



**PATIENT**

Pickle Dasaro

**SPECIES**

Feline

**BREED**

Domestic Shorthair

**SEX**

Neutered Male

**AGE**

13 Years

**WEIGHT**

17.2 Pounds

**INTERPRETED BY**

Eric Lindquist, DMV,  
 DABVP (CFM), Cert.  
 IVUSS

**IMAGING PERFORMED BY**

Meghan Morse, LVT,  
 CVT

**HOSPITAL NAME**

Newburgh VH

**REFERRING VET**

Dr. Dasaro

**INVOICE**

35546

**DATE**

11/17/25

**PRESENTING CLINICAL SIGNS**

History: Recently diagnosed diabetes, refractory hypokalemia and hypertension, currently hospitalized for acute onset of pancreatitis, doing well clinically (eating and BG regulated) Current meds: Lantus 2U BID, Baytril, Famotidine, Metoclopramide, Cerenia, Onsior, REnal K+

Abnormal PE/Chem/CBC/UA Results: Chem: ALT 127, AST 255, Lipase 105, Trig 141, K 2.0, Magnesium 1.4

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal. The pelvic urethra was imaged 2.0 cm beyond the cystourethral junction.

The **kidneys** presented a relatively uniform cortical hyperechogenicity when compared to the renal medulla, spleen and liver. No overt masses were noted. Corticomedullary definition was nebulous, and the ratio favored the cortex slightly. The ureters were not visible and assumed to be normal. These changes are most consistent with chronic interstitial nephritis yet infiltrative disease could not be entirely ruled out without biopsy though neoplasia is not suspected. This is a mild to moderate change. The left kidney measured 4.5 cm. The right kidney measured 4.65 cm. Blood flow to the kidneys appeared to be adequate to slightly subnormal. The right kidney was mildly deviated owing to the right adrenal mass. Some adherence of the right adrenal upon the right kidney may be an issue, however, the majority of the right adrenal mass was definitively separated by the right adrenal capsule and right renal capsule.

**Adrenal Glands**

A **right adrenal mass** was noted in this patient; uniform, hypoechoic and swollen with mild pericapsular fat enhancement. The mass measured 3.74 cm x 3.58 cm. The right adrenal mass appears to be resectable. It impinges upon the vena cava yet does not overtly invade it. Slight phrenic vein invasion was noted upon the right adrenal.

The **left adrenal gland** was normal in size and contour, measuring 0.4 cm.

**Spleen**

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted.

**Liver**



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The **liver** was diffusely hyperechoic to falciform fat. Mild attenuating sound beam was noted. The gallbladder and common bile duct were unremarkable. No evidence of metastatic disease.

**Gastrointestinal**

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

**Pancreas**

The left limb of the **pancreas** was hypoechoic and irregular (a region of approximately 2.0 cm x 1.5 cm) with a slight microcystic change with slight inflammation. Minor inflammatory pattern was noted at the left pancreatic base as well.

**ULTRASONOGRAPHIC FINDINGS**

- Mild to moderate interstitial nephrosis renal pattern
- Right adrenal mass, appears resectable
- Nodular hyperplasia/chronic active pancreatitis pattern in primarily the left limb
- Hyperechoic liver

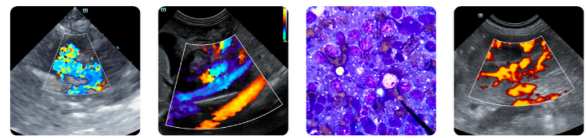
**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

CT evaluation for surgical planning would be ideal in this patient yet subjectively appears resectable with minor right phrenic vein invasion. Strong concern for Conn's syndrome. Aldosterone levels and blood pressures are warranted. The diabetic state and hypertension are likely secondary to the right adrenal mass. Right adrenal carcinoma is suspected. Biopsy of the caudal pole or removal of the caudal pole of the left pancreatic limb could be considered at surgery for right adrenalectomy.

The pancreatic presentation is not suspected to be neoplastic in nature, however, cannot be completely ruled out. It is likely nodular hyperplasia with some level of inflammation.

**ABOUT SONOPATH CT SERVICES:**

**SonoPath CT Services** are offered at the SonoPath Imaging and Veterinary Education Center, 141 Main St (rt 206), Andover, New Jersey, a 20-minute drive west on route 80/206 North from the route 80/287 interchange/Parsippany, New Jersey. More information can be found at <https://sonopath.com/services/vetimaging/>



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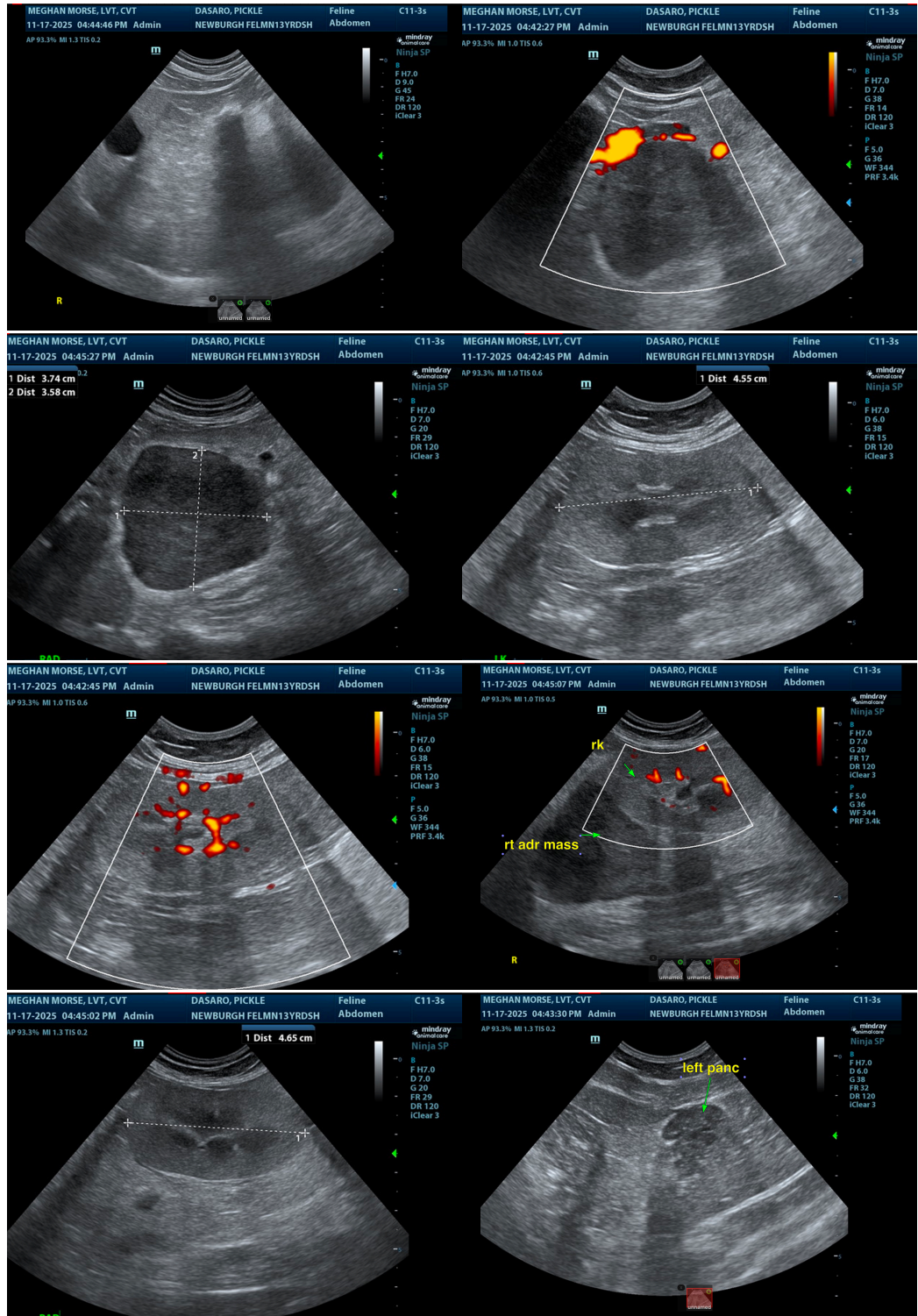
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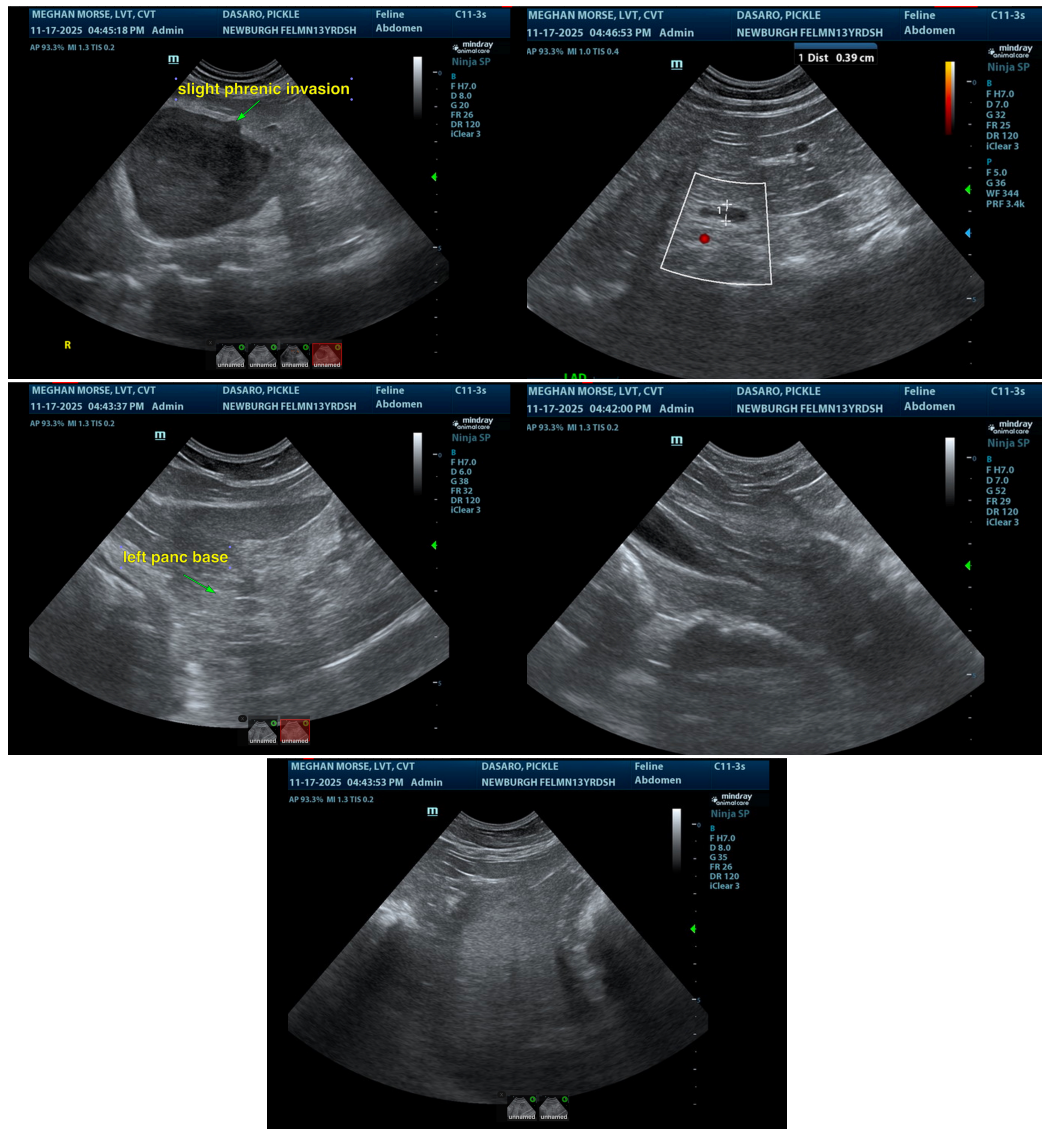
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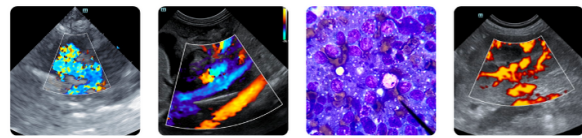


The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**Eric Lindquist**, DMV, DABVP(CFM), Cert. IVUSS,  
CEO, Owner, Founder -- SonoPath.com  
[info@SonoPath.com](mailto:info@SonoPath.com)

**Feline Hyperaldosteronism**



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<http://www.sonopath.com/Hyperaldosteronism>

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**Description:** Feline hyperaldosteronism can be caused by either a unilateral aldosterone-secreting adrenal tumor or bilateral adrenal hyperplasia. The resultant oversecretion of aldosterone results in hypokalemia, hypernatremia, and metabolic alkalosis. Primary hyperaldosteronism and secondary hyperaldosteronism caused by renal disease may be difficult to differentiate. Hyperaldosteronism is associated with clinical signs that result from systemic hypertension caused by an expansion in blood volume or polymyopathy resulting from hypokalemia. There is no breed predilection and the disease tends to occur in older cats between the ages of 6 and 13 at a mean age of approximately 10 years.

**Clinical Signs:** The most common clinical sign is hypokalemic polymyopathy, which presents as a ventroflexion of the neck. Other signs are paresis, hind limb weakness, and acute onset blindness.

**Diagnostics:** The most common laboratory findings are severe hypokalemia and elevated serum creatine kinase activity. Abdominal ultrasonography will show either unilateral or bilateral adrenomegaly and/or an adrenal mass. The diagnosis is confirmed by the presence of severely elevated plasma aldosterone concentrations. Plasma renin concentrations may be decreased or within normal reference range. In animals without markedly elevated aldosterone concentrations, an increased plasma aldosterone-plasma renin ratio may be useful in establishing the diagnosis. A CT scan can be used to detect subtle changes within the adrenal cortex and better delineate the extent of the adrenal mass if surgery is being considered.

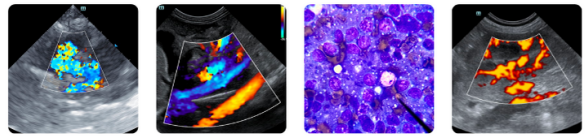
**Treatment:** Treatment of primary hyperaldosteronism resulting from a unilateral adrenal tumor consists of potassium supplementation and administering an aldosterone blocker, such as spironolactone, as well as amlodipine. Once stabilized, surgical removal of the adrenal mass should be considered. In cases of idiopathic adrenal hyperplasia that give rise to hyperaldosteronism, medical treatment is the only option available; however, most cats will eventually succumb to progressive renal insufficiency.

## References:

Ash RA, Harvey AM, Tasker S. Primary hyperaldosteronism in the cat: a series of 13 cases. *J Feline Med Surg* 2005;7:173-82.

Chiaromonte D, Greco DS. Feline adrenal disorders. *Clin Tech Small Anim Prac* 2007;22:26-31.

Duesberg CA, Nelson RW, Feldman EC, et al. Adrenalectomy for treatment of hyperadrenocorticism in cats: 10 cases (1988-1992). *J Am Vet Med Assoc* 1995;207:1066-70.



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Javadi S, Djajadiningrat-Laanen SC, Kooistra HS, et al. Primary hyperaldosteronism, a mediator of progressive renal disease in cats. *Dom Anim Endocrinol* 2005;28:85-104.

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