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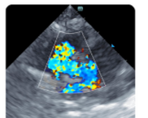
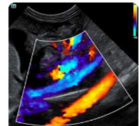
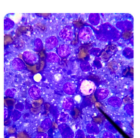
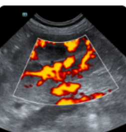

SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT

Leah Muonio

SPECIES

Feline

BREED

DSH

SEX

FS

AGE

14 years

WEIGHT

5 kg

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Alpine Animal Hospital

REFERRING VET

Dr. Lindsy S

INVOICE

12050

DATE

6/1/2026

PRESENTING CLINICAL SIGNS

Hx dramatic weight loss in the past 2 years (from 19lb down to 10.5). Soft stool No vomiting, good appetite. POssibly thickened GI loops on palpation. Working diagnosis: Concern for enteropathy +/- thyroid dz.

Abnormal PE/Chem/CBC/UA Results: Chem BUN 44, Creat 2.2, SDMA 21.8 (mild increases, but similar to levels in 2025), Ca still 11.7 (was 11.7 in March as well) CBC Normal T4 3.5 (rise from 2.5 in March) LABS attached

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 left kidney presents normal size with normal shape and architecture. Mild loss of corticomedullary distinction. Renal pelvic dilation noted measuring 3.6 mm in width. No pyelectasia, ureteral dilation or nephrolithiasis. The left kidney measured 3.2 cm in length.

The right kidney presents normal size with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis. The right kidney measured 3.7 cm in length.

Adrenal Glands

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The left adrenal measures 4.1 mm in width.

The right adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The right adrenal measures 4.6 mm in width.

Spleen

Spleen is at the upper limits of normal in size (8.5 mm in width) with subtly scalloped or undulating capsular contour. Parenchyma is normal in echogenicity with a mildly coarse/heterogenous echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Within the left liver there is an ill-defined hyperechoic lesion that measures approximately 9.8 mm x 12.3 mm in width. This lesion appears mildly cavitated, and most likely primary hepatobiliary neoplasia such as cholangiocarcinoma, or lymphoma. A benign cholangiocystadenoma is also possible.

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

Gastrointestinal

Within the lumen of the pylorus there is an 8.2 mm x 13.8 mm heterogenous mass lesion that has blood flow. The remainder of the stomach, other than the pylorus, is mildly fluid filled. This is most

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likely due to delayed gastric emptying from the pyloric mass lesion. The fundus of the stomach wall has normal layering and thickness.

Small intestines appear normal in thickness, with the majority of the small bowel measuring approximately 2.2 mm in width, and segments measuring up to 3.2 mm in width. There is diffusely mild mucosal fogging consistent with a possible inflammatory enteropathy such as inflammatory bowel disease or small cell lymphoma, or less likely mast cell disease.

Colon contains normal contents with normal wall thickness.

Pancreas

The visible pancreas diffusely hypoechoic and has dilated pancreatic ducts present throughout. There is no significant surrounding hyperechoic fat.

Free Abdomen

Mild right iliac lymphadenopathy measuring 3.4 mm in width. Iliac lymphadenopathy is most likely reactive and less likely due to neoplasia.

Multiple enlarged hypoechoic, rounded mesenteric lymph nodes with a presentative node measuring 4.8 mm x 16.0 mm in size. These are consistent with possible metastatic neoplasia or possibly reactive.

Regional enlarged lymph nodes surrounding the pylorus with a representative node measures 3.7 mm x 10.3 mm in width.

No free abdominal fluid is seen.

Other

Cardiac image provided and appears normal.

ULTRASONOGRAPHIC FINDINGS

- Iliac lymphadenopathy. Likely reactive and less likely due to neoplasia.
- Regional enlarged lymph nodes surrounding the pylorus as well as enlarged hypoechoic, rounded mesenteric nodes. These nodes may represent metastatic neoplasia from the pyloric mass. It is possible these are reactive cause.
- Age related kidney changes with left sided renal pelvic dilation.
- Intraluminal, heterogenous mass lesion within the pylorus. Given the location, differentials include most likely adenocarcinoma or lymphoblastic lymphoma. Also consider leiomyosarcoma, less likely a benign leiomyoma. Remainder of the stomach, other than the pylorus, is mildly fluid filled. This is most likely due to delayed gastric emptying from the pyloric mass lesion.
- Ill-defined, hyperechoic lesion within the left liver. This lesion appears mildly cavitated. Differentials could most likely include primary hepatobiliary neoplasia such as cholangiocarcinoma, or lymphoma. A benign cholangiocystadenoma is also possible.
- Diffusely mild mucosal fogging consistent with a possible inflammatory enteropathy such as inflammatory bowel disease or small cell lymphoma, less likely mast cell disease.

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- Scalloped spleen – can be associated with benign or malignant infiltrative disease. Common causes include a reactive spleen secondary to immune stimulus or early infiltrative round cell neoplasia such as lymphoma or mast cell tumor.
- Diffusely hypoechoic pancreas with dilated pancreatic ducts throughout, and no significant surrounding hyperechoic fat. Patient appears to have a mild reactive pancreatitis, most likely due to the aforementioned disease processes within the abdomen.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

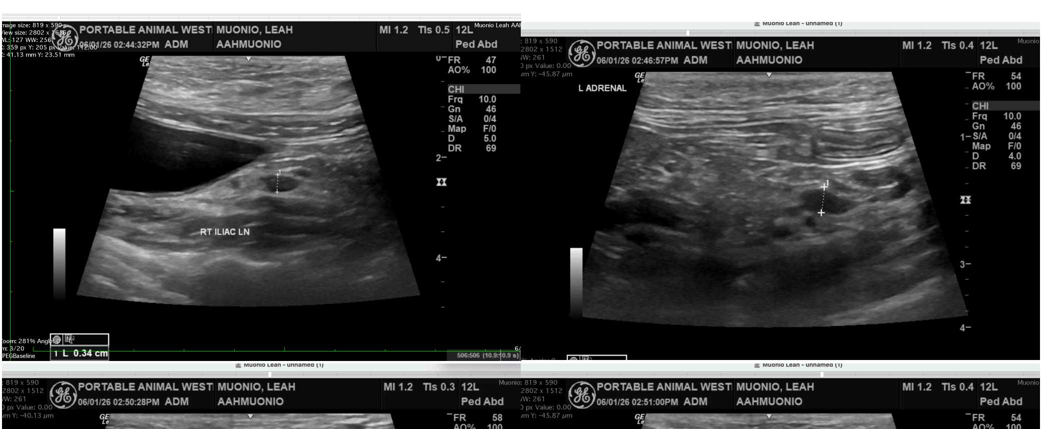
Recommend an ultrasound guided FNA of the mass lesion within the pylorus, and submission for cytology. If cytology is non-diagnostic, then recommend performing a CT scan to determine if surgical resection is feasible. If the mass resection is done, then recommend submission for histopathology.

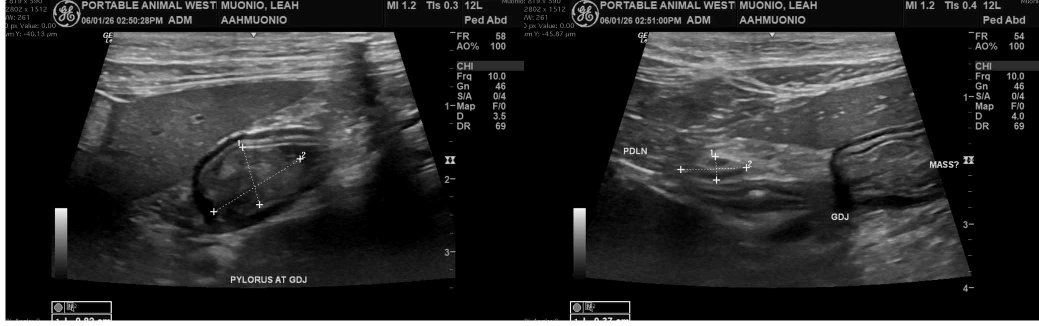
If possible, recommend a fine needle aspirate of one of the regional lymph nodes surrounding the pyloric mass, as well as other accessible nodes, and submission for cytology to help determine if metastatic neoplasia may be present.

Recommend fine needle aspirate of the liver lesion and spleen, and submission for cytology.

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. If chronic enteropathy is identified via GI panel, then consider biopsies of the GI tract.

Prognosis at this time appears guarded, pending results of the diagnostics.





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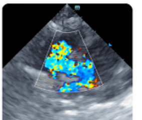
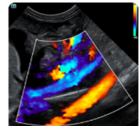
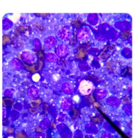
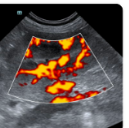

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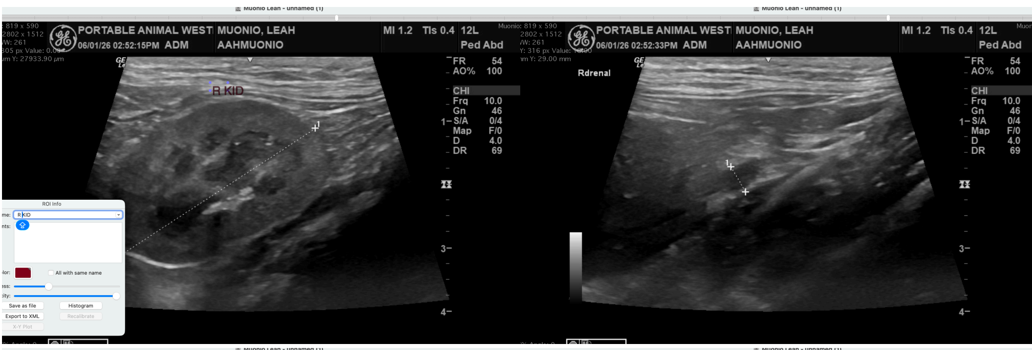

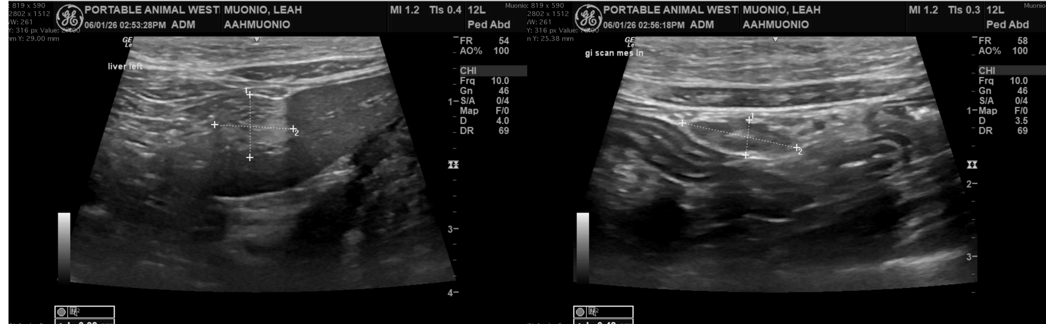

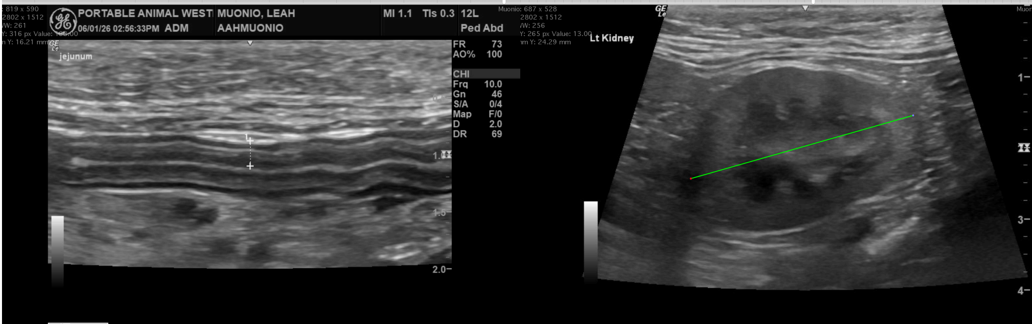

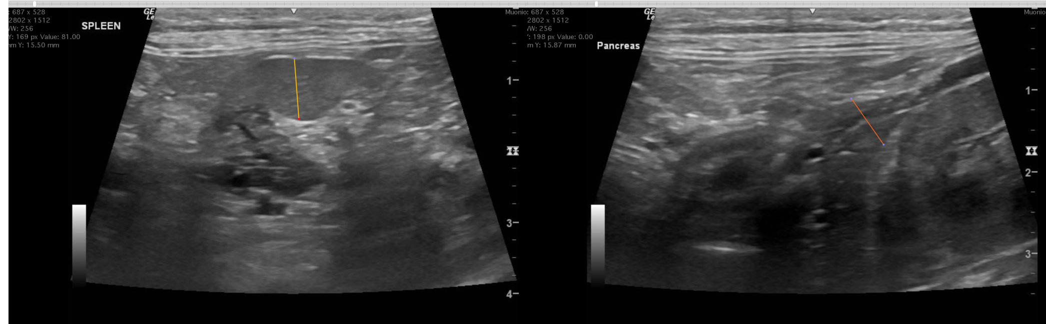

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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