**PATIENT**

Bianca McNamara

**SPECIES**

Feline

**BREED**

Domestic Shorthair

**SEX**

Spayed Female

**AGE**

8 years

**WEIGHT**

12 lbs

**INTERPRETED BY**Beth Johnson, DVM  
DACVIM**IMAGING PERFORMED BY**

Amy Mayhew LVT

**HOSPITAL NAME**

SVS Imaging Michigan

**REFERRING VET**Wixom Family Pet  
Practice**INVOICE**

31233

**DATE**

6/24/22

**PRESENTING CLINICAL SIGNS**

History of weight loss (1lb), drooling from left side of mouth, occasional vomiting (1x weekly). Currently on novel protein diet pea and rabbit. Tense abdomen.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****Urinary System**

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.

Left kidney is normal in size (3.82 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.

Right kidney is normal in size (3.82 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**

Left adrenal gland is normal in size (0.41 cm), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is unable to be well visualized in these images, but the area is examined without evident pathology.

**Spleen**

Spleen is subjectively large in size with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a mildly coarse/heterogeneous echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

**Liver**

Liver is subjectively enlarged (swollen contour). Mild parenchymal remodeling with diffusely mildly coarse architecture and increased portal markings is present. No focal nodules or masses are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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.

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**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, foreign material or infiltrative disease. 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.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

**Pancreas**

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

**Free Abdomen**

There is no evidence of peritoneal effusion or apparent lymphadenopathy noted in these images. There is a historically reported Bate's body noted.

**ULTRASONOGRAPHIC FINDINGS****PRIMARY FINDINGS:**

**Scalloped spleen** – can be associated with benign or malignant infiltrative disease. Common causes include a reactive spleen secondary to immune stimulus or early infiltrative round cell neoplasia such as lymphoma or mast cell tumor.

**Hypoechoic hepatomegaly** – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also be considered.

**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.

**Age related pancreatic remodeling.**

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Recommendations for this patient include:

- Given the hypoechoic liver and mild gallbladder debris cholangiohepatitis is a differential, but given the lack of laboratory abnormalities to support cholangiohepatitis, combined with the high globulin count, infiltrative neoplasia a top concern. Therefore, recommendations include a FNA of the spleen and liver if the patient's coagulation status is appropriate and pre-medicate with Diphenhydramine.



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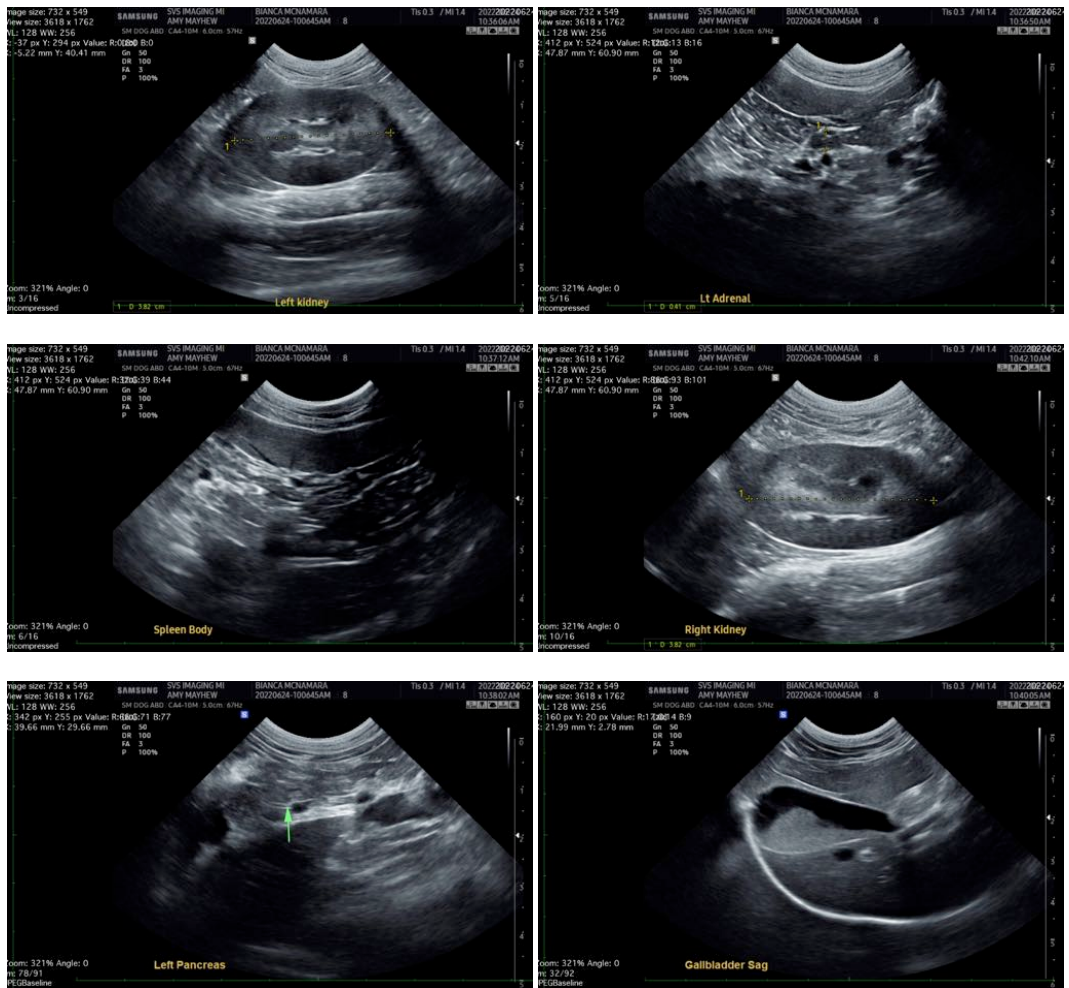
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- Given the weight loss, pending results of cytology a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.
- If a diagnosis is not obtained from the afore recommended diagnostics, given the left-sided drooling combined with high globulin count a potential neurologic deficit could be present and consultation for CNS disease including infectious diseases such as FIP, infiltrative lymphoma, etc. can be considered.



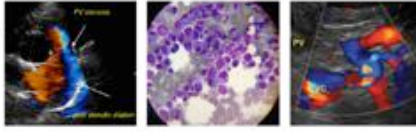
The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

**IMAGING PERFORMED BY**

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Beth.Johnson@SonoPath.com

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