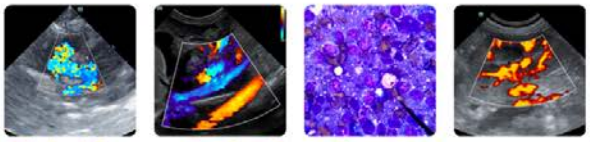


PATIENT

Molly Simpson

SPECIES

Feline

BREED

Ragdoll

SEX

Spayed Female

AGE

15 Years 9 Months

WEIGHT

6.69

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Ukachi Ugorji, DVM

HOSPITAL NAME

Craig Road Animal Hospital

REFERRING VET

Ukachi Ugorji, DVM

INVOICE

74600

DATE

4/20/26

PRESENTING CLINICAL SIGNS

Owner reports Molly has not been eating or drinking since Thursday. Owner notes lethargy and attempts to hide. Owner states Molly lost approximately 2 lb since Friday and is currently about 6 lb. Owner previously took Molly to another clinic where blood work (CBC/chemistry) was performed; owner reports T4 and urinalysis were also done and stated to be normal. No vomiting or diarrhea were reported in the transcript

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a large amount of echogenic non-shadowing debris, most consistent with exfoliated cells, crystals, mucous and/or small blood clots likely combined with incidental suspended lipid. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortex are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Right kidney measures 3.4 cm in length.

The left kidney presents normal size (3.0 cm) with normal shape and architecture. Normal corticomedullary distinction. There is mild renal pelvic dilation measuring 2.4 mm in width. No 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 3.0 mm in width.

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The left adrenal gland measures 3.5 mm in width.

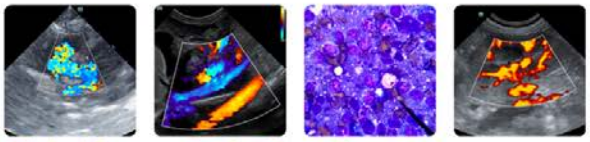
Spleen

The spleen is normal in size and echogenicity with several hyperechoic lesions that are non-capsule displacing, most likely benign myelolipomas, not clinically significant.

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 presents normal size with anechoic contents. Normal gallbladder wall. No evidence of bile duct distention or obstruction.



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Gastrointestinal

The stomach has normal wall layering and thickness. Diffusely, the small bowel has lost normal layering. There is mucosal fogging. It measures 3.0 mm in width, which is mildly excessive. The ileum is fluid dilated. Ileal wall appears to have mild loss of layering. The colon contains a marked amount of anechoic fluid with hyperechoic striations present throughout this fluid.

Pancreas

The visible pancreas is mildly hypoechoic. No significant surrounding hyperechoic fat.

Free Abdomen

There is a rounded, hypoechoic perihepatic lymph node present measuring 6.5 mm in width.

Numerous moderately to markedly enlarged mesenteric lymph nodes are present throughout the omentum. A representative node measures 4.2 mm in width.

No free abdominal fluid is seen.

ULTRASONOGRAPHIC FINDINGS

- Potential pathologic urinary bladder debris.
- Diffuse small intestinal disease including ileum and jejunum with imminent diarrhea - Possibly due to an infiltrative disease such as lymphoma, less likely mast cell or possible inflammatory bowel disease. Given the appearance of the intestines, infectious disease such as feline infectious peritonitis is not highly suspected.
- Rounded, hypoechoic perihepatic lymph node – Possible neoplastic disease such as infiltrative disease (lymphoma versus mast cell) or possibly metastatic neoplasia, although no primary tumor is seen.
- Moderately to markedly enlarged mesenteric lymph nodes - Consistent with either infiltrative neoplasia such as lymphoma or mast cell most likely. Less likely these nodes are reactive or enlarged due to metastatic neoplasia.
- The patient appears to have reactive pancreatic inflammation, most likely due to underlying suspected GI disease.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not already performed, recommend urine culture to rule out lower urinary tract infection or possible pyelonephritis, given the renal pelvic dilation of the left kidney.

I suspect the patient may have underlying small cell GI lymphoma and that this is the cause of the enlarged lymph nodes. Biopsies of the GI tract would be needed to confirm.

Recommend submitting a Texas A&M GI panel to screen the patient's cobalamin, folate, TLI, and fPLI. Specifically, cobalamin would determine if ileal disease is present and if supplementation is needed. If ileal disease is determined to be present, it may be contributing to patient's clinical signs through malabsorptive disease. Consider biopsies either surgically or endoscopically if ileal disease is present.

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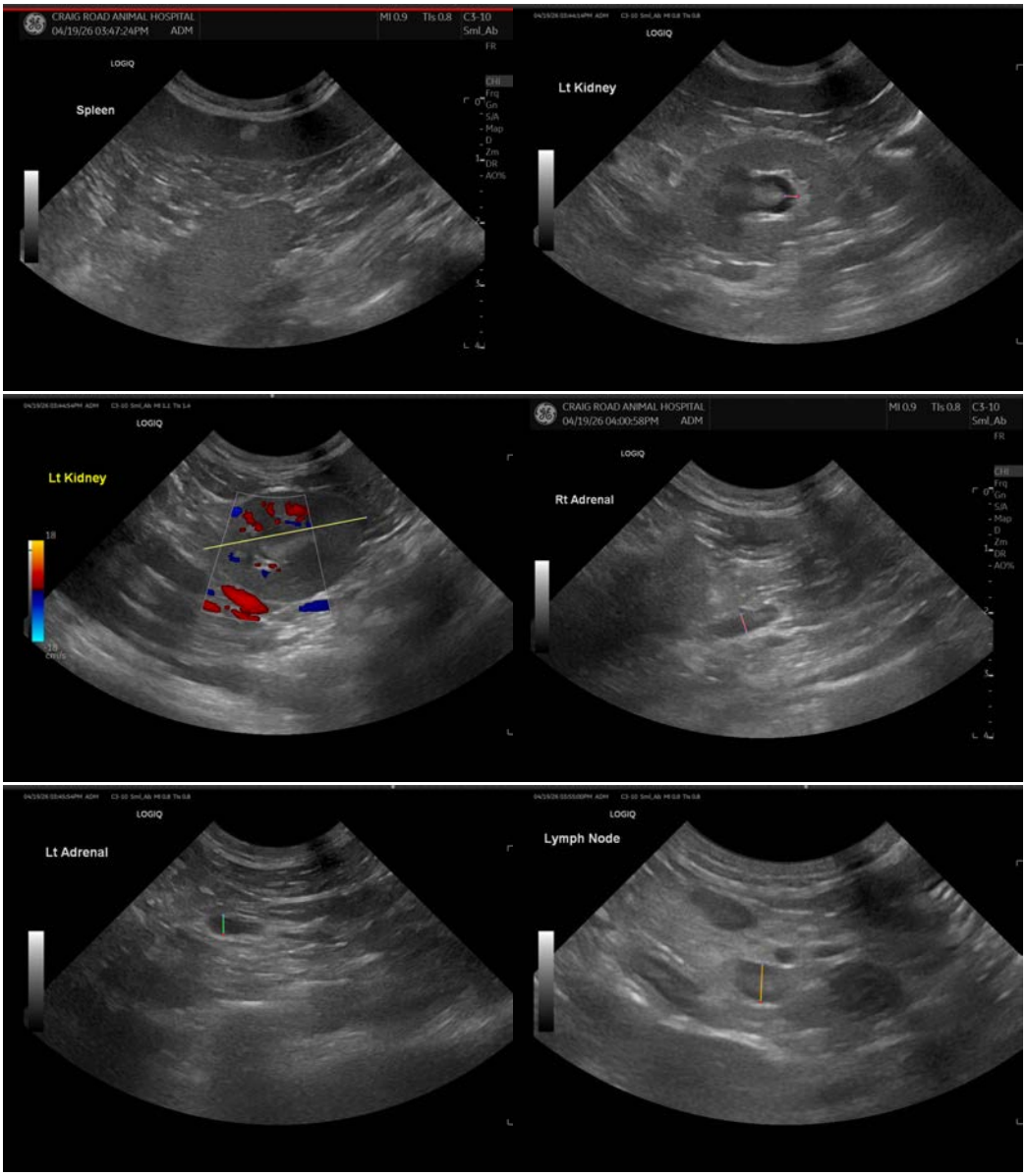
If the Texas A&M GI panel confirms a chronic enteropathy, a chronic enteropathy with acute flare up is most likely the cause of the patient's current clinical signs and weight loss, so GI biopsies would be recommended.

It is unclear as to the cause of the hyperechoic striations throughout the fluid in the colon. Rule out parasitism. If patient has a lifestyle conducive to possible parasitism, submit fecal pathogen PCR testing.

If histoplasmosis is endemic to patient's region and has lifestyle conducive to acquiring this disease, consider testing for histoplasmosis via urine antigen testing.

If possible consider ultrasound guided fine needle aspirate of the enlarged perihepatic lymph node with submission for cytology to help determine the cause of its enlargement.



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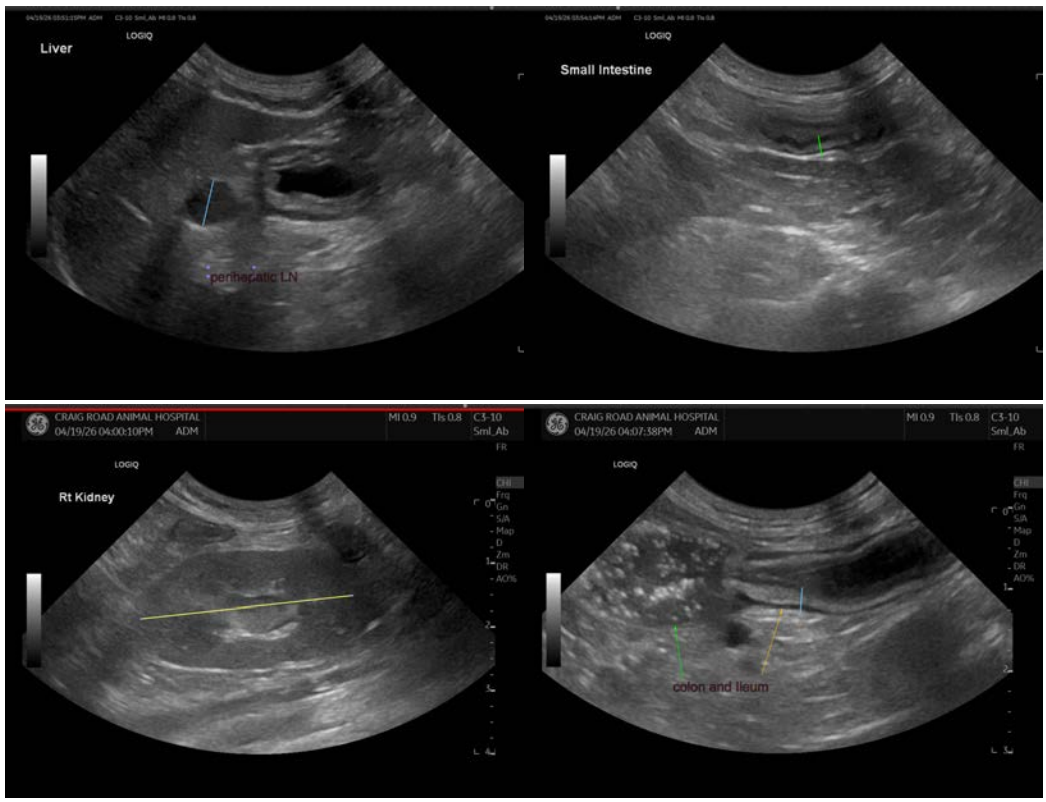

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

Veterinary Internal Medicine Specialist
info@SonoPath.com