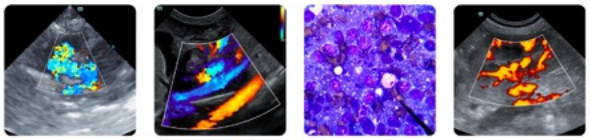


PATIENT

Remy Goodell

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

13 years

WEIGHT

11.8 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Dr. Scott

HOSPITAL NAME

Dr. Wyckoff VH

REFERRING VET

Dr. Eisenberg

INVOICE

69477

DATE

12/22/25

PRESENTING CLINICAL SIGNS

History: weight loss, good app, occ vomit
CBC/chem- ALT slightly elevated, T4 2.1

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is moderately distended, and the bladder wall appears thin and smooth. The urine is anechoic. The bladder neck and proximal urethra have a normal appearance. No uroliths or ultrasonographic evidence of inflammatory or neoplastic disease are identified.

The left kidney is normal in shape and size, measuring 3.97×2.26 cm, with a cortical thickness of 0.32 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 4.23×2.55 cm, with a cortical thickness of 0.35 cm in the sagittal plane. In both kidneys, the renal cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. Multiple small echogenic foci consistent with early nephrolith formation are identified within the renal calyces bilaterally, the largest measuring approximately 3.15 mm within the right kidney. No pyelectasia or hydronephrosis is observed.

Adrenal Glands

Both adrenal glands are not clearly visualized and could not be reliably evaluated.

Spleen

Splenic thickness measures approximately 0.77 cm. The splenic parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

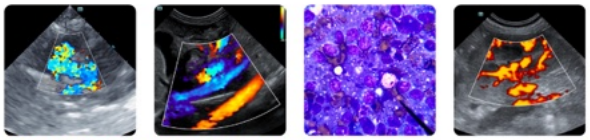
Liver

The liver is subjectively normal in size, with sharp margins and a regular contour. The hepatic parenchyma is uniform and isoechoic relative to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is identified.

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

Gastrointestinal

The stomach appears laterally and ventrally displaced, contains only a minimal amount of digested ingesta, and is otherwise empty and folded. Gastric wall layering is preserved, with a mural thickness of approximately 1.72 mm. The pylorus is not visualized. The duodenum measures approximately 2.12 mm



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and is mildly distended, with a prominent mucosal pattern. The jejunum measures approximately 1.31 mm, with preserved wall layering (mucosa 0.35 mm, submucosa 0.59 mm, muscularis propria 0.18 mm). The ileum measures approximately 1.52 mm, with preserved wall layering (mucosa 0.74 mm, submucosa 0.43 mm, muscularis propria 0.27 mm). The ileocecal junction is not visualized. No ultrasonographic evidence of obstruction, ileus, or intraluminal foreign material is identified. The colon measures approximately 0.63 mm in wall thickness and contains formed fecal material within the descending colon.

Pancreas

The pancreas is not clearly visualized.

Peritoneal Cavity

A large intra-abdominal mass of likely mesenteric or omental origin is identified, characterized by predominantly hyperechoic (fat-like) echogenicity with multiple internal cavitary and nodular components. The mass does not demonstrate clear continuity with hepatic, splenic, or gastric parenchyma and shows limited mobility with respiration. Overall ultrasonographic features are most consistent with a fat-origin mass, with liposarcoma considered the primary differential diagnosis. Definitive characterization cannot be achieved with ultrasonography alone. No Doppler color study was performed.

No abdominal effusion or ultrasonographic evidence of peritonitis is identified. Cranial mesenteric and ileocecal lymph nodes are not visualized. The iliac trifurcation appears normal.

ULTRASONOGRAPHIC FINDINGS

- Large heterogeneous abdominal mass with fat-like echogenicity and internal cavitations, without clear organ dependency.
- Bilateral early nephrolith formation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The identified intra-abdominal mass demonstrates a predominantly adipose echogenicity with marked heterogeneity, including multiple internal nodules and cavitary areas. Such features can be explained by secondary changes within a fat-origin mass, including necrosis, hemorrhage, or degenerative transformation, which have been described in reports of necrotic intra-abdominal lipomas and other adipose tissue lesions.

An inflammatory process affecting omental or mesenteric fat (focal fat necrosis or omental infarction–like lesions) is less likely but also considered; Isolated inflammation or necrosis of abdominal fat has been reported in cats and may present ultrasonographically as a mass-like lesion with altered fat echogenicity.

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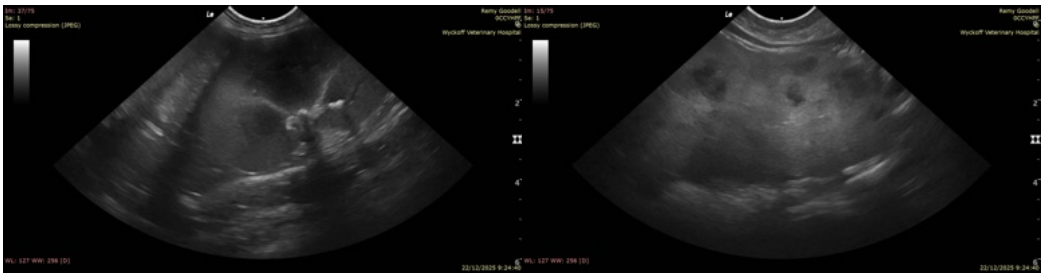
Overall, ultrasonographic appearance supports a mass of omental or mesenteric origin. However, ultrasonography alone cannot give a definitive diagnosis. Further characterization would require advanced imaging or histopathologic evaluation.

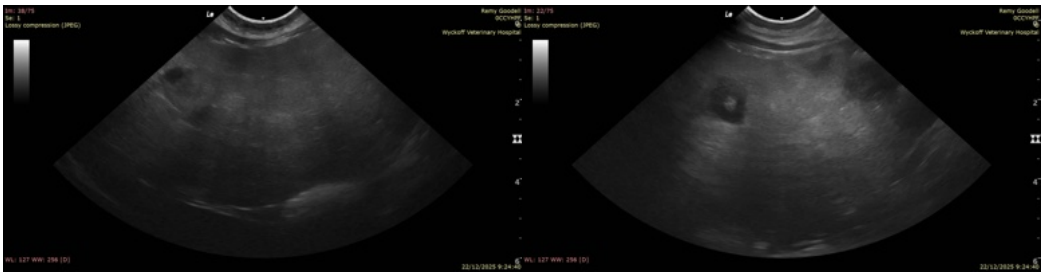
No ultrasonographic evidence of diffuse gastrointestinal disease, intestinal obstruction, or primary hepatic pathology is identified. The mild elevation in ALT may be secondary to chronic gastrointestinal disturbance or mass effect rather than primary hepatopathy.

Renal findings are limited to early nephrolith formation, without evidence of obstruction or renal insufficiency at this time, and are considered an incidental but clinically relevant finding requiring monitoring.

Recommendations

- Advanced diagnostic characterization of the abdominal mass is strongly recommended, including biopsy, or surgical exploration, to establish definitive diagnosis.
- If surgical planning are desired, contrast-enhanced CT is recommended to better define the mass origin, internal composition, and vascular features.
- Thoracic imaging is recommended prior to any surgical intervention to evaluate for metastatic disease.
- Continued monitoring of renal findings, including urinalysis and renal parameters, given early nephrolith formation.
- Clinical management and prognosis should be guided by histopathologic diagnosis of the abdominal mass.





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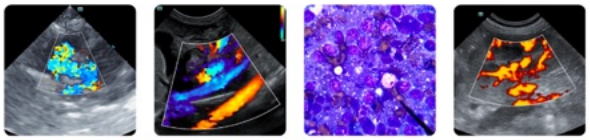

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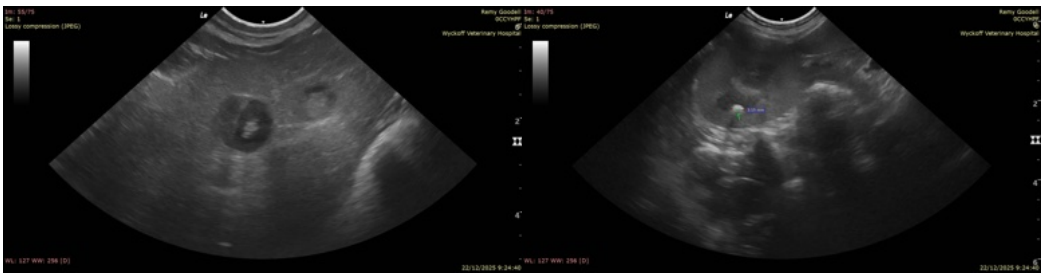

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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