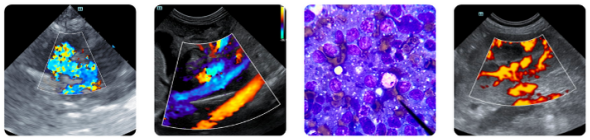




**PATIENT**

Scooter Lydum

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

16 years

**WEIGHT**

11.2 lbs

**INTERPRETED BY**

Alicia Angosto Guerrero, DMV, PgDip, MSc.

**IMAGING PERFORMED BY**

Dr. Jack Reese

**HOSPITAL NAME**

Willow Run Veterinary Clinic

**REFERRING VET**

Dr. Jack Reese

**INVOICE**

10744

**DATE**

11/13/2025

## PRESENTING CLINICAL SIGNS

Patient presented to local emergency clinic for GI upset, lethargy. At time of evalulation, admission to hospital, patient was noted to be hypertensive and hypokalemic. No other notable changes were present on labwork or physical exam. Responded well to supportive care, discharge on amlodipine and RenalK. O has not been able to administer medications at home due to P compliance - recommend further diagnostics to determine underlying cause.

Abnormal PE/Chem/CBC/UA Results: Hypokalemia (mild) NIBP: 202/143 (159 MAP) average reading.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is anechoic. Normal appearance of the proximal urethra and vesicoureteral junction. There are no calculi, and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 4.13x2.49 cm, and the thickness of the cortex is 0.54 cm, in the sagital plane. The cortical is hyperechogenic compared to liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is slightly decreased. There is no evidence of pyelectasia, nephroliths or hydronephrosis.

The right kidney is normal in shape and size: 4.12x2.56 cm, and the thickness of the cortex is 0.50 cm, in the sagital plane. The cortical is hyperechogenic compared to liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths or hydronephrosis.

### *Adrenal Glands*

The left adrenal gland measures 0.55 cm at the cranial pole and 0.49 cm at the caudal pole, with focal intraparenchymal mineralization.

The structures labeled as the right adrenal gland raise anatomic doubt, as their position appears more cranial and ventral than expected for the true right adrenal gland. Given their location, these images may not accurately represent the right adrenal gland.

### *Spleen*

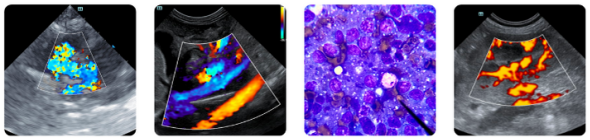
Splenic thickness is 0.52 cm. Parenchyma of normal echogenicity with fine, homogeneous echotexture and no focal lesions. Capsule smooth and regular.

### *Liver*

A 5.79 x 4.19 cm hyperechoic, heterogeneous hepatic mass is identified. Additionally, there is a multicystic lesion measuring 0.5×0.8 cm, compatible with a small hepatic cyst or early cystadenoma. The rest of the loiver parenchyma appears normal. Adjacent hepatic lymphadenopathy is present.

The gallbladder is normally distended. The wall is thin except for a polypoid/adenomatous structure measuring 4.5×2.85 mm. No dilation of the cystic duct or common bile duct is observed.

### *Gastrointestinal*





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The stomach is semidistended with small amounts of ingesta and gas in the lumen. Mural thickness (1.53–1.80 mm) and wall layering are preserved.
Duodenum: 2.09 mm
Jejunum: 2.29 mm
Ileum: 1.98 mm
Normal wall layering. The ileocecal junction was not clearly visualized. No signs of inflammation, ileus, or foreign material identified.

Colon: 0.51 mm with formed feces in the descending segment.

### *Pancreas*

Right limb, body (5.38 mm) and left limb (5.37 mm) normal in appearance. Pancreatic parenchyma is isoechoic to surrounding omental fat. The pancreatic duct measures 1.68 mm. No signs of active inflammation or neoplastic disease are observed.

### *Free Abdomen*

No abdominal effusion or peritonitis observed. Cranial mesenteric and ileocecal lymph nodes were not visualized. The iliac trifurcation appears normal.

The structure labeled as the right adrenal gland appears to be positioned more cranially and ventrally than expected for the true right adrenal. Based on its anatomical location, this structure may be more consistent with a hepatic lymph node, as these nodes in cats are commonly found adjacent to the portal hilus and along the portal vein. However, this interpretation should be made cautiously, as image orientation and patient positioning can influence perceived anatomy.

## PRIMARY FINDINGS

- Left adrenal gland enlarged with intraparenchymal mineralization.
- Large hepatic mass.
- Suspected regional hepatic lymphadenopathy.

## SECONDARY FINDINGS

- Bilateral renal cortical hyperechogenicity.
- Small multicystic hepatic lesion.
- Polypoid gallbladder lesión.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The patient presents with a large, heterogeneous hepatic mass. A hepatocellular carcinoma represents the main differential, as it is a well-differentiated, locally confined tumor that may not cause significant hepatocellular injury. For this reason, normal liver enzyme activity does not exclude this diagnosis, since transaminases frequently remain within reference range unless there is diffuse hepatic involvement or substantial necrosis. The adjacent nodule is located very close to the pylorus and hepatoduodenal region, raising a high suspicion that it represents a hepatic lymph node affected by the mass, although this cannot be definitively confirmed based on ultrasonography alone.

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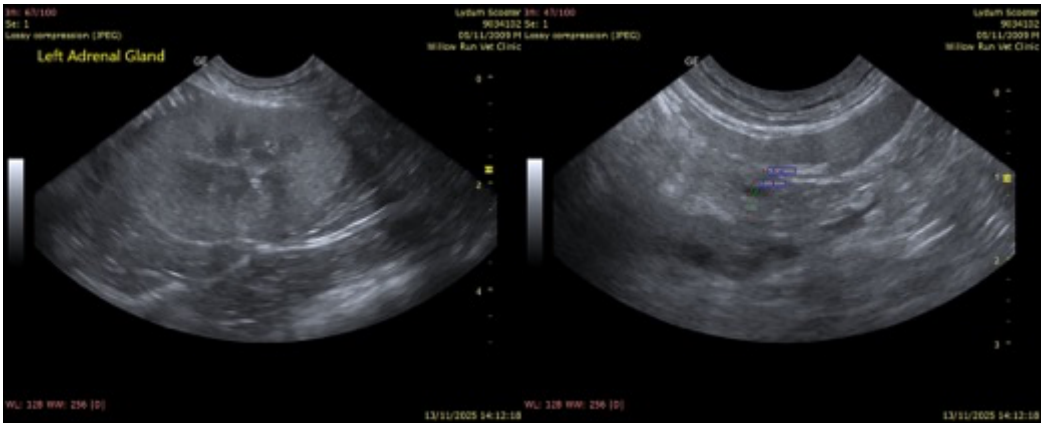
The left adrenal gland is mildly enlarged and displays intraparenchymal mineralization. Considering the patient's systemic hypertension and hypokalemia, primary hyperaldosteronism remains also a clinically plausible diagnosis.

The hypoechoic nodule located in the right cranial abdomen raises significant anatomical doubt regarding its identification as the right adrenal gland. Its position appears more ventral and cranial than expected for the true right adrenal, and its rounded morphology is more consistent with a hepatic lymph node, particularly in the context of a large hepatic mass, where lymph node enlargement is common. Therefore, while adrenal disease cannot be entirely ruled out, the location and ultrasonographic features make a hepatic lymph node a more likely interpretation.

Renal changes—increased cortical echogenicity and mild loss of corticomedullary definition—are consistent with chronic kidney disease and are common in geriatric cats.

Recommendations

- CT scan of the abdomen (and thorax if staging is desired):
  To characterize the hepatic mass, evaluate lymph nodes, and complete oncologic staging.
- FNA or, preferably, histopathologic biopsy of the hepatic mass.
- Primary hyperaldosteronism testing.
- Continued management of hypertension and correction of hypokalemia while completing diagnostic work-up.



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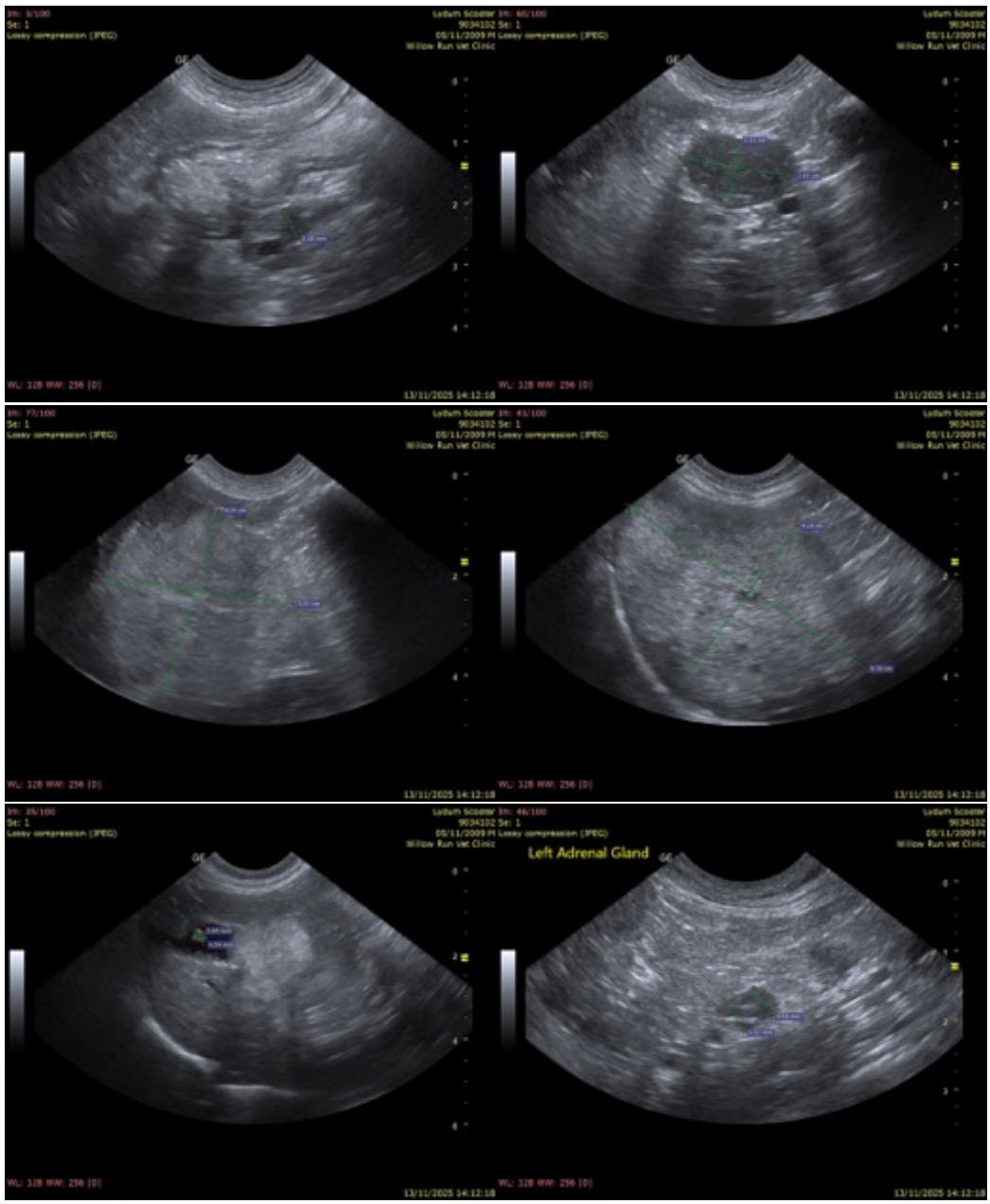


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

info@SonoPath.com