



PATIENT

Buster Bohenek

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

2011

WEIGHT

8.8

INTERPRETED BY

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

IMAGING PERFORMED BY

Rebekah Jakum, CVT,
ARDMS/RVT

HOSPITAL NAME

White Haven
Veterinary Hospital

REFERRING VET

Dr. Volters

INVOICE

14654

DATE

03/26/26

PRESENTING CLINICAL SIGNS

- 2 month duration weight loss of 2.2#, decreased appetite, possible vomiting/diarrhea
- Medication: prednisolone, metronidazole

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Echogenic to particulate nondependent mild sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. Areas of medullary mineral to small renoliths were present. The left kidney measured 3.7 cm in length. The right kidney measured 3.5 cm in length.

Adrenal Glands

The left and right adrenal glands were not definitively visualized potentially secondary to suppression given recent steroid administration. No obvious pathology.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted. The spleen measured 1.0 cm width level of the mid spleen.

Liver & Gallbladder

The liver presented mildly enlarged with mild rounded symmetrical contour and mildly nonhomogenous parenchyma exhibiting coarse echotexture. Focal to intermittent discrete hypoechoic nonhomogenous noncapsule deforming ventral hepatic intraparenchymal nodules were present with an example measuring 0.90 cm in diameter.

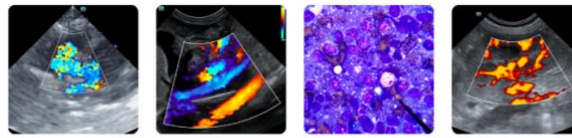
The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The proximal common bile duct was dilated and tortuous without overt post hepatic obstruction.

Gastrointestinal

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

The small intestine presented intact wall layering with overall maintained wall layer ratio and borderline thickened wall.

Normal visible colon wall layers were present with semi formed fecal matter.



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Pancreas

The pancreas was normal in size and contour with heterogeneous mildly hyperechoic parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Hepatopathy with discrete intraparenchymal nodules.
- Mild nonobstructive proximal common bile duct dilation.
- Intact borderline thickened small intestine.
- Heterogeneous remodeled pancreas.
- Semi formed fecal matter in colon.
- Age-related kidneys with mild medullary mineral.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Primary considerations in this case may include cholangiohepatitis combined with potential chronic pancreatitis and suppressed IBD given recent steroid therapy with potential for suppressed or emerging intestinal or hepatic neoplasia, i.e. lymphoma in conjunction with discrete hepatic nodules.

Further assessment may include (assuming normal clotting status and using a 25-gauge needle) hepatic FNA cytology in conjunction with a GI panel to include PLI, TLI, cobalamin and folate. Gastrointestinal support and empirical therapy for triaditis with clinical and sonographic monitoring would be a more conservative approach. Biopsies may be required for a definitive diagnosis.





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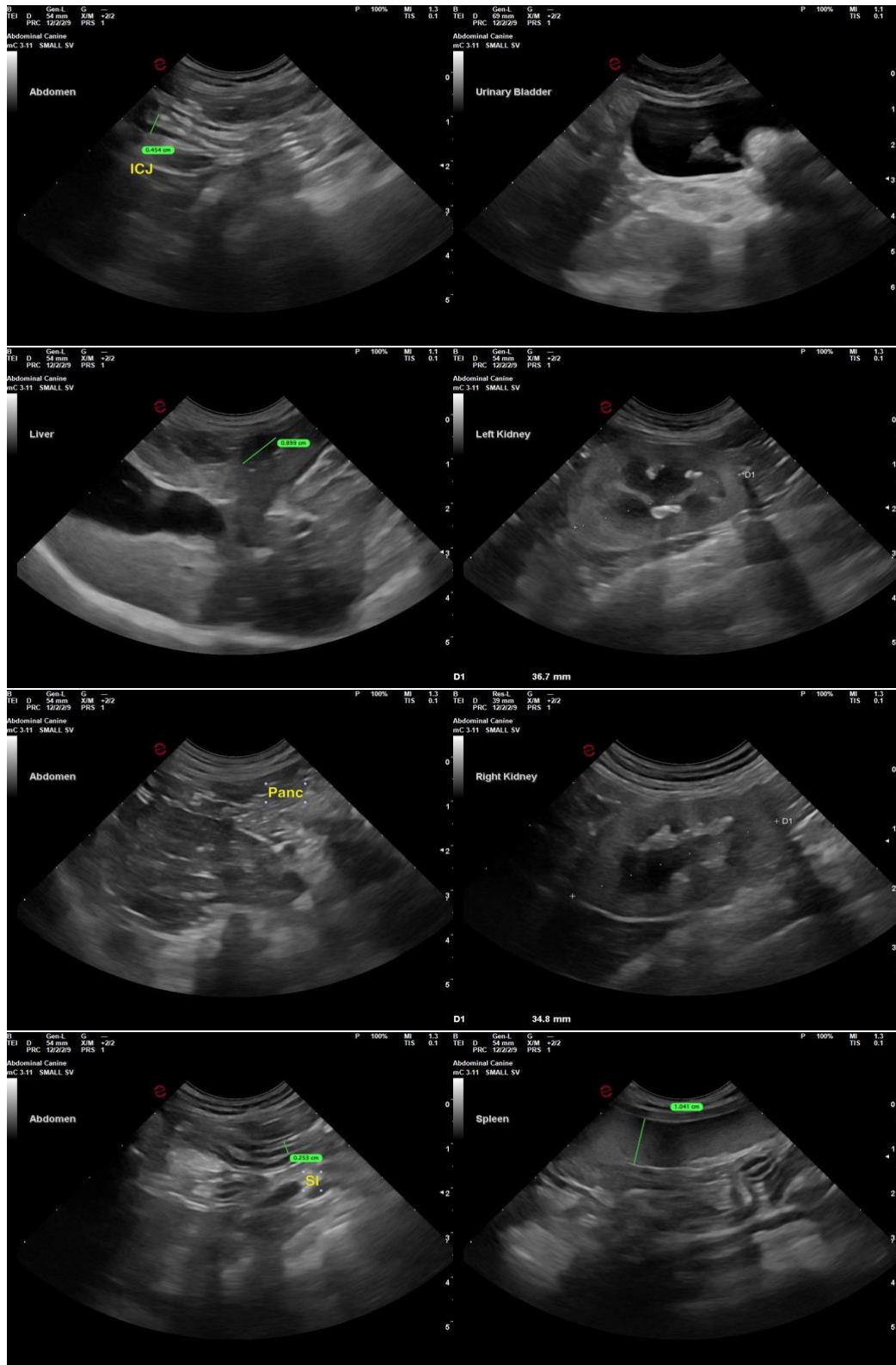
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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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