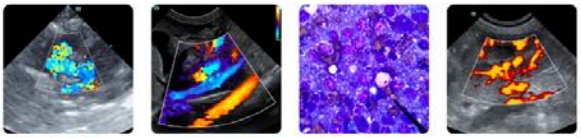

PATIENT

Google Kurtz

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

14 Years 10 Months

WEIGHT

9.1 lbs

INTERPRETED BY

Greg Kuhlman, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Rebecca Hamilton

HOSPITAL NAME

Animal Paradise Hospital

REFERRING VET

Dr. Elshafie

INVOICE

75973

DATE

6/17/26

PRESENTING CLINICAL SIGNS

Vomiting blood, loss of appetite, Hx of Liver tumor

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 moderate echogenic non-shadowing debris, most consistent with incidental suspended lipid in a cat, possibly combined with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also 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.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices 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. Left kidney measured 4.3 cm. Right kidney measured 4.3 cm.

Adrenal Glands

The right adrenal gland was not visualized.

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The left adrenal gland measures 2.5 mm in width.

Spleen

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

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is moderately heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion

The gallbladder presents normal size with anechoic contents. Normal gallbladder wall. The common bile duct is diffusely distended, measuring up to 6.0 mm in width.

Gastrointestinal

The stomach wall appears to be diffusely thickened, measuring 1.0 cm in width with loss of layering. The stomach wall has a heterochoic echotexture. The stomach contains a moderate amount of hypoechoic fluid. Within the lumen of the stomach there is a 1.3 cm x 2.3 cm hyperechoic lobulated mass lesion present. Diffusely the jejunum is thickened due to a moderately thickened muscularis layer. The jejunum wall measures 3.3 mm in width. Colon contains normal contents with normal wall thickness.

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Pancreas

Pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and has a mildly irregular undulating contour. Parenchyma is coarse with mixed echogenic remodeling noted. No pancreatic duct dilation is noted.

Free Abdomen

There are numerous mildly to markedly enlarged mesenteric lymph nodes present throughout the abdomen. The nodes are hypoechoic and rounded. There is what appears to be a markedly enlarged mesenteric lymph node present in the mid abdomen that measures 2.5 cm x 2.0 cm.

No free abdominal fluid is seen.

ULTRASONOGRAPHIC FINDINGS

- Urinary bladder debris.
- Age related renal changes.
- Heterogeneous liver.
- Diffusely thickened stomach with intramural mass lesion.
- Thickened jejunum.
- Chronic pancreatitis pattern.
- Enlarged mesenteric lymph nodes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently performed, recommend urinalysis. If patient has active urine sediment, recommend urine culture and antibiotic sensitivity.

The changes seen within the gastric wall and gastric lumen are most likely attributed to malignant neoplasia such as lymphoblastic lymphoma, mast cell disease, adenocarcinoma, or leiomyosarcoma. Possibly but unlikely a benign hematoma. Recommend fine needle aspirate of the thickened gastric wall and intraluminal gastric mass, submitting for cytology. If cytology is indeterminate as to etiology of the gastric changes, consider endoscopic biopsy of the gastric wall.

The thickened muscularis layer of the jejunum is most likely a second disease attributed to small cell lymphoma or less likely possibly mast cell disease. Consider submitting a GI panel. If a chronic enteropathy is identified on GI panel then consider GI biopsies.

The enlargement of the mesenteric lymph nodes is most likely due to metastatic neoplasia (from gastric lesions), however infiltrative neoplasia such as lymphoblastic lymphoma or mast cell disease cannot ruled out. Recommend fine needle aspirate of one or several of the enlarged mesenteric lymph nodes to help further characterize the cause for the mesenteric lymph nodes enlargement.

Suspect the patient has had intermittent episodes of pancreatic inflammation and currently appears to have mild acute pancreatitis. Suspect the patients pancreatic Inflammation is secondary, and the pancreas is most likely reacting to the patient's gastric and/or small bowel disease.

The appearance of the liver lesions is suggestive of metastatic neoplasia (primary neoplastic disease suspected to be the gastric lesions). Recommend fine needle aspirate of one or several of these hepatic lesions and submit for cytology to characterize these lesions further. Regarding the common bile duct distention, there is most likely an obstructive process occurring caused by either the gastric lesions or the enlarged mesenteric lymph nodes.

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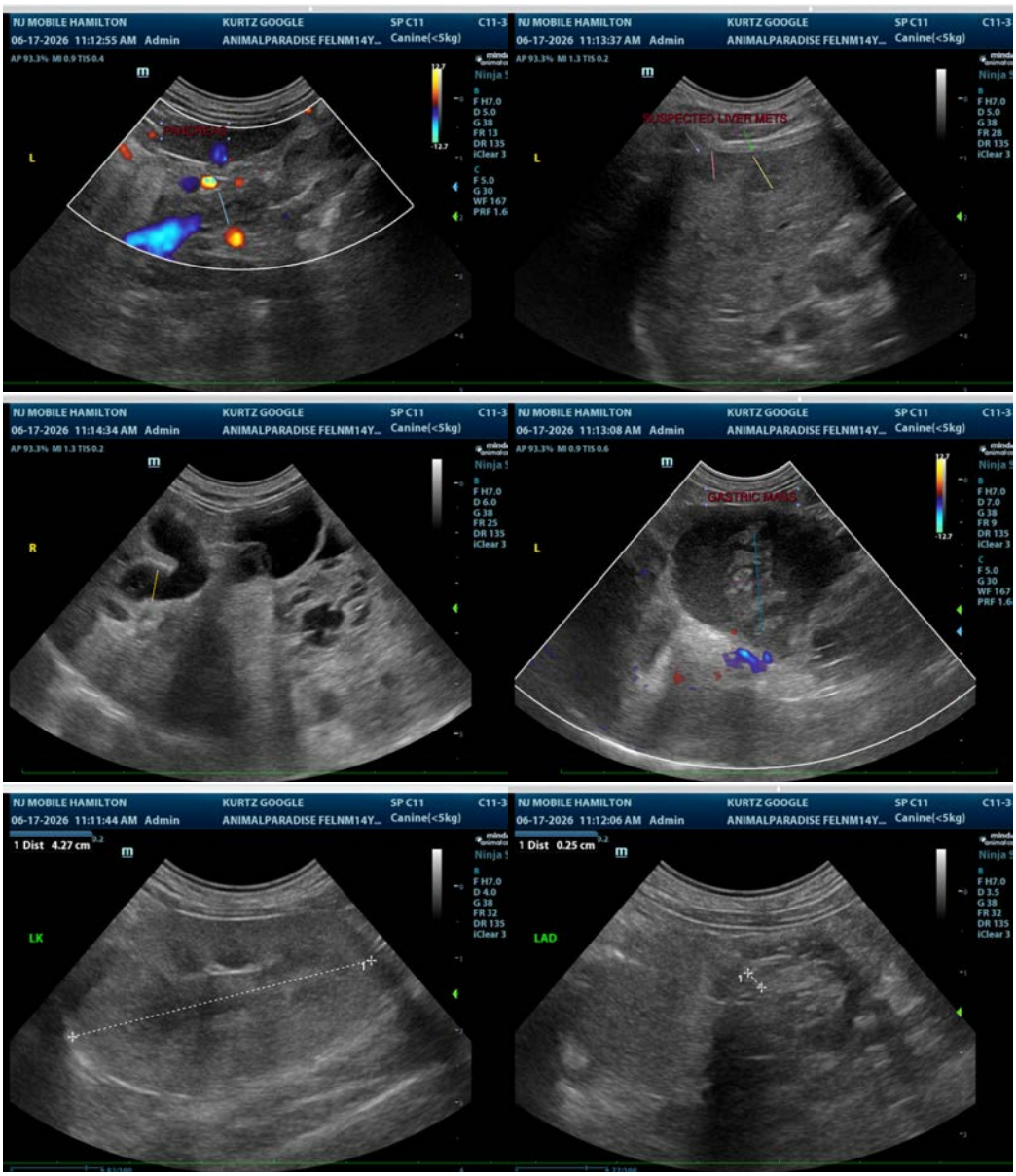
The primary recommendation is to perform FNAs of the hepatic lesions, gastric lesions and enlarged mesenteric lymph nodes. If cytology is inconclusive as to cause of these changes consider exploratory laparotomy to obtains biopsies of any abnormal tissues for histopathology.

Given the multiple abnormalities seen on this exam, patient's prognosis appears guarded to poor.



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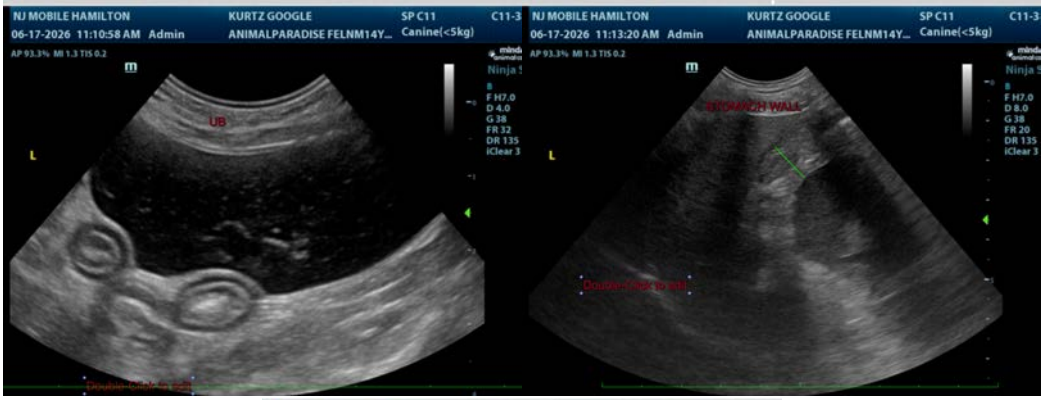

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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