

PATIENT

Jeffrey Novak

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

14 Years

WEIGHT

11.06 lbs

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Dr. Sheldon

HOSPITAL NAME

Advanced PetCare of
Oakland

REFERRING VET

Dr. Sopoliga

INVOICE

72779

DATE

12/26/25

PRESENTING CLINICAL SIGNS

Decreased appetite, weight loss, lethargy. Hx hyperthyroidism. Also has heart murmur and arrhythmia. Thoracic radiographs show cardiomegaly and left caudodorsal lung mass (r/o carcinoma). Labwork NSF.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

The left kidney is normal in shape and size, measuring 4.09×2.74 cm, with a cortical thickness of 0.36 cm in the sagittal plane.

The right kidney is normal in shape and size, measuring 4.48×2.28 cm, with a cortical thickness of 0.37 cm in the sagittal plane.

In both kidneys, the renal cortex is increased in echogenicity. The corticomedullary ratio is normal, and corticomedullary definition is preserved. A medullary rim sign is noted. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Color Doppler shows a normal pattern.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. The left adrenal gland measures 0.33 cm at the cranial pole and 0.34 cm at the caudal pole. The right adrenal gland measures 0.31 cm at the cranial pole and 0.30 cm at the caudal pole.

Spleen

Splenic thickness is 0.96 cm. The parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular. Splenic vasculature appears normal.

Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma appears isoechoic compared to the falciform fat. Two small hyperechoic nodules are identified, measuring approximately 0.71×0.62 cm and 0.41×0.44 cm. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The wall is thin, and the contents are primarily anechoic with a small amount of biliary sludge. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty, containing only a small amount of digested food material, with a mural thickness of 1.94 mm and preserved wall layering.

The duodenum could not be reliably measured. The jejunum measures 2.59 mm (mucosa: 1.55 mm; submucosa: 0.40 mm; muscularis propria: 0.40 mm). The ileum measures 1.33 mm (mucosa: 0.38 mm; submucosa: 0.45 mm; muscularis propria: 0.29 mm), with normal wall layering.



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The ileocecal junction measures 3.12 mm, with a muscularis thickness of 0.93 mm. No signs of inflammation, ileus, or foreign material are identified.

The transverse colon measures 0.83 mm and contains semi-formed feces. The descending colon measures 0.87 mm and contains more formed feces.

Pancreas

The pancreas measures approximately 6.33 mm. Pancreatic parenchyma is isoechoic compared to the adjacent omental fat. The pancreatic duct measures 0.75 mm in diameter. No signs of active inflammation or neoplastic disease are evident.

Free Abdomen

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

There is some uncertainty regarding the presence of a very small amount of pleural effusion visible from the hepatic acoustic window; however, this finding may be artifactual and cannot be confirmed.

PRIMARY FINDINGS

- Bilateral increased renal cortical echogenicity with preserved corticomedullary definition and medullary rim sign.

SECONDARY FINDINGS

- Two small hyperechoic hepatic nodules.
- Questionable trace pleural effusion visualized from the hepatic window.

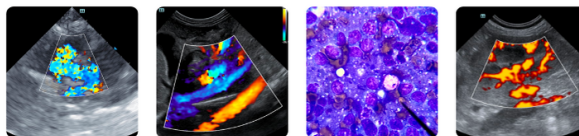
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Abdominal ultrasonography does not identify a primary abdominal mass, diffuse organ infiltration, or significant lymphadenopathy that would clearly account for the patient's weight loss, lethargy, and decreased appetite.

The most significant abdominal abnormality is the presence of two small, well-defined, homogeneous hyperechoic hepatic nodules. Based on their ultrasonographic appearance, these lesions are most consistent with benign processes such as nodular hyperplasia or focal fibrotic change. However, in the context of a cat with suspected primary pulmonary carcinoma, metastatic disease cannot be completely excluded, despite the lack of hepatic lymphadenopathy or diffuse parenchymal involvement.

In cats, the combination of increased renal cortical echogenicity and a medullary rim sign is most commonly associated with early or subclinical chronic kidney disease, even in the absence of overt laboratory abnormalities.

There is uncertainty regarding a very small amount of pleural effusion visualized from the hepatic window. This finding cannot be confirmed sonographically and may be artifactual; however, given the patient's cardiac disease and thoracic mass, this possibility should be interpreted cautiously and correlated with thoracic imaging and clinical findings.



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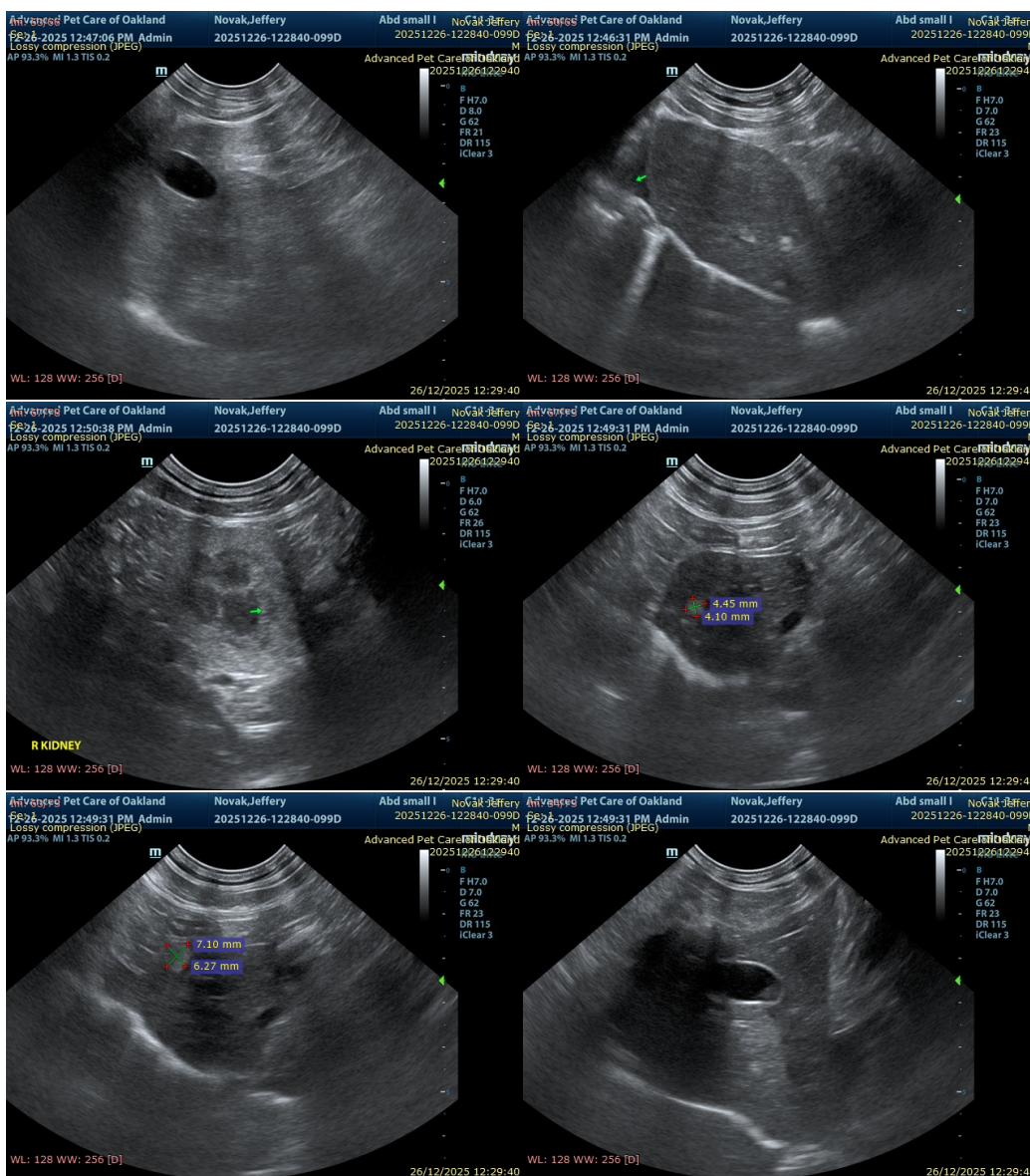
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Recommendations:

- Correlate abdominal findings with thoracic imaging and cardiology assessment, particularly in light of the suspected lung mass, cardiomegaly, arrhythmia, and possible trace pleural effusion.
- Routine monitoring of renal parameters is advised.
- Given the benign ultrasonographic appearance of the small, homogeneous hyperechoic hepatic nodules, short- to mid-term ultrasonographic follow-up is recommended to monitor for stability. Fine-needle aspiration is not routinely indicated at this time unless interval progression is identified or staging requirements change.





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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.

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