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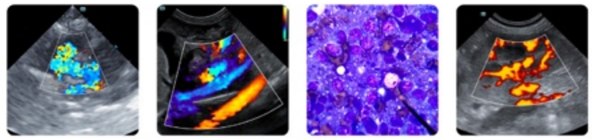


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Blue Toney

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

15 years

WEIGHT

7.46 lbs

INTERPRETED BY

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM

IMAGING PERFORMED BY

Dr. Amy Isaac

HOSPITAL NAME

Valley West & Elk Valley VH

REFERRING VET

Dr. Isaac

INVOICE

68957

DATE

11/24/25

PRESENTING CLINICAL SIGNS

History: Gradual weight loss over the last 6 months. Lost 4 pounds. No vomiting that owner is aware of, but has had some intermittent soft stool. Ravenous appetite. Multiple lab screenings have been NSF. No evidence of hyperthyroidism. Last T4 was 1.4 in August.
Abnormal PE/Chem/CBC/UA Results: No significant findings on PE other than weight loss, muscle loss.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is full with a normal thickness and smooth appearance of the wall. Normal anechoic urine with no sediment or uroliths evident.

Normal appearance of the trigone area, proximal urethra, and iliac blood vessels.

Normal appearance and size of the iliac lymph nodes. Ureters not visualized, which can be considered a normal finding.

Normal renal size (left measured 3.6 cm, right measured 3.3 cm), architecture, echogenic appearance, cortico-medullary differentiation, which maintains a 1:3 cortex to medulla ratio, pelvis, and capsule. No infarcts, mineralization or renoliths evident.

Adrenal Glands

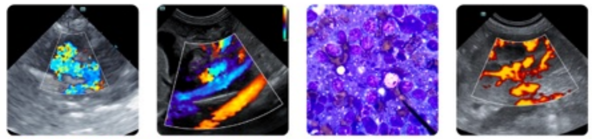
The left adrenal gland is normal in shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 0.25 cm in width. The right adrenal gland was not visualized.

Spleen

Normal size and echogenic appearance. Smooth homogenous parenchyma and regular curvilinear capsule. Normal volume of the splenic vasculature without any overt congestion or thrombosis evident. No inflammatory, neoplastic, infarction, or infiltrative changes evident. The spleen measured 0.8 cm in width.

Liver

Two cystic masses were present. One measured 1.8 x 2.0 cm in size in the left lobe, the other measured 1.7 x 2.1 cm in size in the right lobe. The rest of the liver is of normal size, maintaining a normal echogenic appearance, portal markings, and regular curvilinear capsule. No nodules or additional masses evident. Normal appearance of the hepatic and portal vasculature.



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Gallbladder

The gallbladder is full containing normal anechoic bile. Normal thickness and echogenic appearance of the wall. Normal size and appearance of the cystic and common bile duct.

Gastrointestinal

Focal, mottled echogenic mass in the wall of the stomach measuring 0.5 x 2.0 cm in size. The rest of the gastric wall is of normal thickness with no loss of layering maintaining a 1:3 muscularis to mucosa ratio. Normal appearance of the duodenum, small intestine, ileo-cecal junction, and colon with no loss of layering, 1:3 muscularis to mucosa ratio, normal wall thickness and peristaltic activity, and no distension of the lumen.

Pancreas

The visible sections of the pancreas are of normal size and echogenic appearance with a regular capsule. Normal echogenic appearance of the mesentery and fat surrounding the pancreas.

Free Abdomen

Enlarged mesenteric lymph nodes measuring up to 0.4 x 1.5 cm in size with a hypoechogenic appearance and some having a rounded shape.

No ascites evident.

ULTRASONOGRAPHIC FINDINGS

- Gastric mass.
- Hepatic masses.
- Mesenteric lymphadenomegaly.

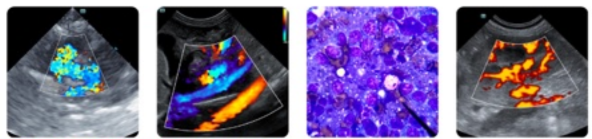
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Etiologies for the gastric mass would be granuloma and possibly neoplasia.

The most likely etiology for the hepatic masses would be cystadenomas with cyst adenocarcinomas and primary hepatocellular carcinoma a less likely differential diagnosis. Hematomas would be an unlikely differential diagnosis.

Etiologies for the mesenteric lymphadenomegaly would be reactive hyperplasia, lymphadenitis and possibly infiltrative neoplasia.

Although the small intestine appears ultrasonographically normal, with the presenting clinical signs, an underlying enteropathy such as parasitic enteritis, dietary hypersensitivity, inflammatory bowel disease and exocrine pancreatic insufficiency should still be considered.



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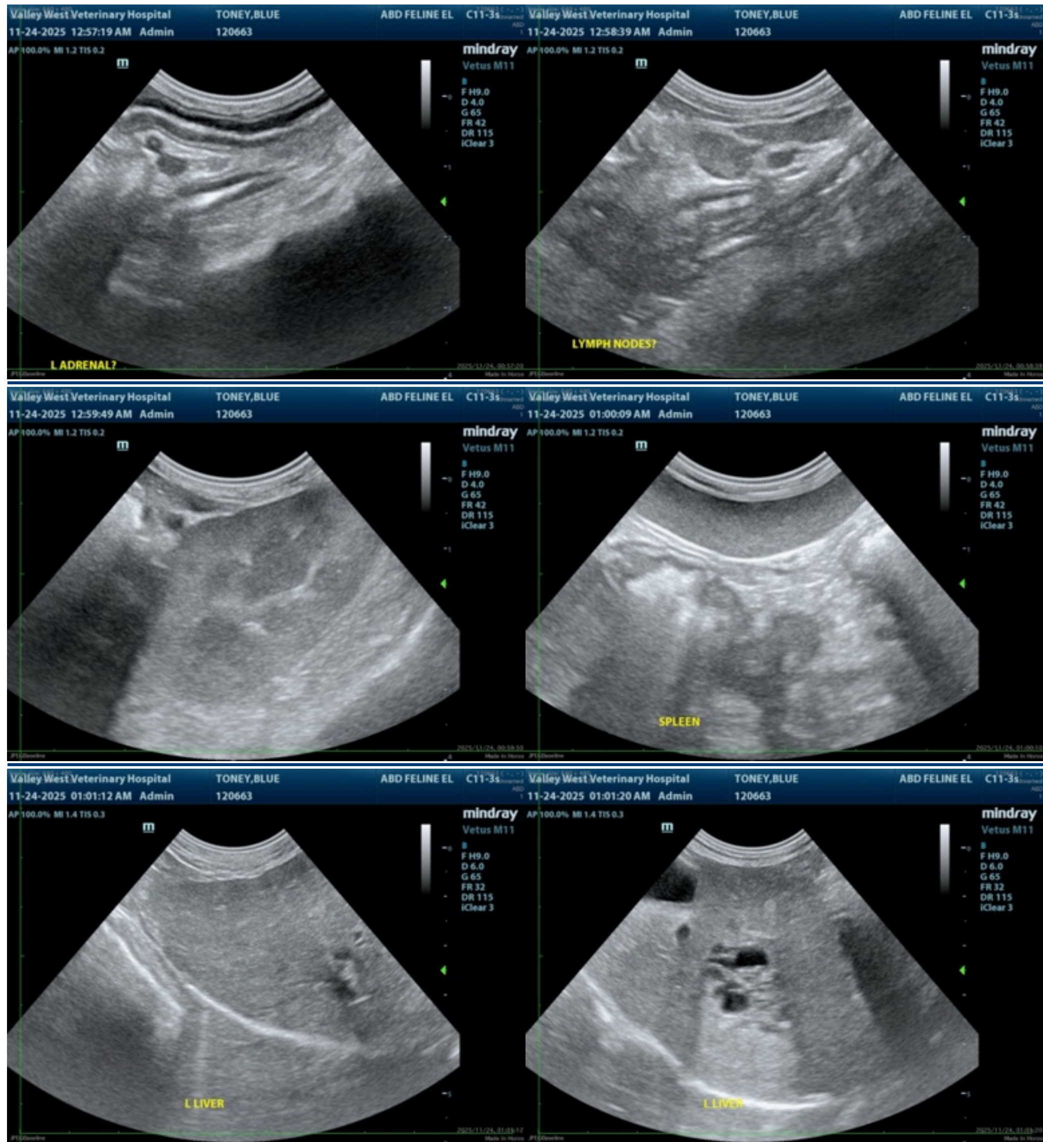
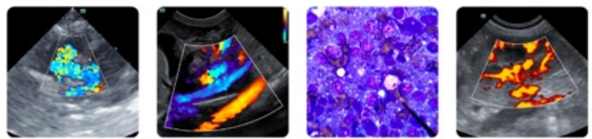
Further assessment would be three view thoracic radiographs, fecal analysis, cobalamin, folate, and TLI assay, FNA cytology of the hepatic masses, gastric wall mass and hepatic masses.

Endoscopy of the upper GI tract with biopsies could also be considered.

Specific therapy would be dependent on an etiological diagnosis.

Symptomatic management that could be considered would be feeding a novel protein/hypoallergenic diet, cobalamin supplementation, course of Fenbendazole and possibly a course of Prednisolone.





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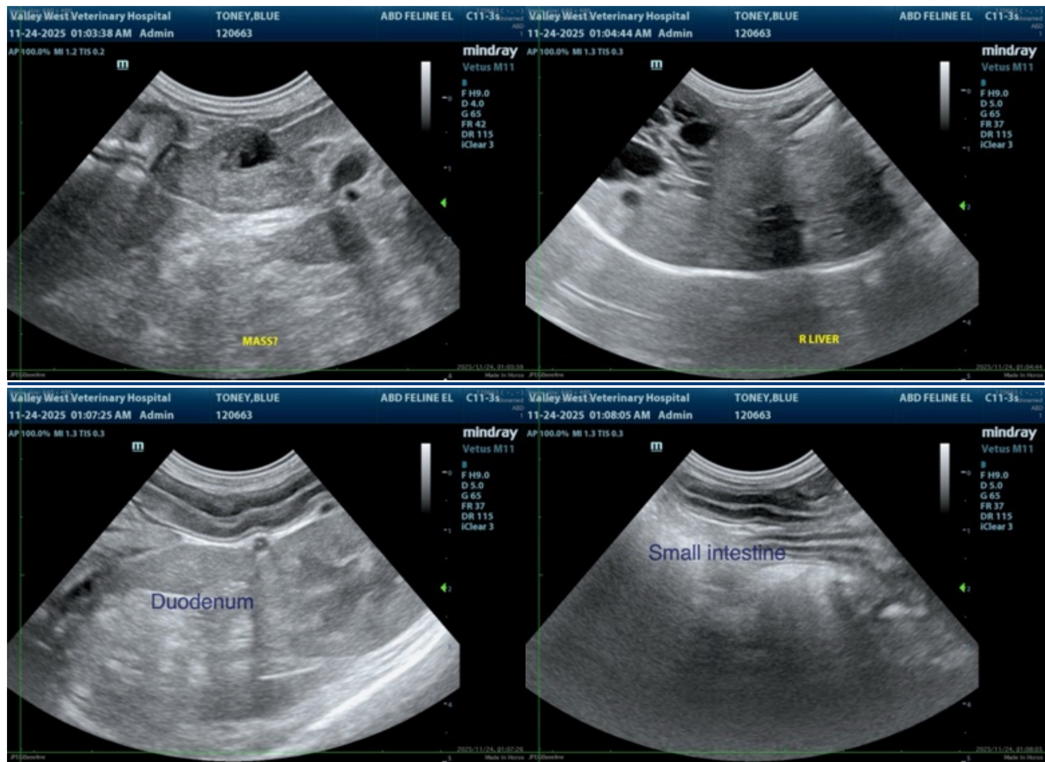

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM (Internal Medicine)

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