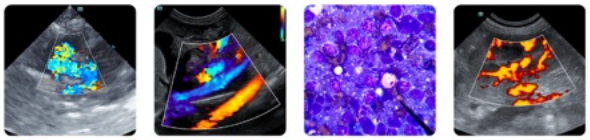


PATIENT

Thor Edmonston

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

13 years

WEIGHT

10.25 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Anshu Gupta

HOSPITAL NAME

Liverpool Village AH

REFERRING VET

Dr. Russell

INVOICE

69813

DATE

1/5/26

PRESENTING CLINICAL SIGNS

History: 13.5 year old cat presented 12/30 because owner felt a mass on the side of the cat but at the appointment they could not find the mass. On PE the cat was found to have what felt like a large mid-abdominal mass and it possibly what they were feeling when the cat was laying down? He has significant hepatomegaly on abdominal rads. The cat has a history of a grade 2/6 heart murmur. I am concerned about a cancerous liver process going on.
Abnormal PE/Chem/CBC/UA Results: He had a non-regenerative anemia (27.6%), AST of 78, BUN 42 and ProBNP of 260.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The bladder wall appears thin and smooth. The urine is turbid, with scant suspended echogenic material. The bladder neck and proximal urethra appear normal. No uroliths are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic disease.

The left kidney is normal in shape and size, measuring 3.95×2.26 cm; cortical thickness was not recorded. The right kidney is normal in shape and size, measuring 4.05×2.48 cm; cortical thickness was not recorded. In both kidneys, the renal cortex is increased in echogenicity, resulting in increased corticomedullary distinction. The corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

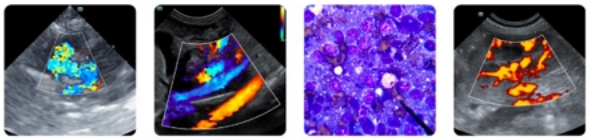
Both adrenal glands demonstrate normal shape and echogenicity. The left adrenal gland measures 0.37 cm at the cranial pole and 0.35 cm at the caudal pole. The right adrenal gland could not be reliably measured.

Spleen

Splenic thickness measures 0.52 cm. The splenic parenchyma demonstrates mildly decreased echogenicity with a fine homogeneous echotexture and no focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal or even decreased in size, with markedly irregular, serrated margins. A large cystic lesion measuring approximately 7.29×4.81 cm is identified within the hepatic parenchyma. Additionally, within what appears to be the caudate hepatic lobe, there is a second large multicystic lesion measuring at least 3.2×2.69 cm. No obvious periportal lymphadenopathy is identified on this examination.



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The gallbladder lumen is normally distended. The gallbladder wall is thin, and the contents are anechoic. No dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty and folded, with a mural thickness of 1.89 mm and preserved wall layering. The pylorus is not clearly visualized. The duodenum measures 2.06 mm. The jejunum measures 1.51 mm, and the ileum measures 1.24 mm, with preserved wall layering. The ileocecal junction measures 1.41 mm.

No ultrasonographic evidence of gastrointestinal inflammation, ileus, or foreign material is identified. The colonic wall measures approximately 0.78 mm, with a small amount of formed feces in the descending colon.

Pancreas

The pancreas measures approximately 6.61–7.20 mm in thickness. Pancreatic parenchyma is isoechoic relative to the adjacent omental fat but appears mildly heterogeneous. Several small, hypoechoic nodules are noted within the left pancreatic limb, the largest measuring approximately 2.8×3.6 mm. The pancreatic duct measures approximately 0.90 mm. No ultrasonographic evidence of active peripancreatic inflammation is identified.

Peritoneal Cavity

No abdominal effusion or evidence of peritonitis is observed. Cranial mesenteric and ileocecal lymph nodes are not visualized; surrounding regions appear unremarkable. The iliac trifurcation appears normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Subjectively small liver with markedly irregular, serrated margins.
- Large cystic hepatic lesion.
- Additional multicystic lesions, the largest within the caudate hepatic lobe.
- Mildly heterogeneous pancreas with small hypoechoic nodules.

SECONDARY FINDINGS

- Increased renal cortical echogenicity bilaterally.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver shows markedly irregular, serrated margins, consistent with advanced architectural distortion and hepatic remodeling. In cats, this pattern may be seen with end-stage chronic hepatobiliary disease but is also commonly associated with infiltrative or proliferative biliary processes, including neoplasia.

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Multiple large cystic and multicystic hepatic lesions are present, including one dominant cystic structure exceeding 7 cm, which would readily account for the abdominal mass palpated by the owner and clinician. The combination of severe hepatic remodeling and large cystic lesions is not typical of simple benign hepatic cysts. The apparent hepatomegaly on imaging may be explained by large cystic hepatic lesions, potentially mimicking an enlarged liver silhouette.

The differential diagnosis for these findings includes:
- Biliary cystadenoma or cystadenocarcinoma.
- Cystic degeneration associated with chronic or neoplastic hepatobiliary disease.

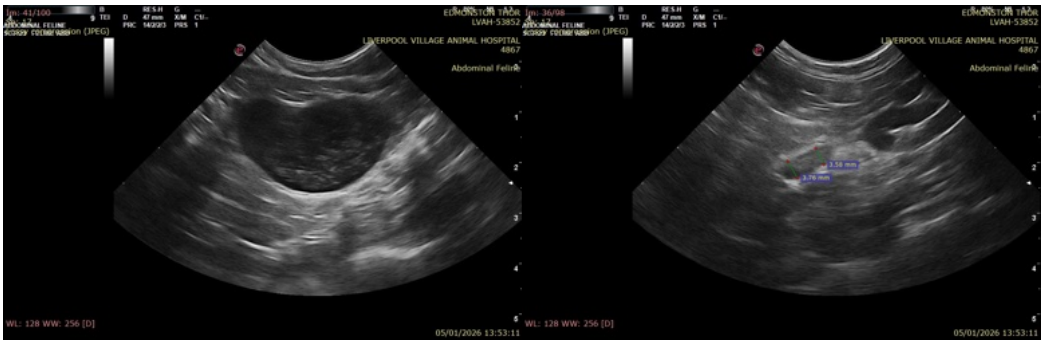
The absence of discrete periportal lymphadenopathy or abdominal effusion cannot exclude malignancy, particularly in cystic or biliary-origin hepatic tumors.

The non-regenerative anemia may be secondary to chronic hepatic disease, anemia of chronic inflammatory disease, or paraneoplastic processes, and is clinically consistent with the degree and severity of hepatic abnormality identified.

Pancreatic findings (mild heterogeneity with small hypoechoic nodules) are nonspecific and may represent incidental nodular change (nodular pancreatic hyperplasia) or mild chronic pancreatitis.

Recommendations

- Full hepatic function assessment (ALT, AST, ALP, GGT, bilirubin, bile acids if clinically appropriate), and coagulation profile prior to any invasive hepatic procedure.
- While the imaging findings raise concern for significant hepatic pathology, ultrasound alone cannot determine lesion etiology.
    - Ultrasound-guided fine-needle aspiration of the cystic hepatic lesions is not expected to be diagnostically reliable, given the predominantly cystic nature of the lesions and the low cellular yield typically obtained.
    - Decisions regarding surgical exploration or biopsy are deferred to the attending clinician, who is best positioned to integrate these findings with the patient's overall clinical course, stability, anesthetic risk, and owner goals.



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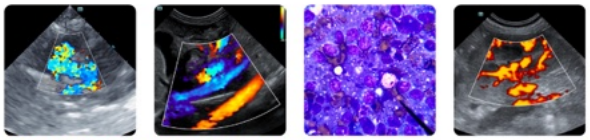

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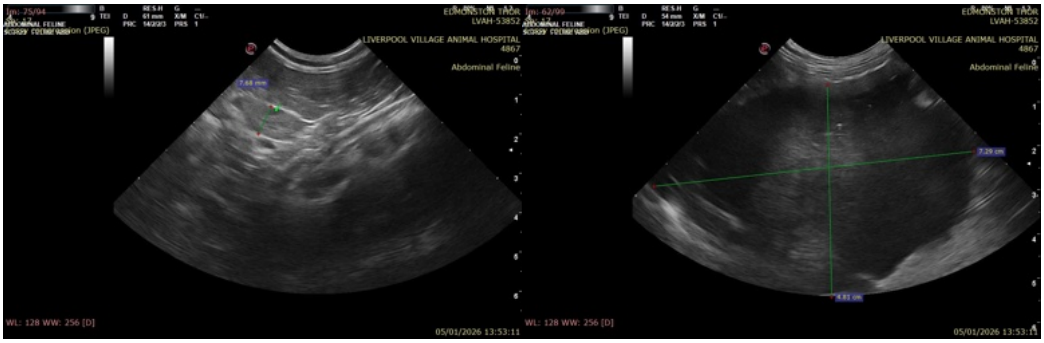

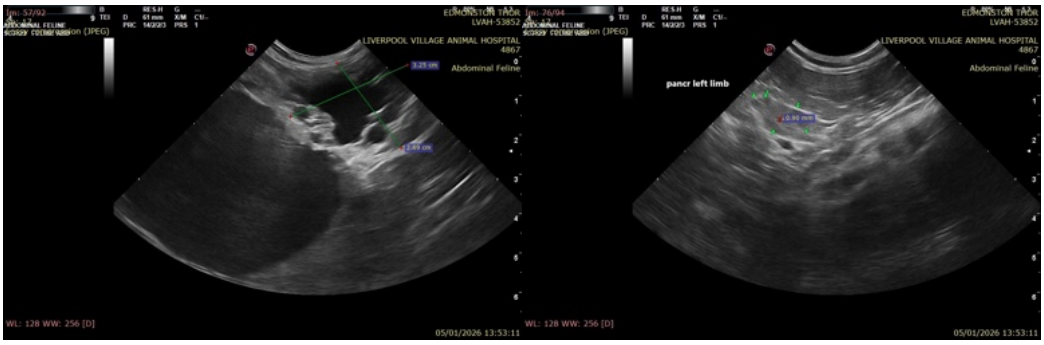

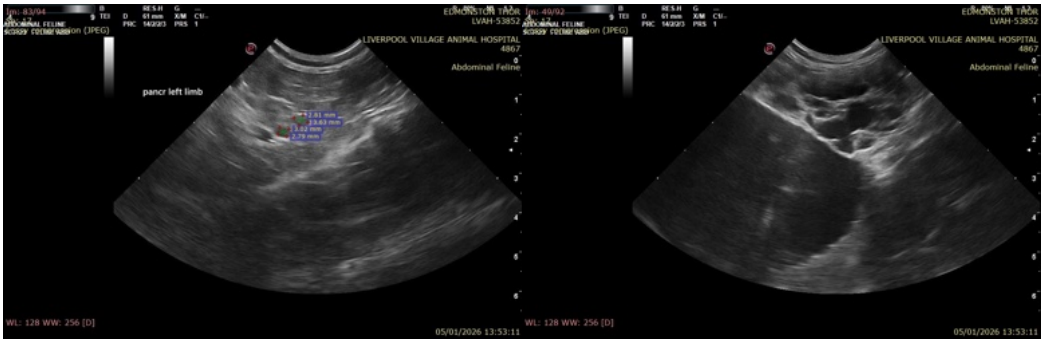

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

MV Esp Ultrasound in Domestic and Wild Animals

info@SonoPath.com