



PATIENT

Violet Conley

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

4 Years

WEIGHT

4.26 kg

INTERPRETED BY

Karen Ebersole, DVM,
DABVP (Canine and
Feline practice)

IMAGING PERFORMED BY

Lindsay Powell, CVT

HOSPITAL NAME

Hershey AEC

REFERRING VET

Dr. Kimberly Davidson

INVOICE

35849

DATE

2/15/26

PRESENTING CLINICAL SIGNS

Chronic intermittent diarrhea for a couple years. In the past week increasing in lethargy and decreased appetite. On prednisolone chronically.

Abnormal PE/Chem/CBC/UA Results: Pale pink and tacky MM Large mass palpated mid abdomen approximately 6 cm diameter EPOC: hyponatremia (147), pCO₂ (24.3 L), Bicarb (11.6 L), HCT 22 PCV/TP:15%, 7.4

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder was normal in size and shape. The bladder wall was normal in thickness for the volume of urine present. The bladder contents were anechoic with echogenic sediment, without visible discrete urolith formation. There was no visible inflammation in the bladder or urethra.

Both kidneys were normal in size with a mildly irregular capsule contour. There was a mild to moderate increase in cortical echogenicity. The corticomedullary junction was mildly indistinct. There was no pelvic dilation. The left kidney measured 3.9 cm in length. The right kidney measured 3.4 cm in length.

The iliac trifurcation was visualized and evaluated. There was normal vascular perfusion with no evidence of thrombus formation. There was no visible lymphadenopathy.

Adrenal Glands

The adrenals were not visualized partly due to adjacent pathology and inflammation present.

Spleen

The spleen was normal in size and shape, with a smooth capsule contour. The parenchyma was finely textured and homogeneous. There were no visible masses, nodules or evidence of infiltrative disease. The vasculature showed good vascularity with power doppler.

Liver/Gallbladder

The liver was subjectively mildly increased in size with an irregular to scalloping capsule contour. The parenchyma was diffusely heterogenous with increased portal markings. The gall bladder was normal in size and contents. The cystic and common bile ducts were normal with no evidence of obstruction or inflammation.

Gastrointestinal

The stomach was normal in size and shape, with a smooth serosal contour. The stomach wall was normal in thickness and layering. Most of the small intestines displayed maintained wall layering. There was intermittent hyperperistalsis. In the mid abdomen, cranial to the bladder, there was a large irregular hypoechoic to heterogenous mass, measuring approximately 8.0 cm x 6.0 cm, and was highly vascular on power doppler assessment. There was marked adjacent mesenteric inflammation. The mass may derive from intestinal wall and also involve other intestinal bowel loops via adhesion. The ICJ was clearly visualized and was normal. Portions of the colon were visualized and visible colon wall appeared normal in the descending colon.

Pancreas



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There was diffuse mesenteric inflammation in the region of the pancreas. The visible portions of the pancreas appeared enlarged and hypoechoic, although large portions of the pancreas were not visible due to mesenteric inflammation.

Free Abdomen

There was small volume peritoneal effusion that was anechoic with echogenic debris.

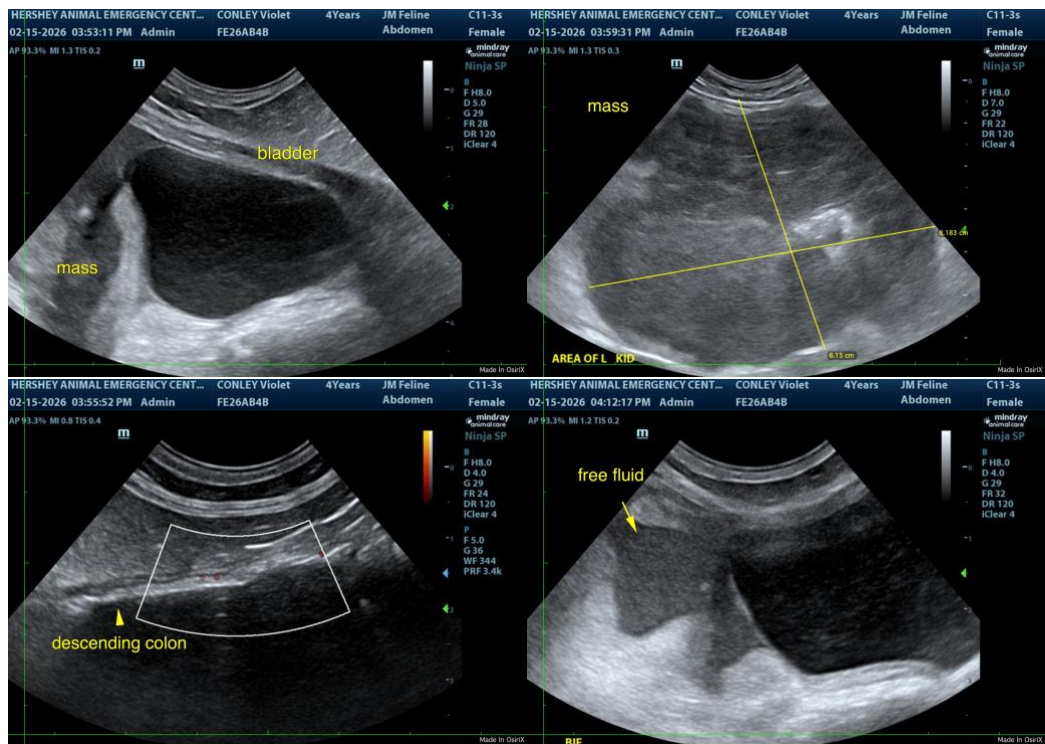
ULTRASONOGRAPHIC FINDINGS

- Large, undifferentiated mid-abdominal mass - suspect intestinal mural mass with adjacent SI involvement
- Peritoneal effusion, small volume - adjacent to mass
- Mesenteric inflammation, severe
- Pancreatitis - suspect secondary to adjacent pathology

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This clinical and sonographic presentation could be seen with neoplasia such as lymphoma or similar. FIP could also present this way. FNA would be needed for further assessment. Three view chest radiographs are recommended to screen for metastasis.

The prognosis is unfortunately guarded, given the degree of pathology present and the likely locally invasive nature of the mass. This mass is unlikely to be surgically resectable.





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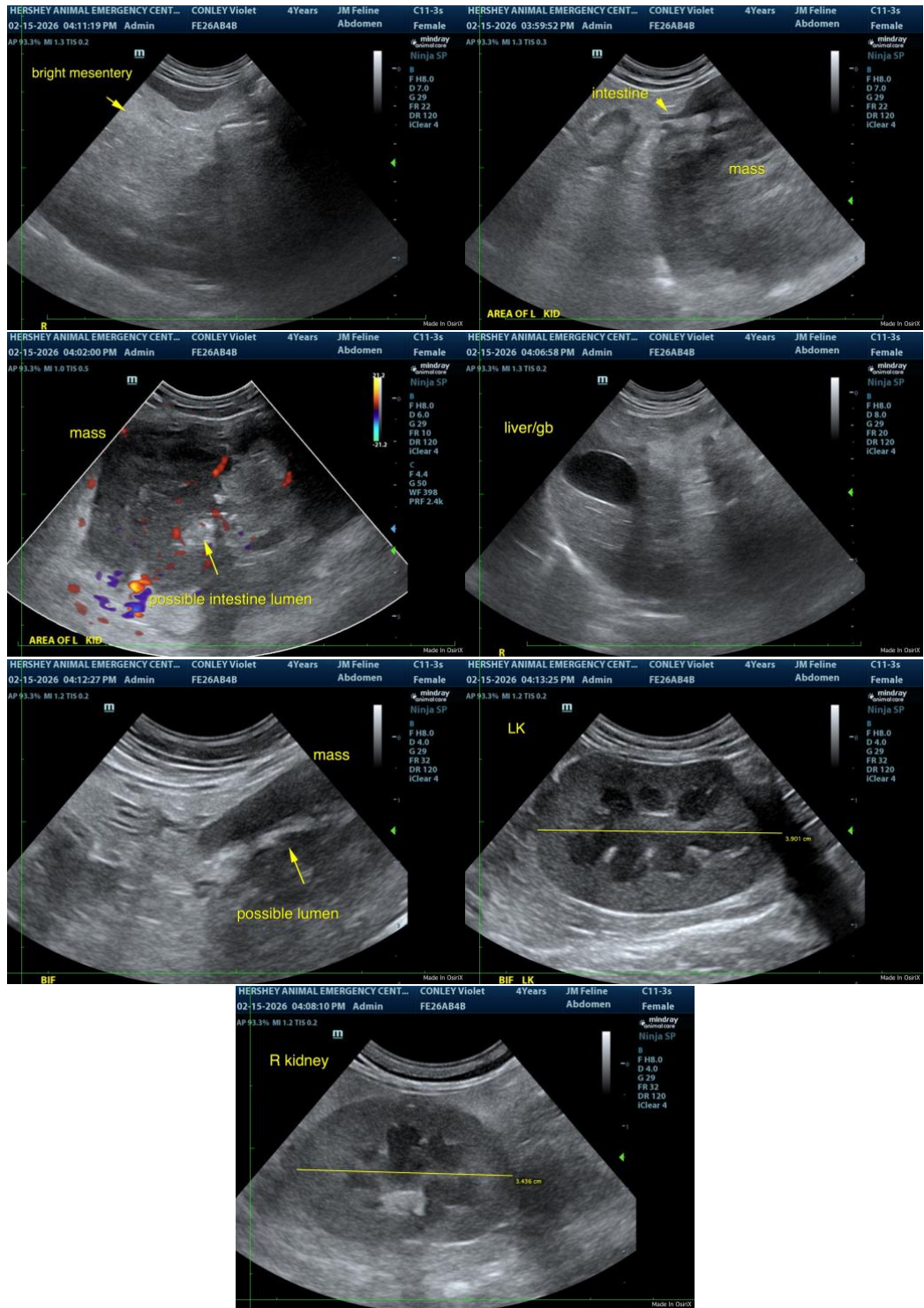
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Karen Ebersole, DVM, DABVP (Canine and Feline practice)

info@SonoPath.com