



PATIENT

Cookie Bogardus

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

14 Years

WEIGHT

10.3 lbs

INTERPRETED BY

Greg Kuhlman, DVM,
DACVIM (SAIM)

IMAGING PERFORMED BY

Kevin Moon, DVM

HOSPITAL NAME

Shiloh Veterinary
Hospital

REFERRING VET

Lisa Wade, DVM

INVOICE

73202

DATE

2/24/26

PRESENTING CLINICAL SIGNS

Presented 2/16 with decreased appetite- would act hungry and start eating, then would walk away. Uncomfortable on abdominal palpation

BW appeared normal, Radiographs show increased gas in intestines, but no obvious mass

Abnormal PE/Chem/CBC/UA Results: CBC/Chem/T4/UA normal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder is moderately distended with anechoic urine. No uroliths are seen. The bladder wall is normal in appearance and thickness. No masses are seen. The ureteral papillae were not seen.

The right kidney is slightly small in size, measuring 3.04 cm. There is mild loss of corticomedullary distinction.

The left kidney presents normal size (2.97 cm) with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis.

Adrenal Glands

The adrenal glands were not visualized.

Spleen

The spleen is normal in size, shape, margination and echogenicity. No masses are seen.

Liver

The liver presents normal size and shape with smooth lobar margins. The parenchyma has normal echogenicity with normal echotexture. No focal lesions are seen. Intrahepatic bile ducts are normal. Normal vascular pattern.

The gallbladder is small in size and appears to have recently contracted. No gallbladder abnormalities are seen on this ultrasound. There is a mild amount of echogenic gravity dependent debris present within the gallbladder that appears clinically incidental at this time.

Gastrointestinal

The stomach has normal wall layering and thickness. The stomach lumen is empty. The upper GI tract does not appear to be obstruction. In the mid jejunum there is a focal hypoechoic intramural mass lesion with intestinal wall thickness of 7.9 mm in width. The lesion measures approximately 2.5 cm in length. The jejunal wall in this focal lesion is diffusely hypoechoic and has lost all normal layering. The remainder of the jejunum and small bowel appear normal in thickness and layering. Colon contains normal contents with normal wall thickness.

There are several mildly to moderately enlarged mesenteric lymph nodes surrounding the jejunal lesion. A representative node measures 1.6 mm x 4.1 mm in size.



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Pancreas

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The visible pancreas is normal in size with normal echogenic parenchyma and surrounded by normal peri-pancreatic mesentery.

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Free Abdomen

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No free abdominal fluid is seen.

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ULTRASONOGRAPHIC FINDINGS

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- Differentials for the focal jejunal lesion include most likely a neoplastic cause such as lymphoblastic lymphoma, less likely but possible mast cell, possibly adenocarcinoma or leiomyosarcoma.

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- The enlarged mesenteric lymph nodes may be reactive but are most likely enlarged due to a neoplastic cause either due to round cell neoplasia or metastatic neoplasia from the jejunal lesion.

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- Slightly small right kidney with mild loss of corticomedullary distinction.

WEIGHT

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

10.3 lbs

Recommend performing a fine needle aspirate of the focal jejunal lesion and submitting for cytology. If cytology is inconclusive, then recommend surgical resection of the mass and submission for histopathology.

INTERPRETED BY

Regarding the small right kidney, recommend full staging, monitoring, and management of the patient per International Renal Interest Society guidelines.

Greg Kuhlman, DVM,
DACVIM (SAIM)

The patient's prognosis at this time appears guarded pending results of the fine needle aspirate or histopathology of the jejunal lesion. Before considering surgery, recommend obtaining 3-view chest x-rays to rule out pulmonary metastatic disease.

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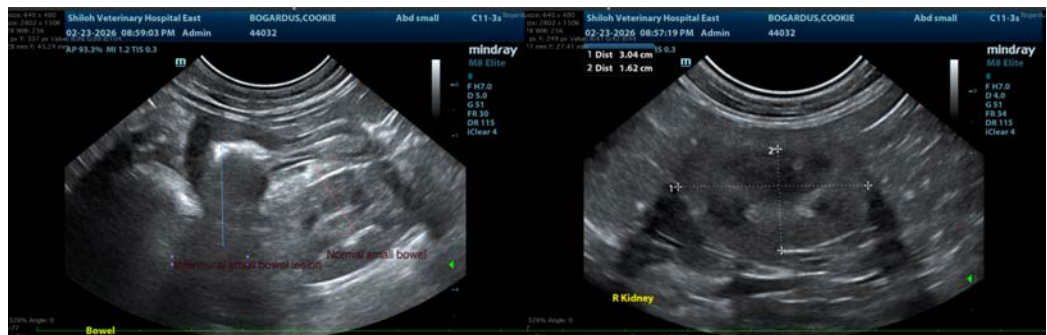
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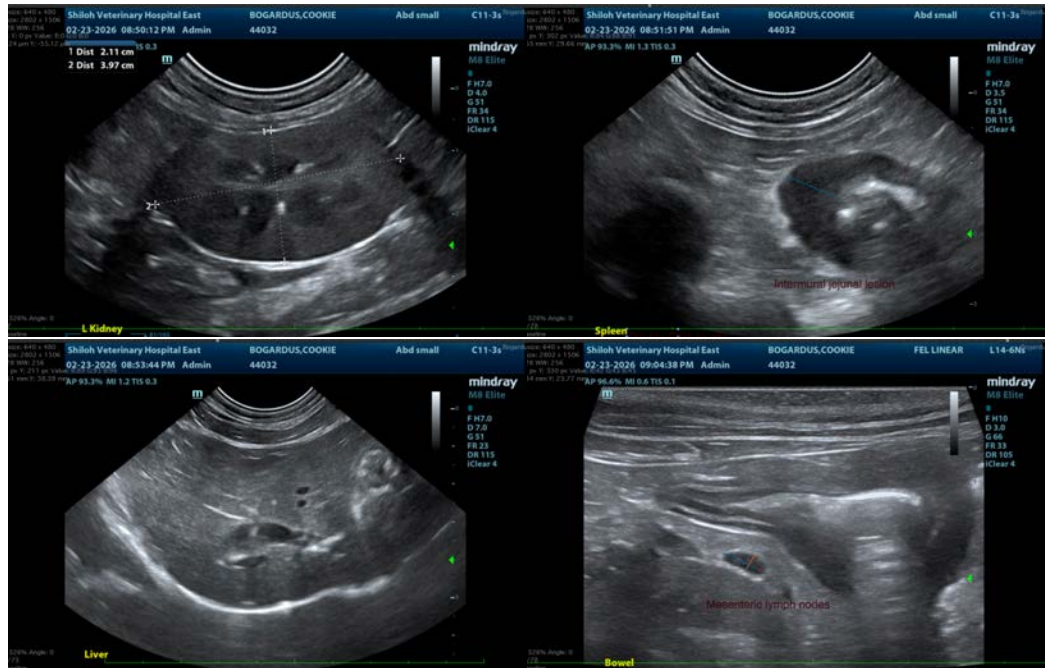
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Greg Kuhlman, DVM, DACVIM (SAIM)

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