis is not made, while much less common in cats, and potentially of low yield, ruling out hypoadrenocorticism could be considered with an ACTH stimulation test.

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



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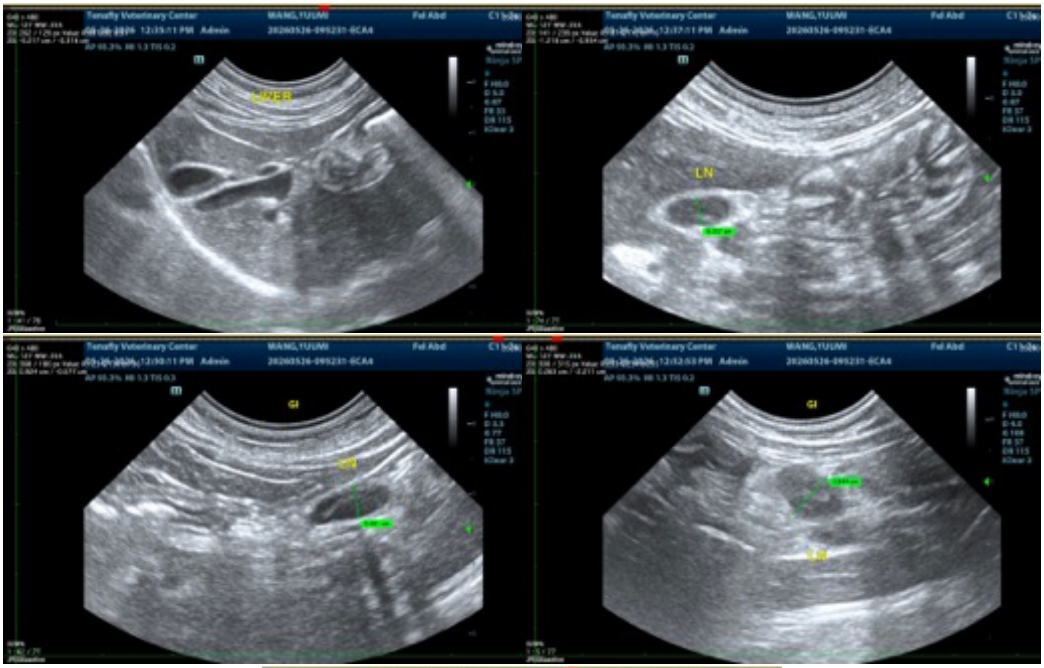

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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