



PATIENT

Mose Rohde

SPECIES

Feline

BREED

Maine Coon

SEX

Neutered male

AGE

16 years

WEIGHT

13.64 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Anleu

HOSPITAL NAME

Ellwood AH

REFERRING VET

Dr. Maro

INVOICE

74437

DATE

4/13/26

PRESENTING CLINICAL SIGNS

History: Lethargic. Decreased appetite. Leaking/dripping stool. Uncontrolled hyperthyroidism. Pulmonary mass in right caudal lung lobe
Abnormal PE/Chem/CBC/UA Results: T4 >20 Anemia Elevated WBC Elevated BUN + CRE

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for this age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The right kidney measured 3.8 cm. The left kidney measured 3.7 cm.

Adrenal Glands

Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient.

Spleen

The **spleen** in this patient was uniform, yet volume contracted. Hydration status should be assessed.

Liver

The **liver** revealed multi-focal, hypoechoic nodular changes. There was mild disruption of architecture and multi-focal, capsular expansion. The changes were fairly subtle, however, the changes were persistent in multiple views. The gallbladder and common bile duct were unremarkable.

Gastrointestinal

The upper **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine



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demonstrated normal luminal chyme and stool consistency respectively. The proximal descending colon revealed a 1.0 cm thick, hypoechoic concentric lesion. This is strongly consistent with a neoplastic event.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxiphoid palpation then low-grade smoldering chronic pancreatitis should be suspected. The pancreas measured 0.83 cm.

Free Abdomen

Sublumbar lymph node was enlarged and rounded in this patient measuring 1.57 cm.

ULTRASONOGRAPHIC FINDINGS

Early colonic infiltrative pattern.

Sublumbar lymphadenopathy.

Prominent pancreas. History of pancreatitis is likely, yet active inflammation is likely minor if present at all.

Undefined hepatic nodular changes. Nodular hyperplasia versus manifestation of infiltrative disease.

Age related renal changes. Kidneys do not appear end stage. Therefore, pre-renal disease or acute renal insult should be considered.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the sublumbar lymphadenopathy along with the colonic lesion, I am concerned for colonic and sublumbar lymphoma or carcinoma with potential metastatic disease to the liver. FNA of all three lesions is indicated. The prognosis is guarded.



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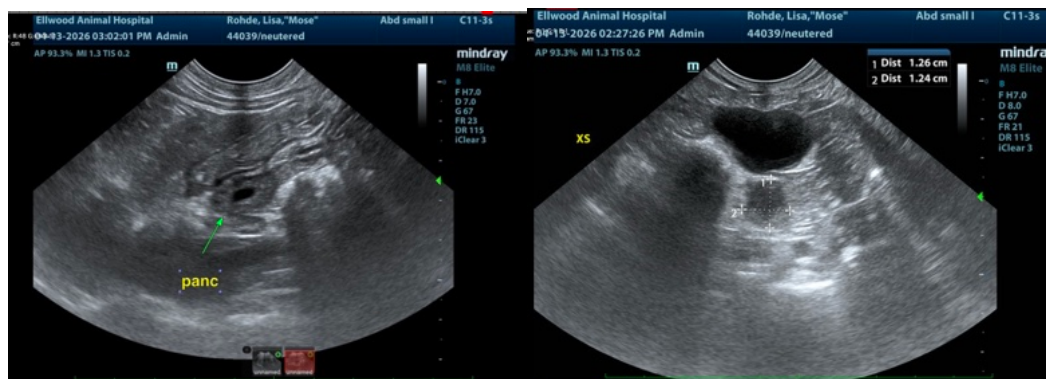
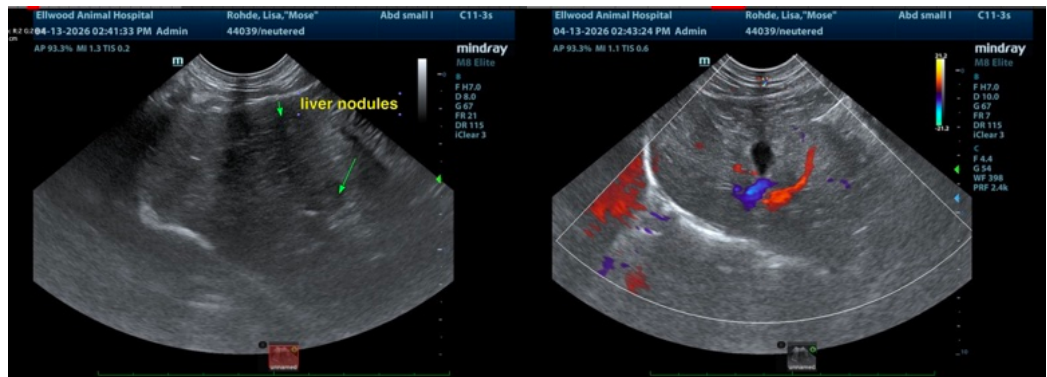
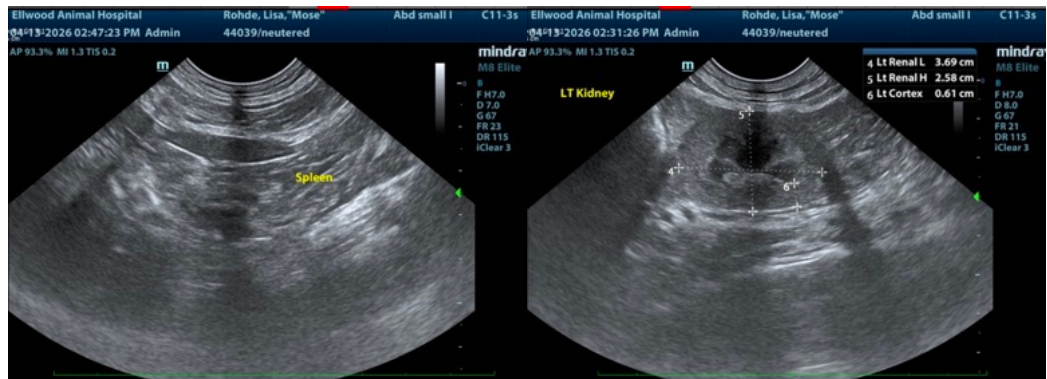
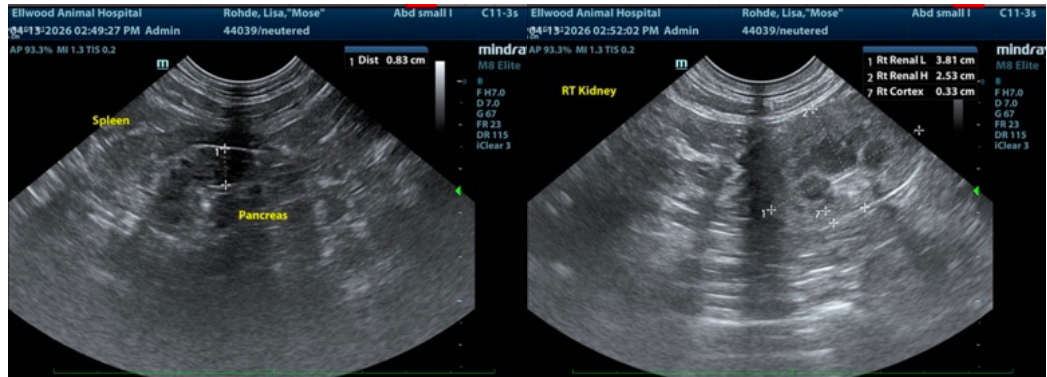
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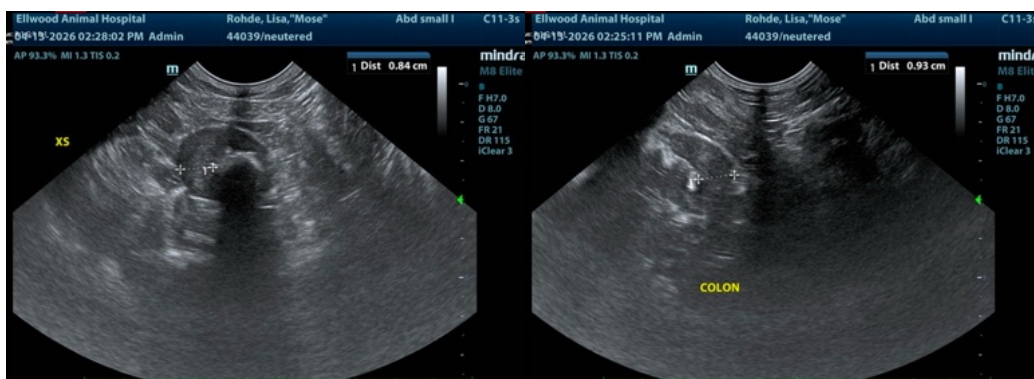
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP (CFM), Cert. IVUSS, CEO of SonoPath.com

info@SonoPath.com