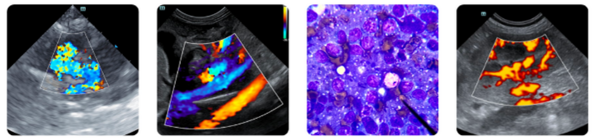


PATIENT

Poopie Taylor

SPECIES

Feline

BREED

Norwegian Forest Cat

SEX

FS

AGE

16 years

WEIGHT

6.52 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Jasmine Palacios

HOSPITAL NAME

River's Edge Pet Medical Center

REFERRING VET

Dr. David Gray

INVOICE

12067

DATE

6/3/2026

PRESENTING CLINICAL SIGNS

Small amounts of urine, decreased e/d, wt loss, lethargic.

Current meds: forti-flora, mirataz, cerenia.

Abnormal PE/Chem/CBC/UA Results: See attached labs from 5/23/26: mild to moderate renal issues.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with the visible wall appearing normal. However, almost the entire lumen is filled with an approximately 3.5 cm x 1.2 cm in size mildly heterogenous, but solid echogenic density. The wall in the areas where the density appears either adjacent to it, or attached to it, are difficult to isolate/visualize.

Kidneys are bilaterally small in size, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. Pinpoint non-obstructive mineral densities are noted bilaterally. There is no pyelectasia observed. Left kidney measures 2.92 cm and the right kidney measures 3.17 cm.

Adrenal Glands

The area of the adrenal glands are examined without evident adrenal gland pathology.

Spleen

Spleen measures at the upper ends of normal limits in thickness, measuring right at 1.0 cm thick at the hilus, with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. Additionally, there is an approximately a 1.0 cm in diameter, hypo- to anechoic non-capsular disrupting nodule/mass within the spleen. Splenic vasculature appears normal.

Liver

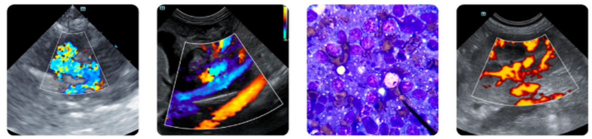
Liver is subjectively enlarged (swollen contour). Mild parenchymal remodeling with diffusely mildly coarse architecture and increased portal markings is present. No focal nodules or masses are observed. Visible vasculature and biliary tree appear normal without distension or congestion. Incidental intrahepatic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

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 without pathologic distension noted in these images, at this time.

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 moderate to severely thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly



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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.

Medial to the spleen, in the mid abdomen, there is an approximately 2.0 cm x 3.2 cm in size homogenous, hypoechoic density consistent with an enlarged lymph node versus other.

Other

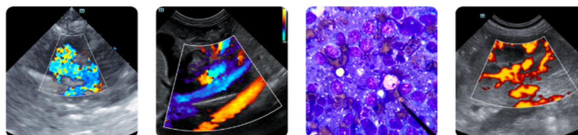
The visible heart base (RA) and pericardium are unremarkable without obvious pathology noted in these images at this time. If cardiac function evaluation is desired, a full echocardiogram is recommended.

ULTRASONOGRAPHIC FINDINGS

- The urinary bladder density/mass is concerning for infiltrative neoplasia. A benign inflammatory process cannot be ruled out but is considered less likely.
- Similarly, the splenic changes are concerning for infiltrative neoplasia such as round cell neoplasia versus other. Although, a benign process cannot be ruled out without tissue sampling.
- Hypoechoic hepatomegaly – This appearance is consistent with an acute hepatopathy or acute cholangiohepatitis. Infiltrative neoplasia (round cell neoplasia) should also 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.
- Suspect aggressive mesenteric lymph nodes – concerning for infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.
- Moderate bilateral chronic kidney changes with punctate non-obstructive nephroliths bilaterally.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The multiple pathologic changes described above may all be related and represent the same



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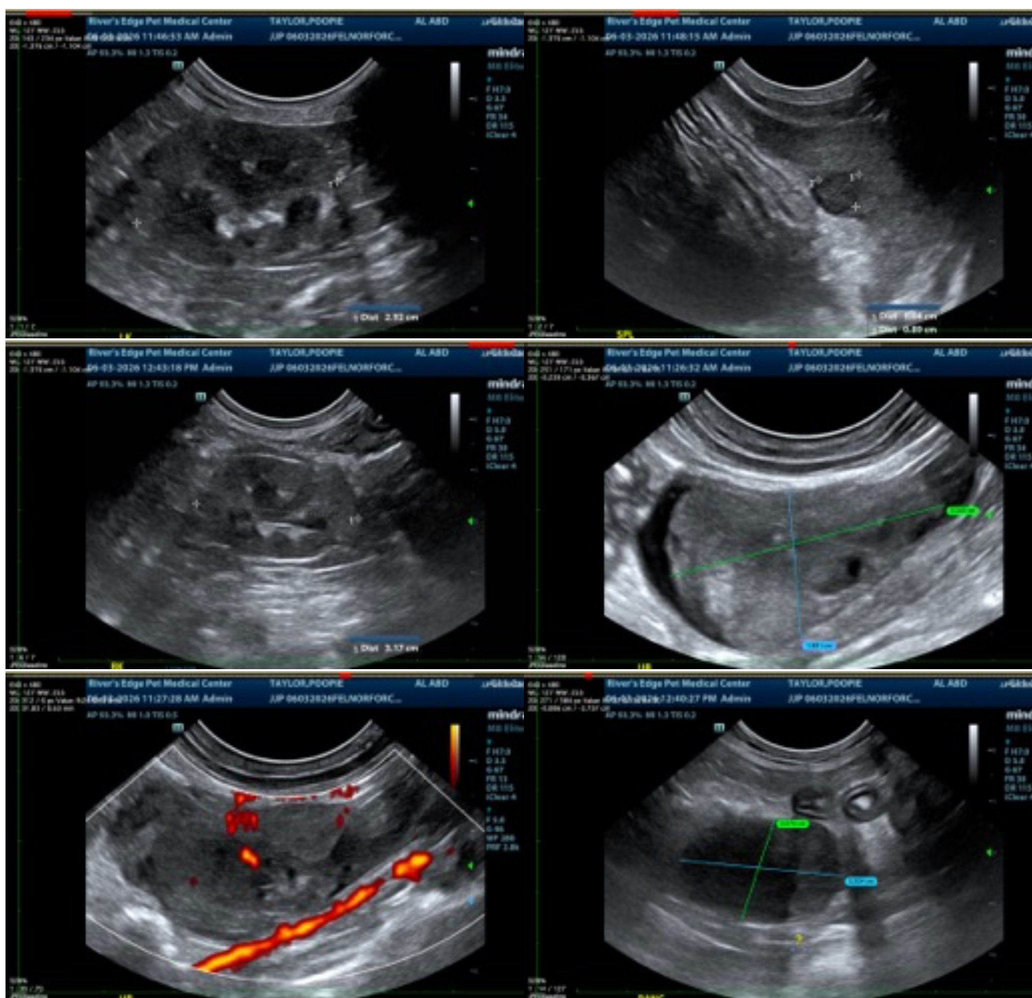
underlying etiology with infiltrative neoplasia being the top differential. Or unrelated isolated etiologies cannot be ruled out. Tissue sampling is recommended, including fine needle aspirates of the suspected enlarged mesenteric root lymph node, the spleen +/- liver, as well as the urinary bladder mass with some risk for tumor seed trailing, etc., if patient's coagulation status is appropriate.

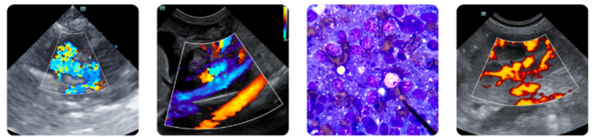
Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration 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.

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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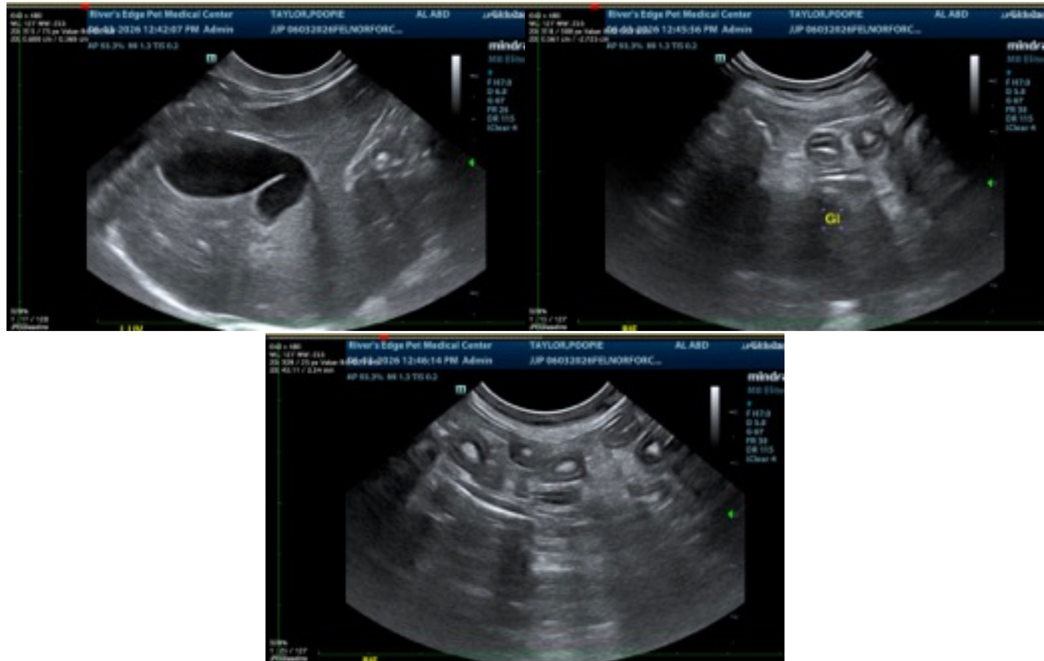

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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