



PATIENT

Achmed Mitana

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

15 years

WEIGHT

10 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Julia Bakker

HOSPITAL NAME

Orange Blossom
Veterinary Imaging

REFERRING VET

Dr. Irene Flegel

INVOICE

12048

DATE

6/1/2026

PRESENTING CLINICAL SIGNS

Patient presented for constipation. After treatment relapse occurred and repeat radiographs showed possible mass effect.

Radiographs - Generally devoid of ingesta, small amount of stool with air in colon/lower GI. Lateral view depicts mass effect in central lower abdomen, with undefined intestine. Full urinary bladder.

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 3.49 cm, and the right kidney measures 3.92 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.45 cm at cranial pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.4 cm at cranial pole and 0.35 cm at caudal pole), 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

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.

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.

In the cranial right abdomen is an approximately 4.0 cm x 5.0 cm ill-defined, coarse hypoechoic mass involving bowel. In additional views, in the right cranial abdomen, the bowel mass appears to be 7.5+



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cm long with the thick loss of layering of the bowel measuring 1.2 cm thick. In the mid to caudal abdomen is an approximately 4.0 cm x 4.4 cm ill-defined hypoechoic density that in other views appears to also be attached to or extending from this bowel mass. Although adjacent lymph node can't be ruled out. Ileocecal colic junction is suspected to be involved, but definitive origin of the mass is difficult to definitively determined. The small bowel that is visible has largely normal thickness and layering with a subjectively mildly prominent muscularis layer in some views.

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 trace free fluid and enhanced hyperechoic fat and mesentery are noted adjacent to the bowel pathology described above.

There is lymphadenopathy adjacent to the bowel mass as described above is suspected but difficult to definitively isolate/measure.

PRIMARY FINDINGS

- The bowel mass, which I suspect involves ileocecal colic junction, although definitive origin is difficult to determine, is concerning for infiltrative neoplasia such as carcinoma versus round cell neoplasia i.e. lymphoma versus other. A benign inflammatory process is possible but considered less likely. Changes adjacent to the bowel mass are concerning for a focal peritonitis, and even potentially some loss of bowel loss integrity and leakage cannot be ruled out.

SECONDARY FINDINGS

- Mild to moderate age-related kidney changes.

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.

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.

Fine needle aspirates of the suspected bowel mass are recommended if patient's coagulation status is appropriate.

If the free fluid can safely be reached, sampling of the free abdominal fluid could also be considered to further investigate/rule in or out a septic abdomen.

Alternatively, or if a cytologic diagnosis is unable to be obtained and/or patient is believed to have a septic abdomen, an exploratory laparotomy for planned resection and anastomosis, and histopathology could be considered. Although, given the size, location, etc. of the mass, if surgery is elected, a pre-surgical planning abdominal CT Scan may be helpful, and consultation with a veterinary



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surgeon is recommended.

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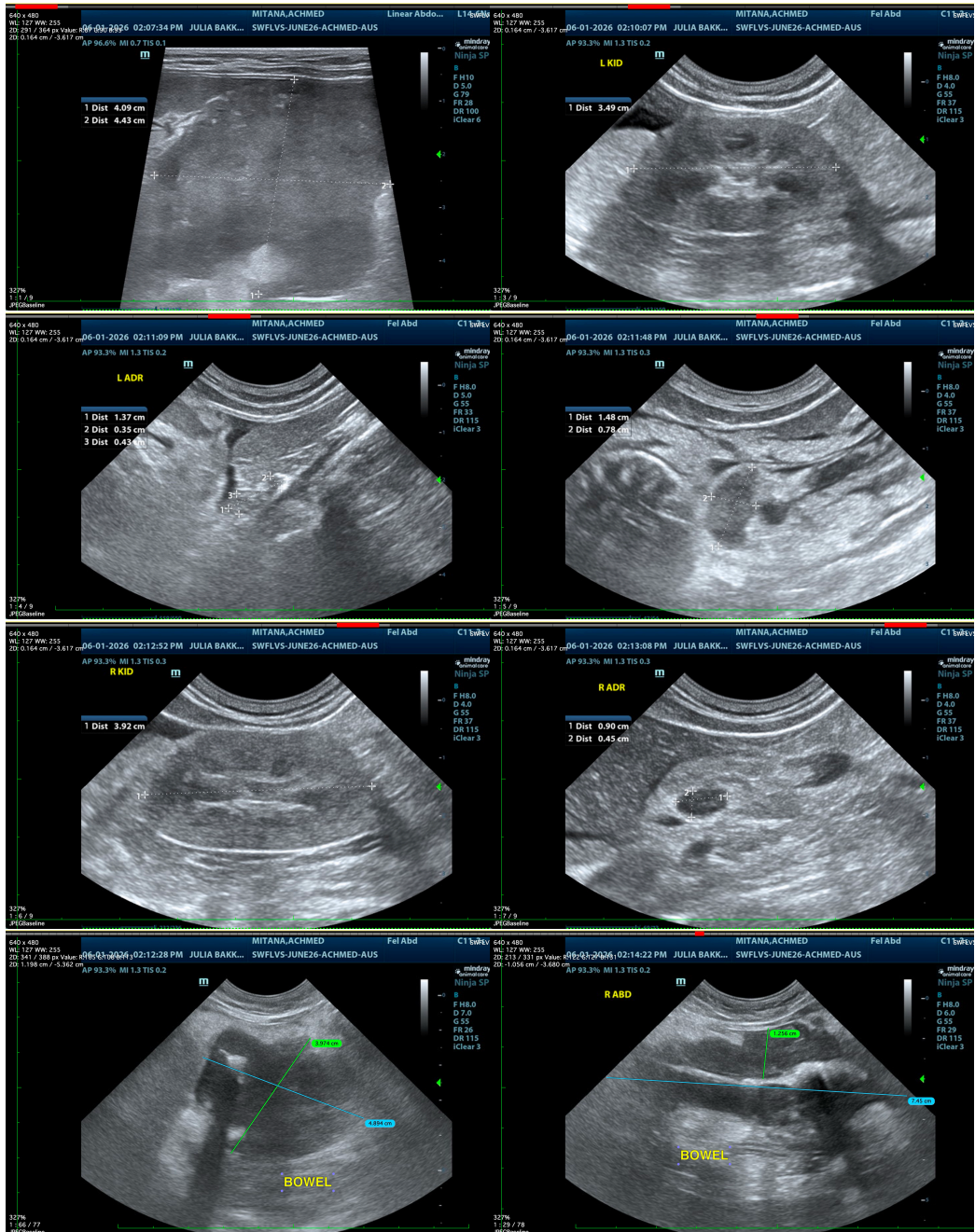
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.



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