



PATIENT

Gracie Readinger

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

14 Years 4 Months

WEIGHT

3.3 kg

INTERPRETED BY

Greg Kuhlman, DVM,
DACVIM (SAIM)

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

VCA Sinking Springs

INVOICE

73796

DATE

3/18/26

PRESENTING CLINICAL SIGNS

AUS to further evaluate abdominal effusion, uncontrolled hyperthyroidism, new elevated LES and progressive leukocytosis with a neutrophilia. Presented to rDVM on 3/9/26 for abdominal distention that occurred over that weekend, abdominal effusion noted, HM, and plantar grade stance. Heart murmur was first detected in Dec 2025 on a recheck visit after starting Methimazole for Hyperthyroidism (Dx in Oct 2025). Presented to the ER on 3/14/26 for further diagnostics. Abd effusion cytology concerned for neoplastic effusion Grade 4/6 parasternal HM (first appreciated in Dec 2025).

Abnormal PE/Chem/CBC/UA Results: ER 3/14/26: Abd eff cytology: Protein rich transudate; suspected neoplastic effusion. Heterogenous pop of non-degenerate neut & vacuolated, reactive macrophages on a lightly basophilic background. Sm numbers of lg epithelioid cells- round to polygonal & arranged individually in sm. clusters. Nuclei are round to oval & central to eccentric. Cells demonstrate binucleation, occ multinucleation & mod anisocytosis/anisokaryosis. No infectious agents. - fBNP: normal - T4: 10.6 H (prev 6.9) - CBC: Hct 30.4%, WBC 39.%, Neut 36.65 H, Plt 166-n - Chem: Alb 2.3-n, ALP 82-n, ALT 530 H, Ca 8.5 L, Cl 101 L, Cr 0.6 L, Gluc 131 H, K 2.8 KTP 5.3 L, Glob 3.0-n, BUN 17.4-n Dec 2025: - CBC: Hct 42%, plts 397-n, Neu 18,873 H, Mono 932 H, NSF - Chem: Alb 2.9-n, Glob 3.2-n, normal LES, normal BUN/Cr/SDMA, NSF

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 right kidney presents normal size (3.5 cm) with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis.

The left kidney presents normal size (3.6 cm) with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis.

Adrenal Glands

The right adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The right adrenal gland measures 4.0 mm in width.

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The left adrenal gland measures 2.6 mm in width.

Spleen

The visible spleen appears normal.

Liver

The liver is diffusely enlarged with rounded margins and a diffuse overall hyperechoic echotexture in the left liver. There are multifocal hypoechoic ill-defined lesions present. Three of lesions are measured and found to be 6.8 mm in diameter and 5.9 mm in diameter and 5.3 mm in diameter. In the mid liver there is a 2.1 cm diameter heterochoic, mainly hyperechoic mass lesion present. In the right liver there is a 3.2 cm in diameter mass lesion present with a hypoechoic rim. The center of the lesion is heterochoic. This lesion appears to reside just cranial to the area of the gallbladder. The mass lesion in the right liver does



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contain blood flow via doppler exam, confirming it as a mass lesion.

The gallbladder presents normal size with anechoic contents. The gallbladder wall is diffusely mildly hyperechoic but appears normal in thickness. The common bile duct is diffusely prominent, measuring approximately 2.5 mm in width, which is within normal size. It is most likely easily visible on this scan due to the free abdominal fluid. No common bile duct or gallbladder issues identified on this scan.

Gastrointestinal

The stomach contains a small amount of retained fluid most likely due to ileus. The stomach wall is normal in thickness and layering. Diffusely, the small intestines are thickened with sections measuring up to 4.9 mm in width due to a thickened muscularis layer. Colon contains normal contents with normal wall thickness.

Pancreas

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

Free Abdomen

There are no enlarged abdominal lymph nodes seen on this exam.

Diffusely throughout the abdomen there is a moderate amount of echogenic free fluid present.

ULTRASONOGRAPHIC FINDINGS

- Enlarged, hyperechoic liver with multifocal ill-defined and well-defined mass lesions of variable echogenicity – I suspect these lesions are most likely neoplastic, either metastatic neoplasia or possibly (and highly likely) primary hepatobiliary neoplasia such as cholangiocarcinoma.
- Moderate amount of echogenic free fluid present in the stomach.
- Thickened small intestine due to thickened muscularis – These findings are consistent with inflammatory GI disease such as inflammatory bowel disease, small cell lymphoma, or mast cell disease.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommend ultrasound guided fine needle aspirate of one or several of these mass lesions to help determine etiologies of lesions.

If hepatic disease and effusion is determined to be non-neoplastic, then consider further workup for inflammatory GI disease such as submitting Texas A&M GI panel to confirm chronic enteropathy. If chronic enteropathy is present, consider GI biopsies either surgically or endoscopically.

Reportedly, the fluid contains cells concerning for neoplasia. Recommend submitting the fluid for analysis and cytology to confirm. If the patient is confirmed to have neoplastic abdominal effusion consistent with carcinomatosis, then prognosis is grave at this time.

Recommend 3-view chest radiographs to determine if pulmonary metastatic disease is present.



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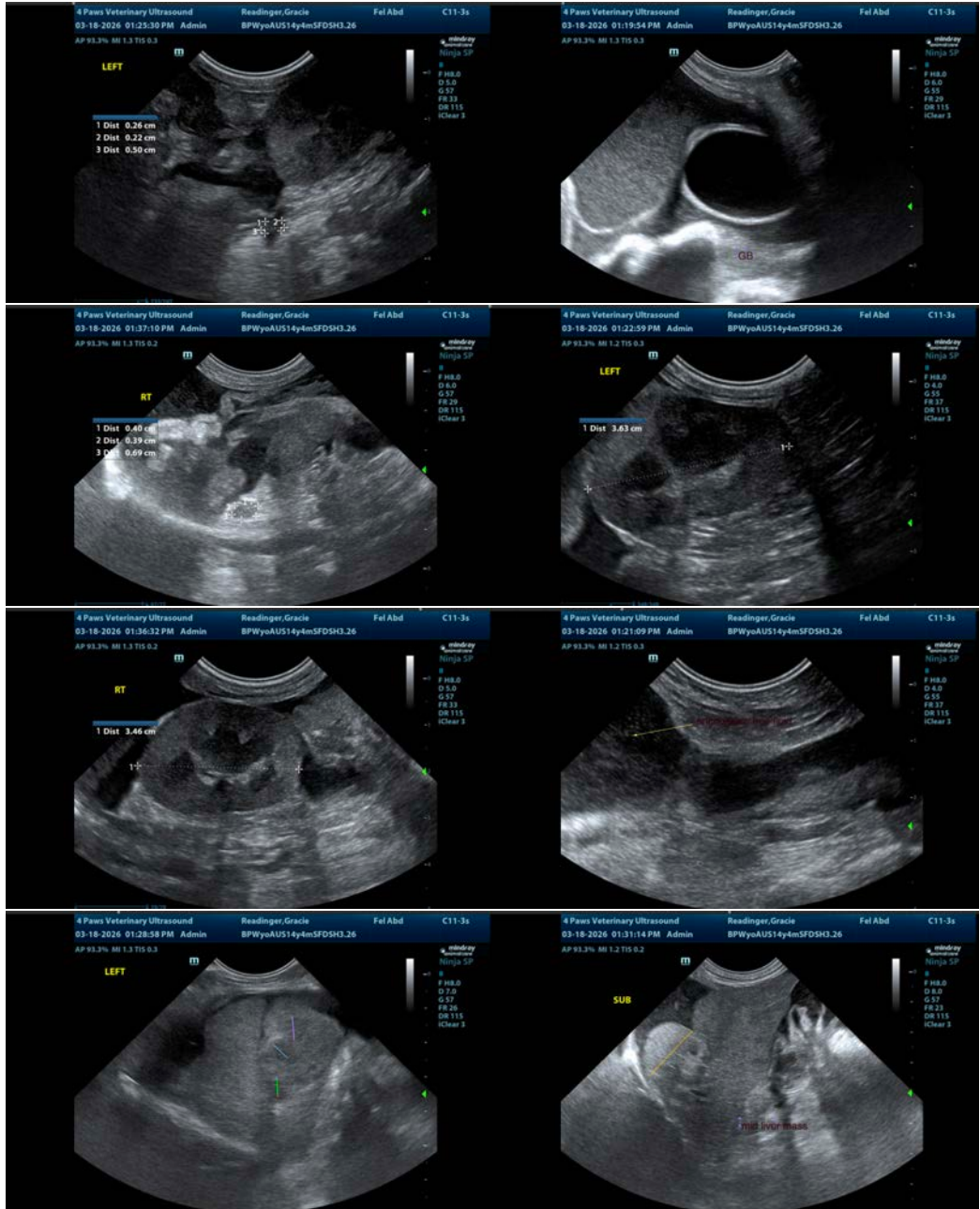
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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