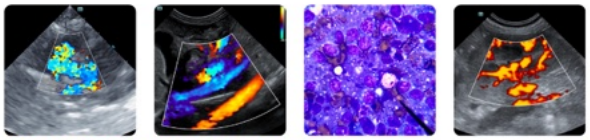


PATIENT

Furiosa Hacker

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

10 years

WEIGHT

8.63 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Judy Schroeder

HOSPITAL NAME

Animal Health Associates

REFERRING VET

Dr. Schroeder

INVOICE

77656

DATE

5/18/26

PRESENTING CLINICAL SIGNS

History: Long history of intermittent vomiting. In past year has become more frequent. Patient is aggressive so physical exams and lab work require sedation.
Abnormal PE/Chem/CBC/UA Results: Patient examined while sedated Thickening/possible diffuse mass effect in cranial abdomen on palpation Chem, CBC, GI panel are pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the urine is predominantly anechoic with scant suspended echoes. Normal appearance of the bladder neck and proximal urethra. There are no calculi and no ultrasonographic evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.34×2.04 cm, with a cortical thickness of 0.28 cm in the sagittal plane. The right kidney is normal in shape and size: 3.85×1.99 cm, with a cortical thickness of 0.30 cm in the sagittal plane. In both kidneys, the renal cortices are mildly hyperechoic compared to the hepatic parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

The left adrenal gland is not confidently visualized. The right adrenal gland measures 0.28 cm at the cranial pole and 0.26 cm at the caudal pole, which are within normal limits for a cat of this size.

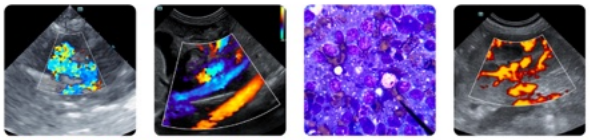
Spleen

Splenic thickness measures 1.90 cm. The splenic margins are mildly rounded. The parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture without focal 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 homogeneous and isoechoic relative to the surrounding falciform fat, with a normal echotexture. No hepatic lymphadenopathy is identified.

The gallbladder lumen is normally distended. The wall is thin and smooth. A small amount of biliary sludge is present. The common bile duct measures 4.57-3.71-2.96-2.69 mm along its visualized course.



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Gastrointestinal

The stomach The stomach is empty and mildly fluid filled, with preserved wall layering and a wall thickness of 2.04 mm.

The pyloric wall measures 3.33 mm. The duodenal wall measures 1.69-1.77 mm. The jejunal wall measures 2.01 mm, with mucosa measuring 1.13 mm, submucosa 0.48 mm, and muscularis propria 0.29 mm. The ileal wall measures 2.24 mm, with mucosa measuring 0.60 mm, submucosa 1.05 mm, and muscularis propria 0.34 mm. Wall layering is preserved throughout the visualized small intestine. The ileocecal junction measures 2.58 mm, with muscularis propria measuring 0.60 mm. No obstructive pattern, foreign material, or significant intestinal ileus is identified.

The descending colon measures 0.84 mm in wall thickness and contains scant fecal material.

Pancreas

Portions of the pancreas are apparently visualized showing subjectively within normal limits aside from mild pancreatic duct dilation.

Free Abdomen

Extending dorsomedially along the proximal duodenum and cranial duodenal flexure, there is an irregular heterogeneous vascularized soft tissue mass measuring approximately 2.78×4.40 cm. The lesion extends into the mid abdomen and courses immediately adjacent to, and possibly partially surrounding or incorporating, the right pancreatic lobe. More caudally and leftward, the lesion also extends between the gastric body and left kidney, immediately dorsal to the pancreatic body and left pancreatic lobe, again making complete separation from the pancreas difficult ultrasonographically. Measurements are partially estimated, as the lesion does not consistently fit entirely within a single imaging field.

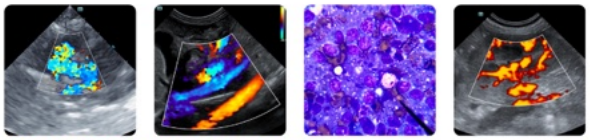
Mild abdominal effusion is present between the hepatic lobes. Mild focal reactive peritonitis surrounding the mass is also observed. The cranial mesenteric and ileocecal lymph nodes are not confidently visualized. The iliac trifurcation region appears normal.

PRIMARY FINDINGS

- Large irregular heterogeneous vascularized cranial-to-mid abdominal soft tissue mass
- Lesion closely associated with and possibly partially incorporating the pancreas
- Mild focal reactive peritonitis and abdominal effusion

SECONDARY FINDINGS

- Subtle pancreatic duct dilation
- Mild to moderate extrahepatic biliary duct dilation
- Diffuse bilateral renal cortical hyperechogenicity
- Splenomegaly with homogeneous parenchyma.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The dominant ultrasonographic abnormality is a large infiltrative heterogeneous soft tissue mass extending through the cranial and mid abdomen, closely associated with the pancreatic region and proximal duodenum. The precise tissue of origin cannot be determined with certainty ultrasonographically, as the lesion appears intimately associated with the proximal duodenum and portions of the pancreas, and partially surrounds or obscures normal pancreatic architecture.

The overall appearance is considered highly concerning for infiltrative neoplasia. Differential considerations include proximal intestinal neoplasia with marked extramural extension/desmoplastic reaction, atypical lymphoma, pancreatic adenocarcinoma, infiltrative pancreatic carcinoma, or invasive mesenteric sarcoma. Visceral mast cell neoplasia is also considered a differential consideration given the infiltrative mesenteric/peritoneal appearance, chronic vomiting history, and concurrent splenomegaly, although the ultrasonographic findings are not specific.
Although a definitive intestinal mural origin is not identified, portions of the lesion closely contact the proximal duodenal region, and a primary infiltrative intestinal process cannot be completely excluded ultrasonographically. The associated focal peritonitis and mild abdominal effusion further support a locally invasive/reactive process.

However, the degree of mass effect, vascularization, infiltrative appearance, and extensive architectural distortion are considered less typical for uncomplicated pancreatitis.

Mild-to-moderate splenomegaly is present. Although nonspecific, reactive or early infiltrative involvement cannot be excluded in the context of the adjacent infiltrative abdominal disease.

The mild pancreatic duct dilation and mild extrahepatic biliary duct dilation may reflect early partial extrahepatic biliary and/or pancreatic duct outflow interference secondary to the regional infiltrative process. No definitive obstructive gastrointestinal pattern is identified at this time.
The small intestinal wall measurements remain largely within expected limits for a cat, with preserved layering and without convincing ultrasonographic evidence of diffuse infiltrative enteropathy or high-grade alimentary lymphoma.

Recommendations

- Ultrasound-guided fine needle aspiration of the mass and the spleen is strongly recommended.
- Cytologic analysis of the abdominal effusion could also be considered if feasible.
- Correlation with pending CBC, chemistry profile, GI panel, bilirubin, pancreatic lipase testing, and clinical progression is recommended.
- Advanced imaging (CT) may help better define lesion origin, extent of disease, vascular involvement, and possible metastatic spread.

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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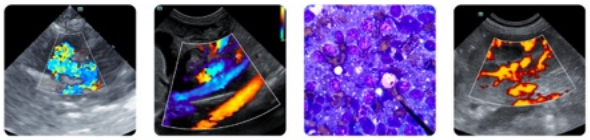

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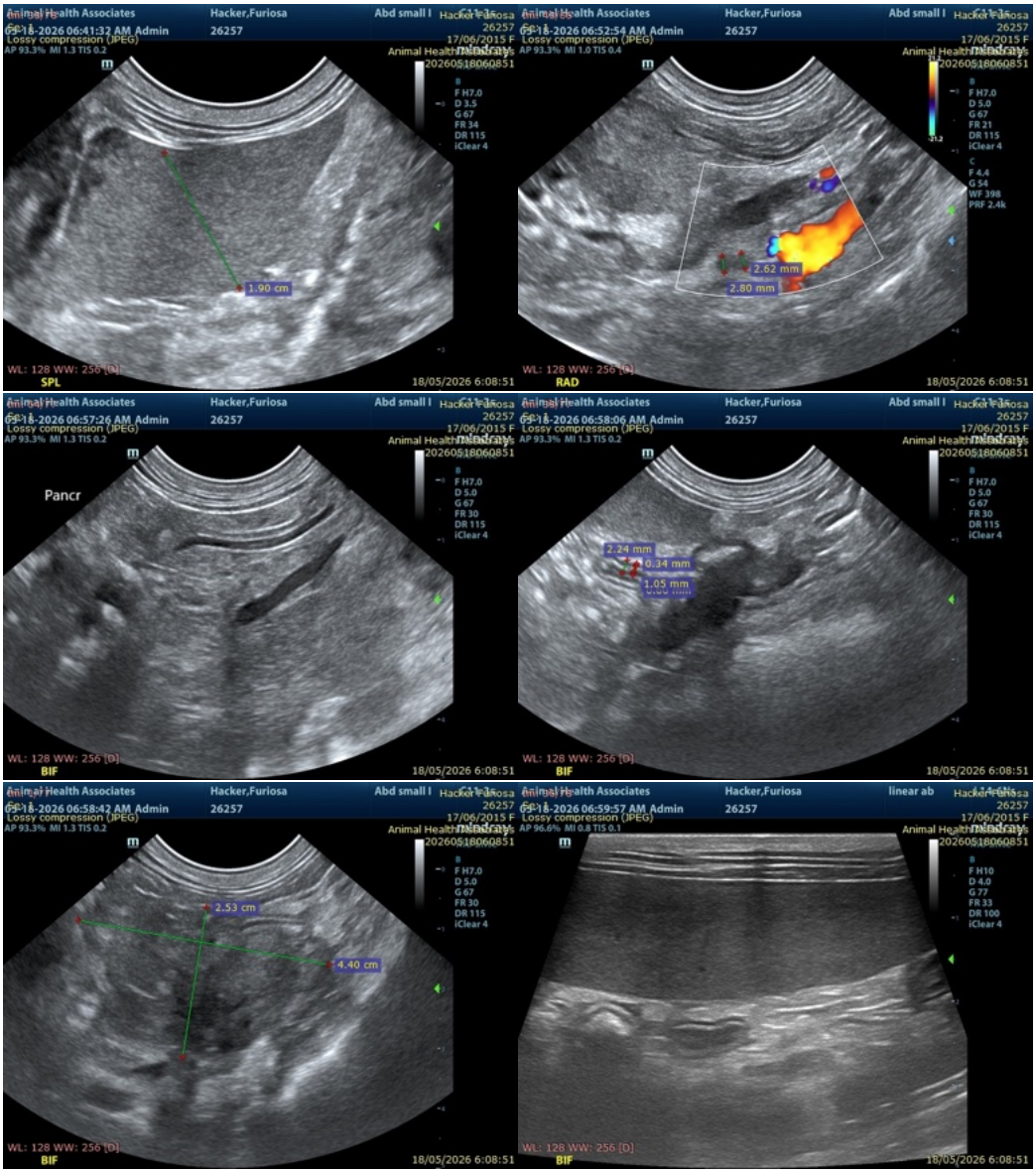

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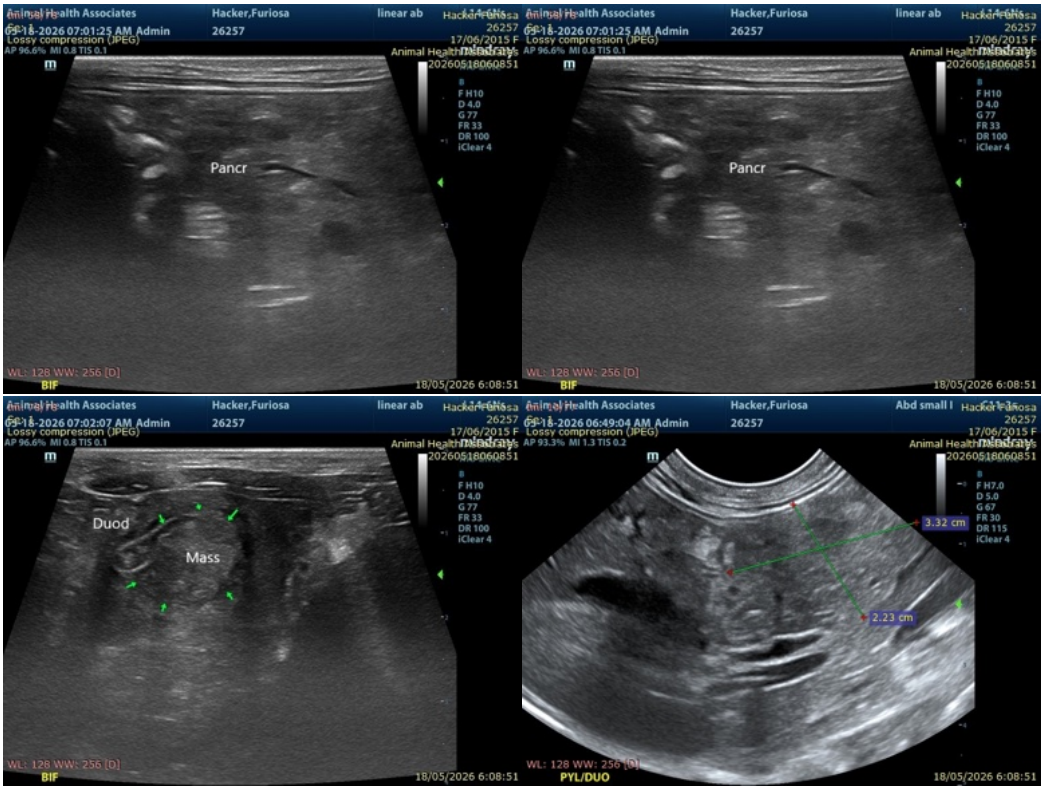

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com