



PATIENT

Oliver Mulligan

SPECIES

Feline

BREED

DSH

SEX

Male Neutered

AGE

7 yrs

WEIGHT

12 lbs

INTERPRETED BY

R. McKenzie Daniel,
 DVM, DABVP
 (Canine and Feline)

IMAGING PERFORMED BY

Meghan Morse, LVT,
 CVT

HOSPITAL NAME

Wantage VH

REFERRING VET

Dr. Bullock

INVOICE

12949

DATE

12/16/25

PRESENTING CLINICAL SIGNS

History: Hx of US- focal hypoechoic colonic wall thickening, enlarged mesenteric LN- may 2025

Current meds: Terbutaline 0.625mg BID

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

Borderline prominent size with symmetrical contour was present in the kidneys. Mildly prominent hyperechoic renal cortex with mildly enhanced corticomedullary border demarcation. Adequate medullary volume with no evidence of left or right retroperitoneal inflammation or effusion. The left kidney measured 4.5 cm. The right kidney measured 4.6 cm.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.37 cm. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.42 cm.

Spleen

The spleen was normal in size and contour. Several to multiple, discrete, hyperechoic, non-capsule deforming to emerging nodules. The nodules suggest that the discrete to emerging nodules suggest benign criteria, i.e. emerging myelolipomas or hyperplasia. The spleen measured 0.83 cm width level of the mid spleen.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of retained ingesta, fluid or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Generalized empty intestinal lumen without mechanical/metabolic ileus, ingesta or foreign material to the level of the colon. Small intestine wall measured 0.24 cm.

The colon was primarily intact with normal wall layering and was non-distended in size containing formed fecal matter. Persistent to possible, mildly progressive, segmentally thickened, transverse to proximal descending colon wall exhibiting hypoechoic wall and loss of colon mural detail. Segmentally thickened colon wall measured potentially up to 0.72 cm width.



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Pancreas

The area of the pancreas was sonographically normal.

Free Abdomen

Solitary visualized, mildly hypoechoic to swollen colic to mid abdomen to jejunal lymph node was present measured 1.2 cm x 0.9 cm. Similar in measured size compared to the previous study. No evidence of peritoneal effusion present.

PRIMARY FINDINGS

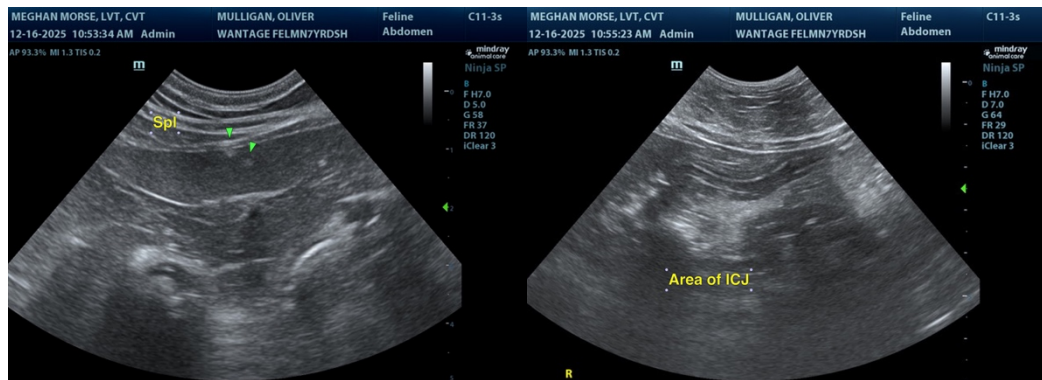
- Persistent to possible mildly progressive thickened transverse to proximal descending colon wall with loss of mural detail
- Static colic to mid abdomen jejunal lymph node
- Sonographically normal empty gastrointestinal tract

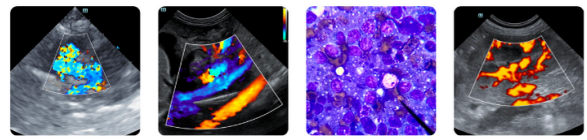
SECONDARY FINDINGS

- Borderline to mild renomegaly exhibiting mild cortical hyperechogenicity - nonspecific

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Considerations for the previously noted to mildly progressive thickened transverse to proximal descending colon wall and lymph node may include inflammatory neoplastic or granulomatous etiologies. FNA cytology of the lymph node could be considered for initial clarification. Definitive diagnosis would require colon and lymph node biopsies for histopathology and should be considered. Continued serial sonographic monitoring would be a more conservative approach.





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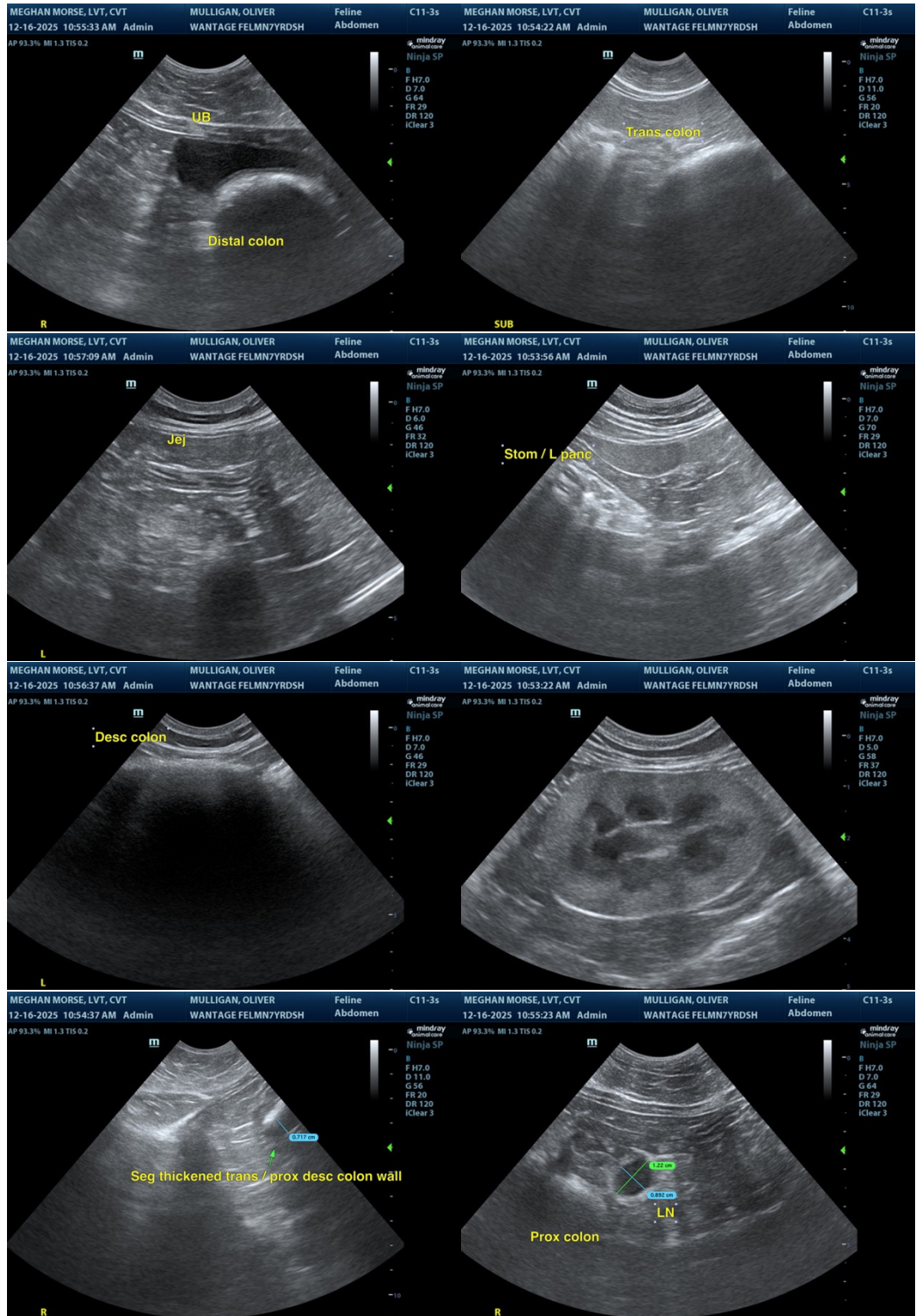
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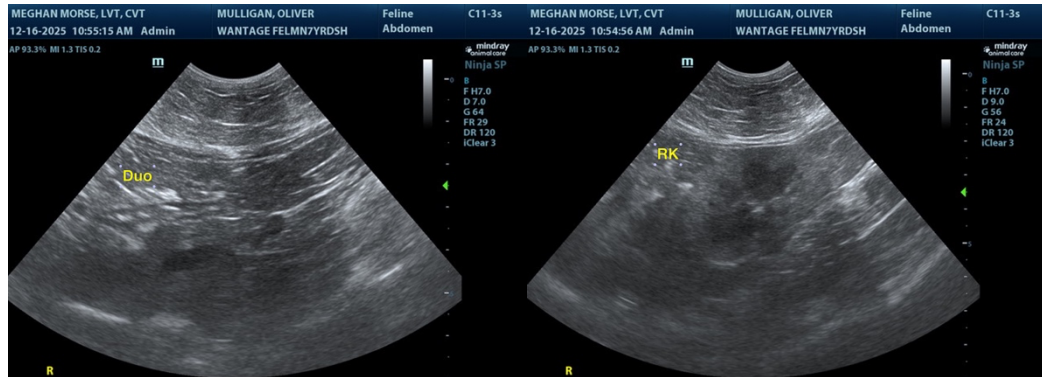
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

info@sonopath.com