



PATIENT

Penny Baarlaer

SPECIES

Feline

BREED

DSH

SEX

Spayed Female

AGE

15 years 5 months

WEIGHT

N/a

INTERPRETED BY

Tam Mengine, DVM,
DABVP (canine/feline
practice)

**IMAGING
PERFORMED BY**

Kerri Becker

HOSPITAL NAME

ACC of North Jersey

REFERRING VET

Dr. Andalaft

INVOICE

10990

DATE

12/19/2025

PRESENTING CLINICAL SIGNS

GI issues vs. mass. Wt loss, lack of appetite, lethargy. Meds- methimazole, pred, cerenia.

Abnormal PE/Chem/CBC/UA Results: ALT-183 CA-13.7 na/k ratio-45 Chol-66 Neut-8662 MONO-710 T411.3 UAph-7 USG-1.025.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine, and no luminal sediment is present. The ureteral papillae, trigone and pelvic urethra are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted.

The left kidney is of subnormal size. Both kidneys are hyperechoic, and exhibit mildly decreased cortico-medullary differentiation. There is no evidence of nephrolithiasis, mineralization, pyelectasia or hydronephrosis. The proximal ureters are not visible (normal). The left kidney is 3.0 cm in length. The right kidney is 3.7 cm in length.

Adrenal Glands

The adrenal glands are both identified in their normal locations. They are normal in size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. The left adrenal gland height is 3.9 mm at the caudal pole. The right adrenal gland height 4.2 mm at the caudal pole.

Spleen

The spleen is of appropriate size and has a normal, homogenous parenchyma with a smooth, continuous capsular surface. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal. Thickness at the splenic hilus is normal at 5.7 mm.

Liver

The liver is of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

Gastrointestinal

The stomach is moderately distended with gas. The gastric wall is 2.1 mm with normal deviations due to rugal folds and exhibits appropriate wall layering. The pylorus is of normal appearance.

The visualized portions of the duodenum, jejunum, and ileum are of normal thickness with intact wall layering that exhibits the appropriate 1:3 muscularis to mucosa ratio. The duodenum is diffusely corrugated. Intestinal motility appears normal.



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The visualized portions of the descending and transverse colon appear unremarkable, with normal wall layering and a wall thickness of 1.0 mm. There is focal marked wall thickening in the region of the ileocecal colic junction, up to 4.2 mm, with loss of wall layering. The associated omental fat is hyperechoic. There is no evidence of obstruction.

Pancreas

The left limb of the pancreas is swollen and hypoechoic, surrounded by hyperechoic mesenteric fat. The pancreatic duct appears normal.

Free Abdomen

There is no free fluid noted within the abdomen. There is hyperechoic, inflamed omental fat noted in the region of the pancreas and the ileocecal colic junction. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

PRIMARY FINDINGS

- Thickened bowel wall in the region of the ileocecal colic junction, most typical of infiltrative neoplasia such as lymphoma, with an inflammatory etiology deemed less likely.
- Hypoechoic left pancreas with steatitis, consistent with pancreatitis.

SECONDARY FINDINGS

- Mild, bilateral chronic renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The appearance of the ileocecal colic junction is concerning for gastrointestinal lymphoma, although, the possibility of severe inflammatory disease cannot be excluded. Colonoscopic biopsy would be recommended for definitive diagnosis. The appearance of the pancreas suggests concurrent pancreatitis. It is possible that the pathology in both organs is less dramatic due to the fact that the patient is already taking corticosteroids, and corticosteroid therapy should be discontinued for at least two weeks if biopsies are pursued. If empiric therapy is desired, then continuing the corticosteroid therapy, in addition to a bland diet and empiric cobalamin supplementation could be considered.





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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.

Tam Mengine, DVM, DABVP (canine/feline practice)

info@SonoPath.com