



## PATIENT

Sugar Lincoln

## SPECIES

Feline

## BREED

Domestic Shorthair

## SEX

Neutered male

## AGE

9 years

## WEIGHT

10.44 lbs

## INTERPRETED BY

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

## IMAGING PERFORMED BY

Laura Klaassen

## HOSPITAL NAME

Animal Care Group of  
Lake Oswego

## REFERRING VET

Dr. Inman

## INVOICE

74824

## DATE

4/24/26

## PRESENTING CLINICAL SIGNS

History: found mass on routine exam. Mild weight loss, chronic URI  
Neutrophilia 15575 Eosinophilia 1416 Platelets 37,000 but clumping liver values normal

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The pelvic urethra was imaged 2.0 cm beyond the cystourethral junction and appeared normal. 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** 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. Hyperechoic, ill-defined, medullary rim sign was noted. The left kidney measured 4.3 cm. The right kidney measured 4.1 cm.

### Adrenal Glands

The **adrenal glands** were not visualized.

### 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 **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some age-related parenchymal remodeling was noted but likely not clinically significant at this time. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. Multi-focal, hyperechoic, microcystic nodules were noted. This is consistent with cystadenomas. An anechoic cyst was noted at the caudal aspect of the left liver measuring 1.7 cm. The mid cranial abdomen revealed a cystic mass that was deriving from the caudal aspect of the left liver. The mass is pedunculated and supported by a bridge of 1.0 cm. The mass itself measured 4.7 x 2.4 cm. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. The hepatic lymph nodes were unremarkable.



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## 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

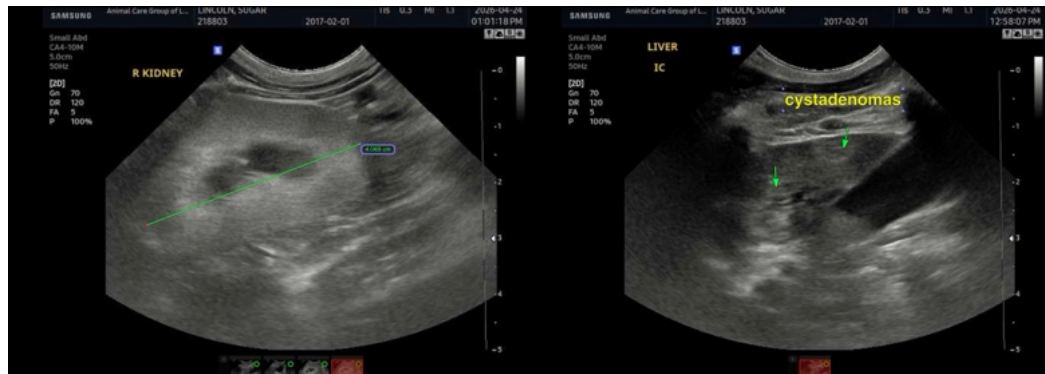
The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

## ULTRASONOGRAPHIC FINDINGS

Cystic left caudal liver mass, likely histopathologically benign, but highly precarious for torsion.  
Cyst adenomatous type liver changes elsewhere.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Surgical removal of the hepatic mass is recommended as this mass has a cystic component with echogenic debris and is at risk for rupture, but lobe torsion is also a strong potential.





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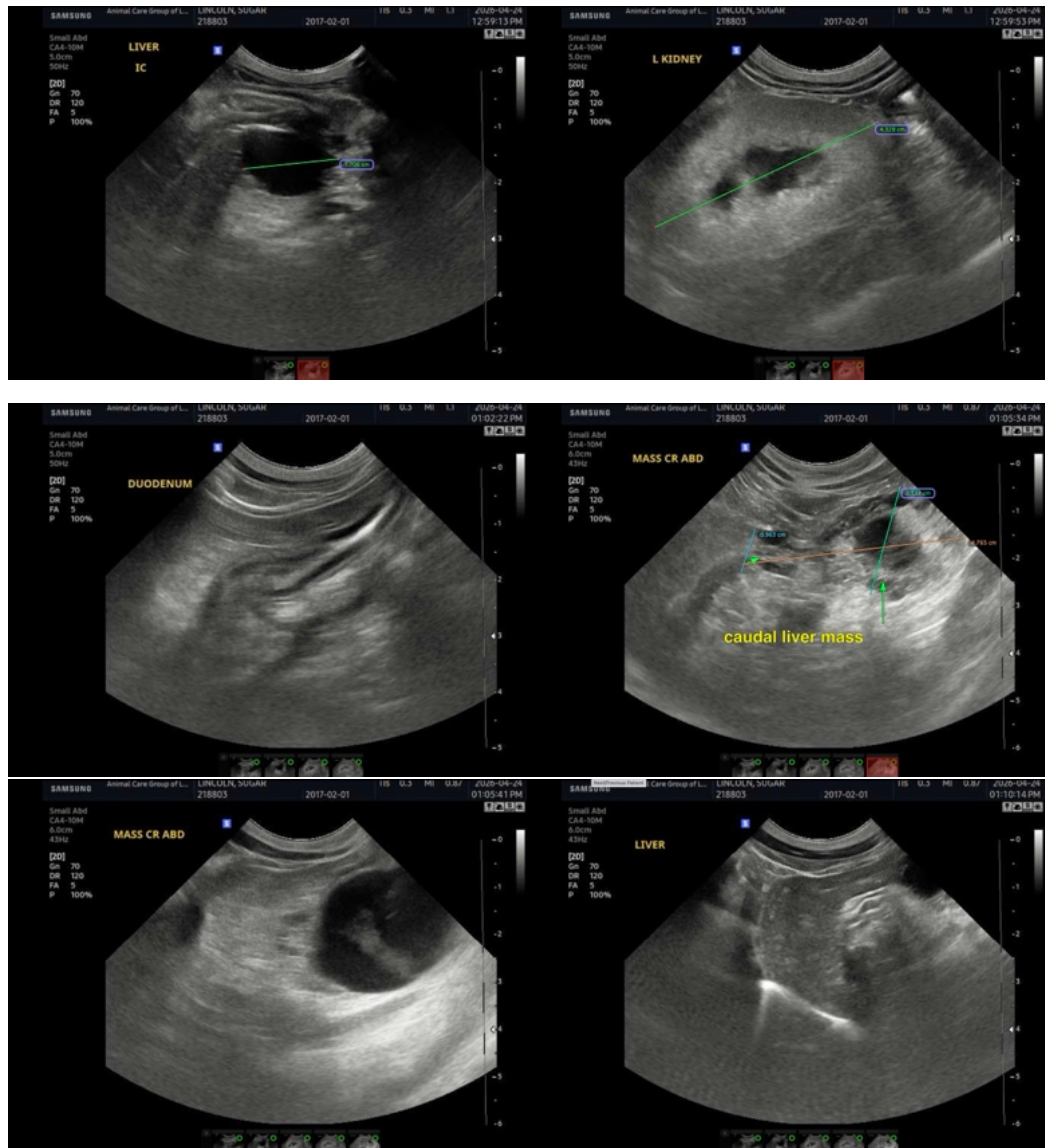
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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 of SonoPath.com

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