



**PATIENT**

Misha Fisher

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

16 Years

**WEIGHT**

12.42 lbs

**INTERPRETED BY**

Dr Brittany Sinclair,  
BVSc(hons),  
DACVECC

**IMAGING PERFORMED BY**

Sara Hansen

**HOSPITAL NAME**

West Eugene Animal  
Hospital

**REFERRING VET**

Dr. Larsen

**INVOICE**

74761

**DATE**

4/28/26

**PRESENTING CLINICAL SIGNS**

Mass effect palpable in the caudal abdomen - no pain noted. Muscle atrophy, Arthritis.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys have a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present. Left kidney measures 3.75 cm. Right kidney measures 4.28 cm.

**Adrenal Glands**

The left adrenal gland is visualized on still images only. It appears to have normal shape, size, position and echogenicity for this breed and age though this could not be confirmed on cine loops. Left measures 0.51 cm in thickness.

The right adrenal gland is not distinctly visualized.

**Spleen**

The spleen is enlarged and hypoechoic with an irregular capsular margin. There are no specific masses or nodules visualized.

**Liver**

The liver is subjectively mildly enlarged with sharp margins. Parenchyma is diffusely somewhat coarse. There are multiple hypoechoic, small, poorly defined nodules noted throughout the parenchyma.

Gall bladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.

**Gastrointestinal**

The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.

In the mid abdomen there is a complex GI mass encompassing at least part of the small intestine. The wall is severely thickened, irregular, and hypoechoic with complete obliteration of wall layering. Near the mass there is a large mass effect suspected to represent an infiltrative lymph node, though a nearby omental or mesenteric mass cannot be ruled out. This may also represent extension of the primary GI mass.

The distal colon is visualized with gas shadowing.

**Pancreas**

The pancreas is not distinctly visualized.



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**Free Abdomen**

Near the small intestinal mass there is a large, irregular mass effect suspected to represent an infiltrative lymph node measuring 5.1 cm x 4.0 cm.

There is scant free fluid noted in every quadrant.

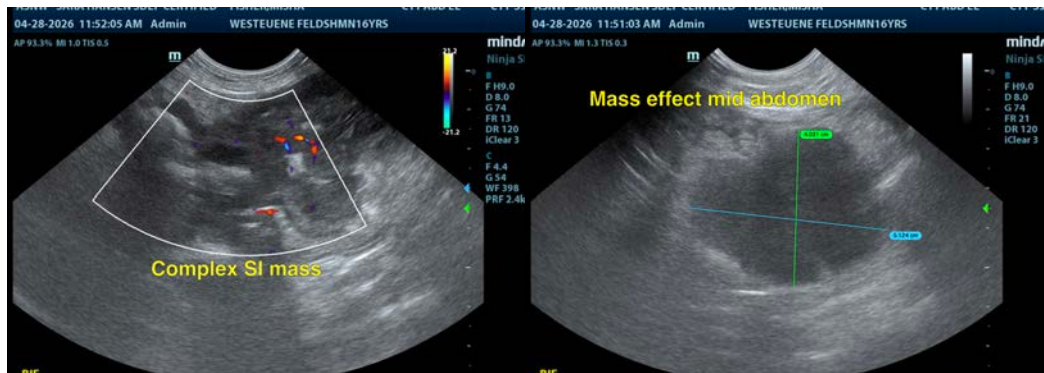
**ULTRASONOGRAPHIC FINDINGS**

- Large small intestinal mass with surrounding mass effect (suspect surrounding lymphadenopathy).
- Scant abdominal effusion.
- Splenomegaly with hypoechoic parenchyma.
- Multiple hepatic nodules.
- Mild degenerative renal changes.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The mass palpated in the abdomen likely represents the GI mass visualized together with surrounding lymphadenopathy. FNA of the small intestinal mass and surrounding lymph nodes is recommended to further define. The presence of scant fluid is concerning for potential leakage from the intestinal mass, though the degree of effusion is relatively scant. Abdominocentesis with plan for fluid analysis and cytology is recommended if sample can be obtained.

The splenomegaly is concerning for metastasis to the spleen, though a reactive splenomegaly is possible. Splenic FNA should be considered. The presence of liver nodules is concerning for metastasis to the liver. Though these nodules may represent reactive or inflammatory nodules, liver FNA should be considered.





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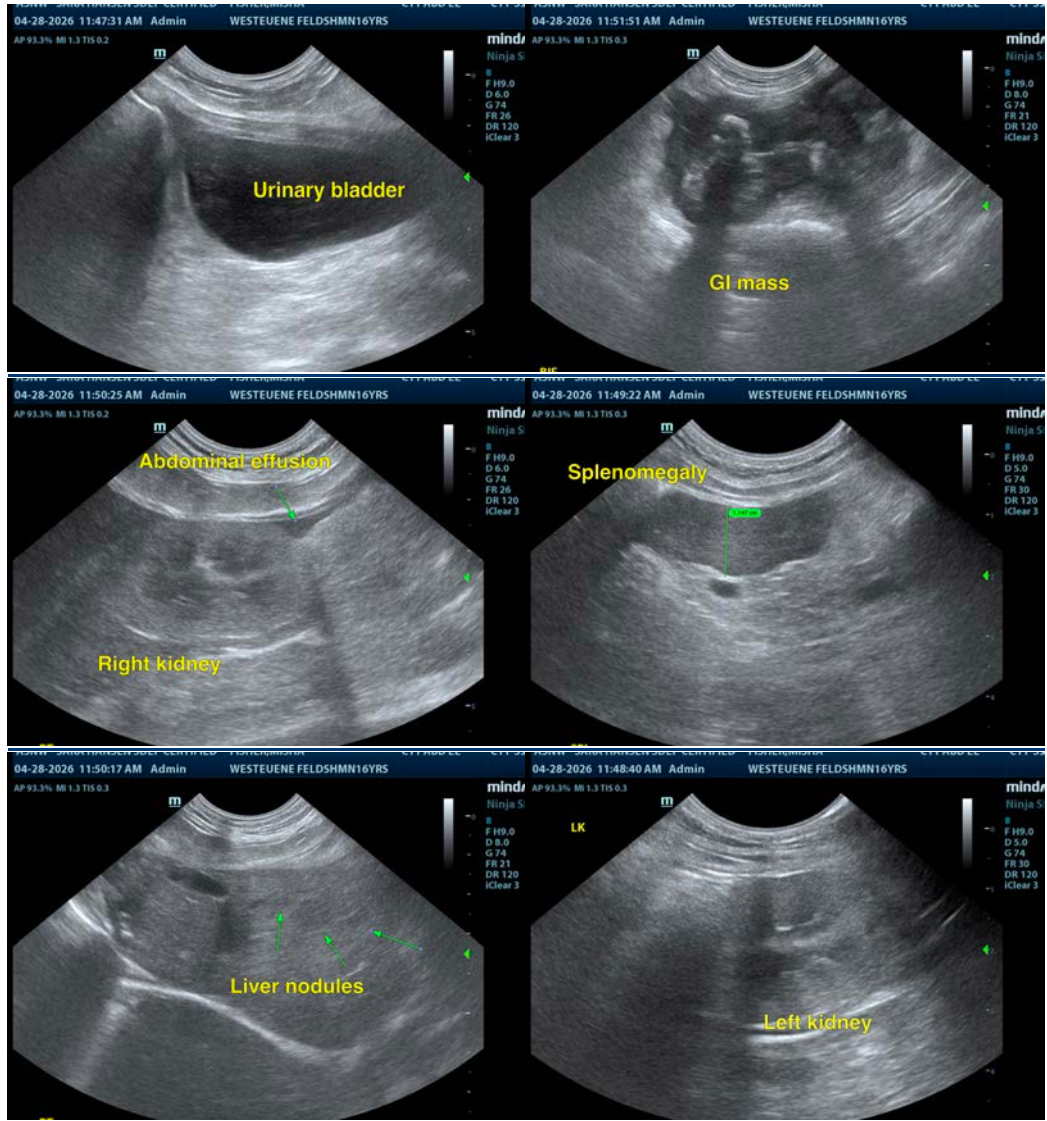
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC  
 info@SonoPath.com