



PATIENT

Dazi Vukovic

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

14 years

WEIGHT

10.5 lbs

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

**IMAGING
PERFORMED BY**

Dr. Loomis

HOSPITAL NAME

Brookwood AC

REFERRING VET

Dr. Loomis

INVOICE

42221

DATE

12/19/22

PRESENTING CLINICAL SIGNS

History: WT loss/ appetite ok to maybe slightly decreased
Abnormal PE/Chem/CBC/UA Results: Mildly elevated BUN (37) All else WNL P is hyperthyroid and is on meds - T4 was 3.1

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 **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for his age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. Minor mineralization was noted in the kidneys. The left kidney measured 3.5 cm.

Adrenal Glands

Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient.

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 was noted.

Liver

The left caudal **liver** in this patient revealed a complex 5.0 cm cystic mass. The liver mass appears to be deriving from the caudate process. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.



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Gastrointestinal

The **gastrointestinal tract** revealed minor variable thickening and echogenic submucosal changes most consistent with low grade end result of chronic GI disease such as IBD and may be related to malassimilation of nutrients if any weight loss is present. A portion of duodenum appeared particularly thickened. The mesenteric lymph nodes were reactive and measured up to 1.5 cm.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

ULTRASONOGRAPHIC FINDINGS

Cystic left-sided liver mass, potentially resectable.

Age related abdominal changes were noted.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The hepatic mass appears resectable and is at risk for rupture. Surgical removal is recommended. The cause of weight loss is likely independent of the liver mass. This is likely cystadenoma or benign cyst, yet should be surgically resected as it is at risk for torsion or rupture.

Maldigestion panel, three view chest radiographs and full CNS examination is recommended to examine for occult disease that could be responsible for the weight loss. Evaluation for competitive eating environments should also be considered.





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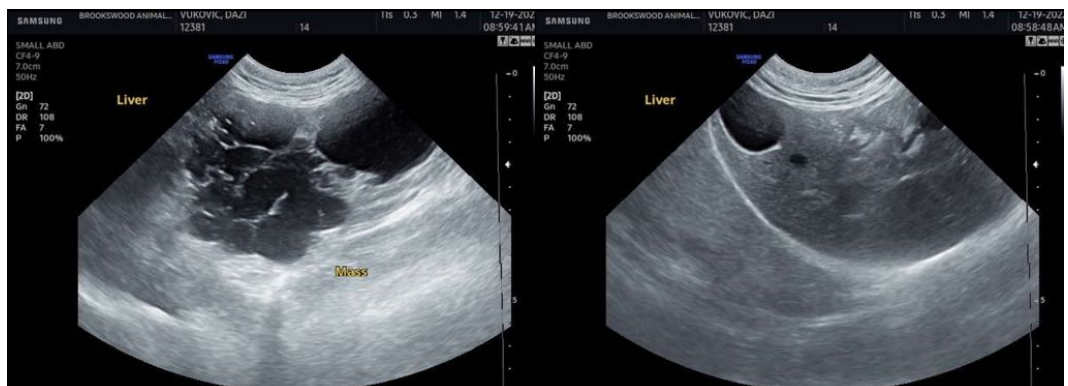
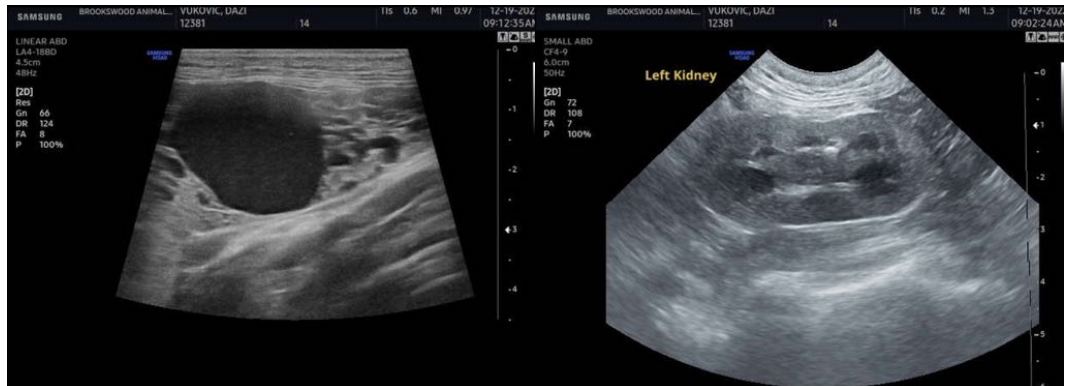
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com
info@SonoPath.com