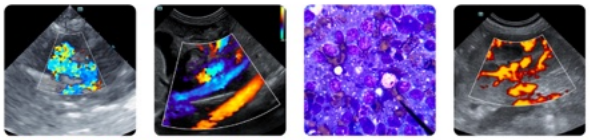


PATIENT

Graycie Tablak

SPECIES

Feline

BREED

Ragdoll

SEX

Spayed female

AGE

16 years

WEIGHT

7.8 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Jelena Janjusevic, DVM

HOSPITAL NAME

Camden Pet Hospital

REFERRING VET

Jelena Janjusevic, DVM

INVOICE

75507

DATE

5/13/26

PRESENTING CLINICAL SIGNS

History: Graycie was seen by urgent care for lethargy, anorexia and starining to urinate on PE large bladder or mass palpable within mid abdomen
Rad report –

1. Large mid soft tissue opaque abdominal mass; a definitive organ of origin cannot be determined from this study. Top considerations include the spleen, pancreas, gastrointestinal tract, and mesentery vs other organs. Given the history of white fluid being aspirated from the abdomen, there is strong consideration that this was from the abdominal mass. Considerations such as an abscess (e.g., pancreatic, lymph node, or mesenteric abscess), granuloma, necrotic neoplasm, or distended lymphatic structure are possible among others.
2. There is no convincing peritoneal effusion, which supports the suspicion that the fluid aspirated was from the large mass.
3. Severe bladder distention, which resolved during cystocentesis
4. Normal thorax without evidence of metastasis

Labs - SDMA 25, Crea 3.9, BUN 58, rest nsf (ALB 3.1) within midabdomen scanned free abd fluid - performed abdominocentesis used 22G butterfly cath - drained 65 ml milk white/chylous fluid
TP - 12.2 mg/dL
Cytology - moderate cellularity mostly neuts and occational lymphocytes

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

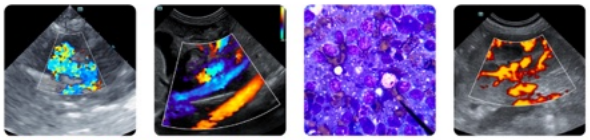
The bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is anechoic. The bladder neck, trigone region, and proximal urethra are unremarkable. There are no calculi, and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, and the cortex is isoechoic compared to liver parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. A medullary cystic structure measuring 0.77×1.50 cm is present, with a sonographic appearance similar to the abdominal cystic lesion and without convincing communication with the renal pelvis. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Doppler color demonstrates a normal vascular pattern.

The right kidney is normal in shape and size: 2.74×2.10 cm, and the thickness of the cortex is 0.36 cm, in the sagittal plane. The cortex is hyperechoic compared to liver parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. Mild pyelectasia (1.08 mm) is present. No nephroliths or hydronephrosis are identified.

Adrenal Glands

Both adrenal glands demonstrate normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: the left adrenal gland is not confidently visualized. The right adrenal gland measures 0.30 cm at the cranial pole and 0.32 cm at the caudal pole.



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Spleen

Splenic thickness is 0.47 cm at the ventral extremity and increases to 1.41 cm at the dorsal extremity. 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 looks uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

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

Gastrointestinal Tract

The stomach is empty and folded, containing gas, with mural thickness measuring 1.56 mm and preserved wall layering. The pylorus measures 2.95 mm. The jejunum measures 2.58 mm, with mucosa measuring 0.92 mm, submucosa 0.72 mm, and muscularis propria 0.63 mm. The ileum measures 2.47 mm, with mucosa measuring 0.85 mm, submucosa 0.52 mm, and muscularis propria 0.85 mm. Wall layering is preserved. The ileocolic junction is not confidently visualized. The colon appears within normal limits.

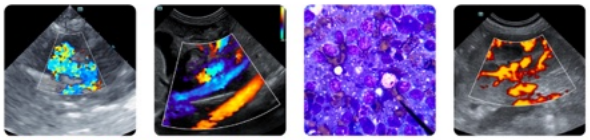
Pancreas

The pancreas is not clearly visualized, although it cannot be definitively determined whether the cystic lesion originates from the pancreas.

Free Abdomen

A rounded cystic lesion measuring approximately 1.53×2.17 cm is identified adjacent to the liver, between the left hepatic lobe and pyloric region. Additional multiloculated cystic extensions are present within the mid abdomen, with the largest component measuring approximately 9×4.32 cm. The lesion contains predominantly anechoic fluid with suspended echogenic debris/echoes.

No sonographic evidence of diffuse abdominal effusion, peritonitis, or lymphadenomegaly is identified. The regions initially labeled as free abdominal fluid appear to correspond to extensions of the cystic lesion itself. The iliac trifurcation region appears normal.



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PRIMARY FINDINGS

- Large complex multiloculated cystic lesion within the mid-to-cranial abdomen containing predominantly anechoic fluid with suspended echogenic debris/echoes.
- Apparent loculated extensions of the cystic lesion initially mimicking free abdominal fluid.
- Small cystic medullary structure within the left kidney without communication with the renal pelvis.

SECONDARY FINDINGS

- Mild right pyelectasia.
- Mild asymmetric prominence of the dorsal splenic extremity.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A large, complex, thin-walled, multiloculated cystic lesion is present within the mid-to-cranial abdomen, containing predominantly anechoic to mildly echogenic fluid with suspended echoes and septal/loculated extensions. The areas initially labeled as free abdominal fluid appear to communicate with, or represent extensions of, this cystic lesion rather than true diffuse peritoneal effusion. Given the aspiration of milk-white/chylous fluid and the low-protein, moderately cellular cytology, the ultrasonographic appearance is most supportive of a lymphatic-origin cystic lesion, such as a mesenteric lymphatic malformation/lymphatic cyst or localized chylous pseudocyst/chyloma-like lesion.
A necrotic or cystic neoplasm cannot be completely excluded ultrasonographically, but the absence of a convincing solid vascular mass component, lack of overt peritonitis, and cytology dominated by neutrophils with occasional lymphocytes make an abscess or aggressive necrotic tumor less supported based on the information currently available.

A pancreatic cyst or pancreatic pseudocyst cannot be completely excluded, as portions of the lesion appear closely associated with the pancreatic region and the pancreas could not be fully characterized with certainty on the current examination. However, the overall ultrasonographic appearance and chylous nature of the aspirated fluid make a primary pancreatic cystic process considered less likely.

The rounded cystic structure adjacent to the left hepatic lobe and pyloric region is considered most likely part of the same multiloculated cystic process rather than a separate independent lesion, potentially representing regional extension/compartmentalization of the suspected lymphatic abnormality.

The small medullary cystic structure within the left kidney is unusual and may represent an unrelated renal cyst; however, given its similar cystic appearance, a concurrent lymphatic/vascular or cystic malformative process cannot be fully excluded. There is no evidence of hydronephrosis or renal pelvic communication based on the current images. Mild right renal pyelectasia is present and may be clinically insignificant or related to the patient's azotemia/urinary history, but no obstructive uropathy is identified ultrasonographically.

Mild asymmetric prominence of the dorsal splenic extremity is present. Although nonspecific, this may represent reactive or regional vascular/lymphatic or inflammatory change associated with the adjacent cystic process.

Recommendations

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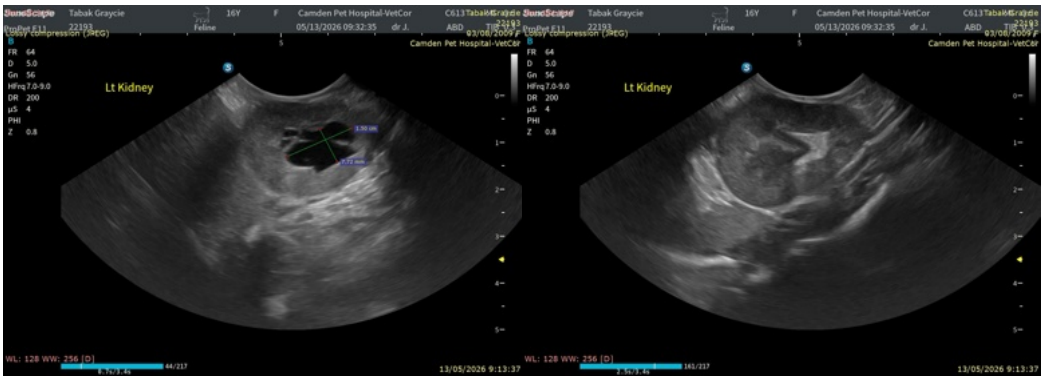
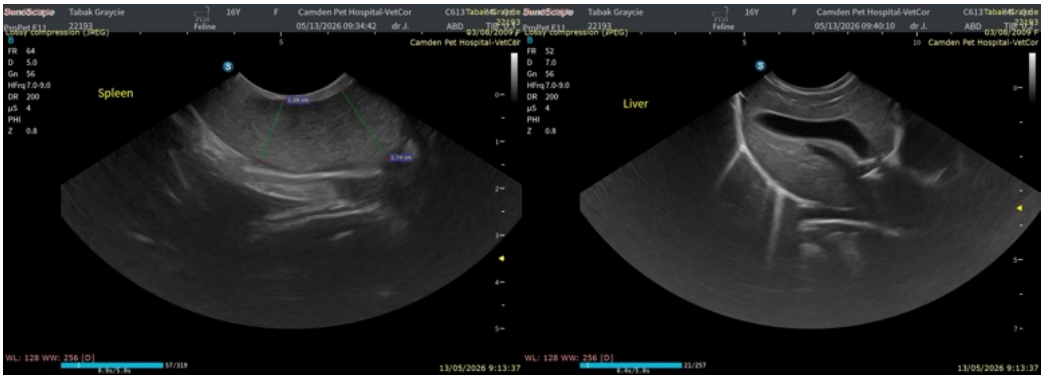
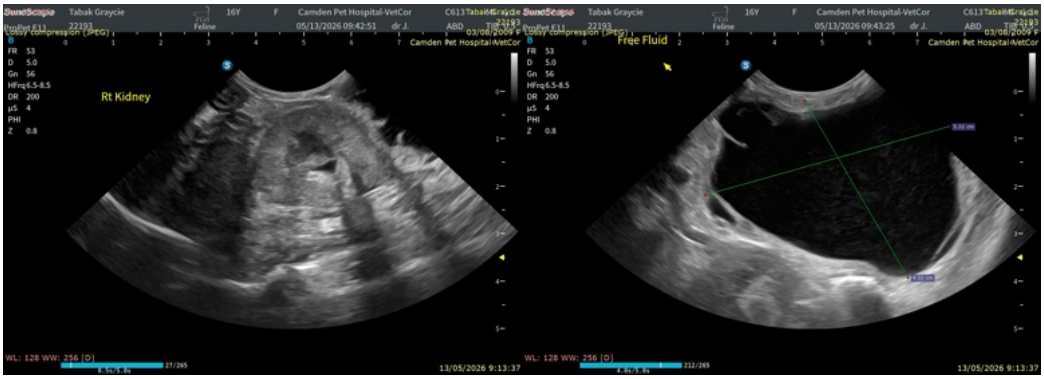
- Submit the aspirated fluid, if available, for triglycerides and cholesterol compared with serum, plus culture/sensitivity.
- If clinically feasible, contrast-enhanced CT is the most useful next imaging step to define organ of origin, relationship to pancreas/mesentery/lymphatics, and surgical options.
- Surgical exploration/excision or biopsy would be required for definitive diagnosis if clinically appropriate.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status.







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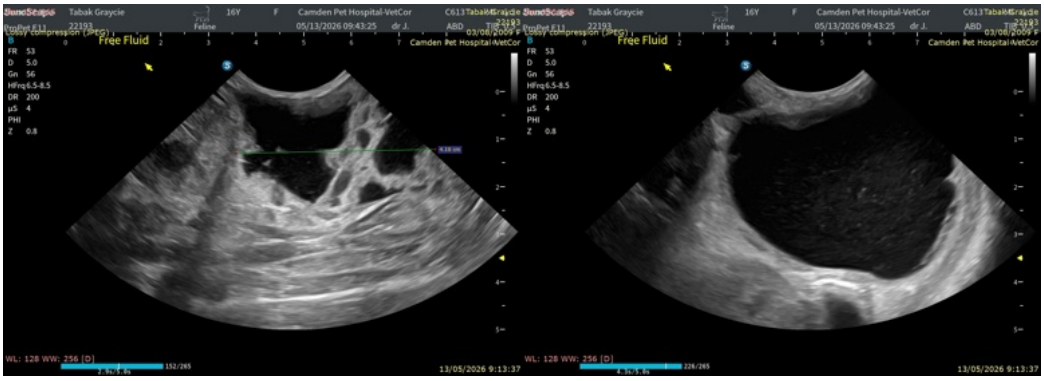

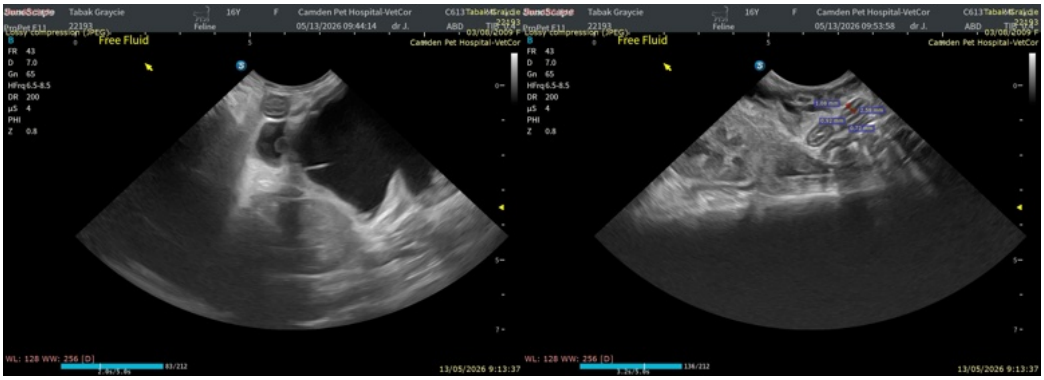

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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