PATIENT

Brady Charlonone

SPECIES

Feline

BREED

DSH

SEX

MN

AGE

17 years

WEIGHT

11.04 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Pamela Harrigan, RDCS, Certified Veterinary Sonographer

HOSPITAL NAME

Rutland Veterinary Clinic

REFERRING VET

Dr. Katie Taylor

INVOICE

12058

DATE

6/2/2026

PRESENTING CLINICAL SIGNS

Seen at ER March 2026 for vomiting. POCUS showed nodular, hypoechoic pancreas. BW at that time showed ALT 203, but otherwise unremarkable. Recheck a few days later and signs had resolved, but had lost 1 pound since October visit. Signs returned in April - resumed EN diet and cobaleqin at home. Now signs have returned - intermittent vomiting; diarrhea. Ca 11.3, PSL 42, neuts 9196.

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 irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. Left kidney is small in size measuring 3.34 cm, and right kidney is small/normal in size measuring 3.6 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.36 cm at cranial pole and 0.33 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.33 cm at cranial pole and 0.34 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

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder contains an approximately 0.5 cm x 0.7 cm shadowing discrete homogenous echogenic density consistent with a non-visibly obstructive cholecystolith.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

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The distal descending colon is moderately thick measuring between 0.3 cm and 0.6 cm thick with a hypoechoic appearance and subtle loss of layering. The other visible colon is normal and layering. The lumen is empty with no evidence of obstruction or foreign material.

Pancreas

Pancreas is prominent in size with swollen irregular contour. Parenchyma is heterogenous characterized by hyperechoic tissue remodeling intermixed with ill-defined hypoechoic nodules. 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.

Medial iliac 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.

PRIMARY FINDINGS

- The subtle loss of layering in the thick distal descending colon is concerning for infiltrative neoplasia such as round cell neoplasia i.e. lymphoma versus other. A benign inflammatory process however could not be ruled out without tissue sampling.
- 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 medial iliac lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Hyperechoic hepatomegaly (feline) – This appearance is most consistent with benign hepatic lipidosis or endocrine/DM hepatopathy. Infiltrative disease such as amyloidosis or round cell neoplasia, such as mast cell tumor or less likely, lymphoma, is also possible.
- A non-visibly obstructive cholecystolith.
- Mild to moderate bilateral chronic kidney disease changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A malignancy panel (PTH, PTHrP, iCa) to Michigan State College of Veterinary Medicine is recommended for further investigation of the reported hypercalcemia.

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.

A routine fecal/giardia exam is recommended if not recently evaluated.

Ultimately, however, tissue sampling is likely necessary. Fine needle aspirates of the enlarged medial iliac lymph node +/- liver +/- pancreas could be considered if patient's coagulation status is appropriate or colonoscopy for further visual evaluation and biopsies of the colon may be necessary if

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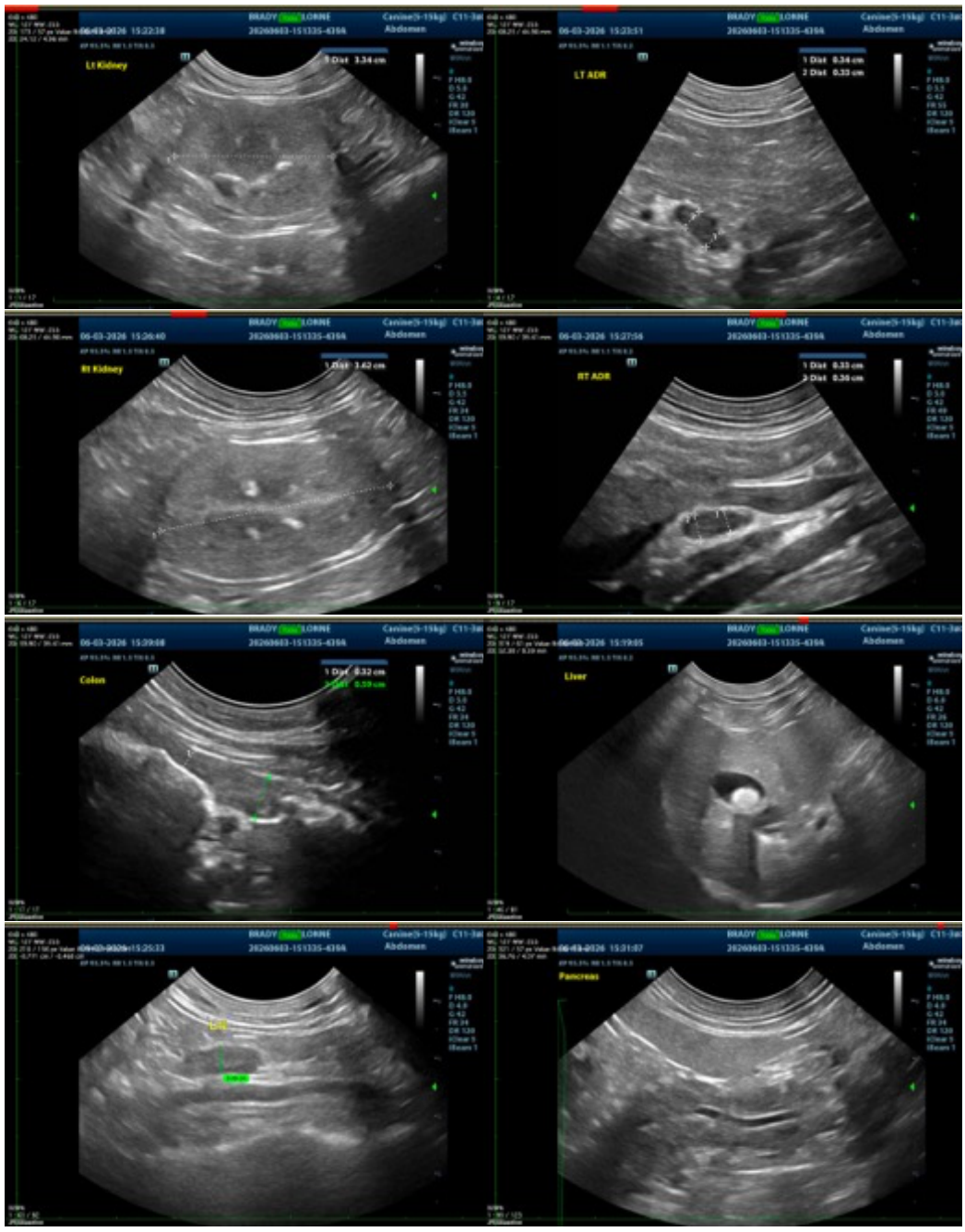
a cytologic diagnosis cannot be obtained.

Other than supportive/symptomatic medical management of clinical signs, further diagnostic and 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