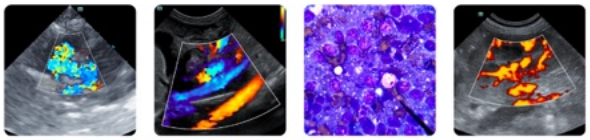


PATIENT

Jackson Stoute

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

11 years

WEIGHT

17 lbs

INTERPRETED BY

Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Ashley Whitesell

HOSPITAL NAME

Dickson AC

REFERRING VET

Dr. Lveine

INVOICE

74868

DATE

4/28/26

PRESENTING CLINICAL SIGNS

History: Presented with urinary obstruction; a urinary catheter was placed and remains in place. Uroliths present on radiographs. Radiographs showed concerns for a diaphragmatic hernia. Is it liver or a mass?
Abnormal PE/Chem/CBC/UA Results: Normal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** presented a minimal amount of urine present with thickened, irregular parenchyma and a slight amount of sand.

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 this age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The left and right kidney measured 4.2 cm.

Adrenal Glands

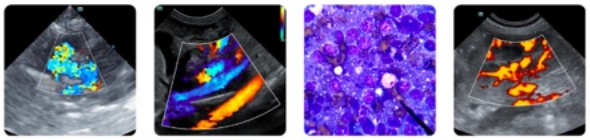
Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. Both adrenal glands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

Liver

The **liver** revealed a mixed echogenic mass in the cranial liver. The mass impinged upon the heart directly and there is no separation with the diaphragm. This would suggest diaphragmatic hernia; however, this could be a congenital lesion with secondary mass formation, which may be benign. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident.



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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.

Free Abdomen

Trace pockets of fluid are also noted.

ULTRASONOGRAPHIC FINDINGS

Mass in the caudal thorax/ cranial abdomen. This appears to be diaphragmatic hernia related. Either primary hernia with secondary mass formation which may be histopathologically benign versus hepatic neoplasia that has invaded through the diaphragm.

Irregular bladder parenchyma with sand, bladder only has a minimal amount of urine. Chronic cystitis with sand versus underlying carcinoma are the primary differentials.

Otherwise, geriatric abdomen.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

I recommend reexamination at full bladder; however, I am strongly concerned for a neoplastic process versus chronic cystitis. Both can present in this fashion. The other concern is hyperechoic, surrounding fat as this is consistent with transmural inflammation.

Ultrasound-guided intracostal approach to mass for FNA would be appropriate. CT evaluation is warranted. I cannot ascertain the exact origin, but it suggests hepatic in nature as it appears continuous with hepatic parenchyma. This may be histopathologically benign. Ultrasound-guided FNA of the mass is recommended to assess for hepatic tissue versus possible lung tissue (less likely). This is either a congenital lesion (if any prior radiographs are present then I recommended examination for the potential primary hepatic diaphragmatic hernia) versus a hepatic mass that has invaded through the diaphragm or diaphragmatic inlet. This appears to impinge upon the heart, yet it does not appear to be part of the pericardium and appears to be separate from the pericardium.

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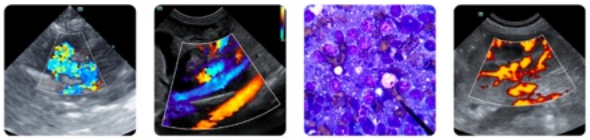

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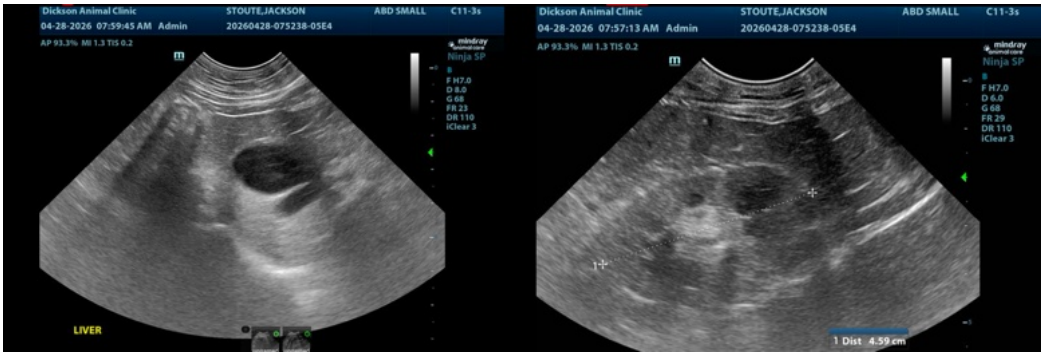

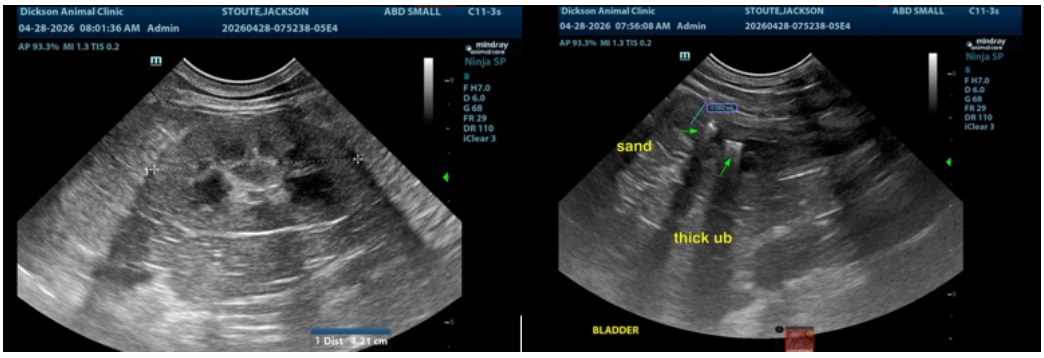

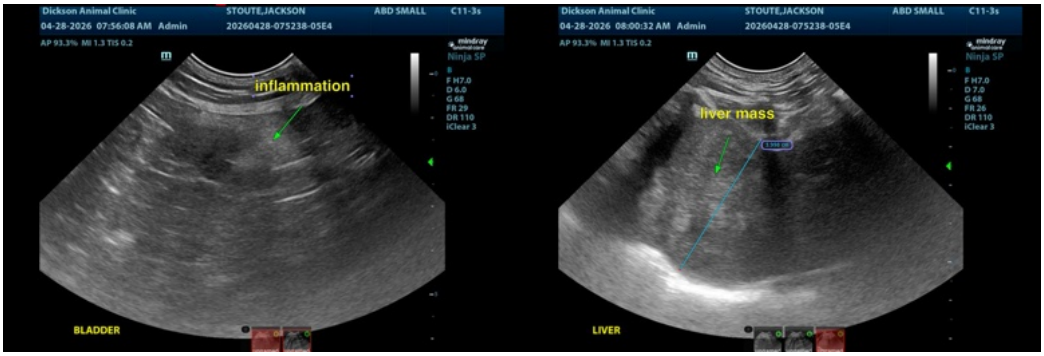

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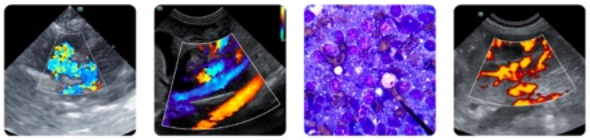

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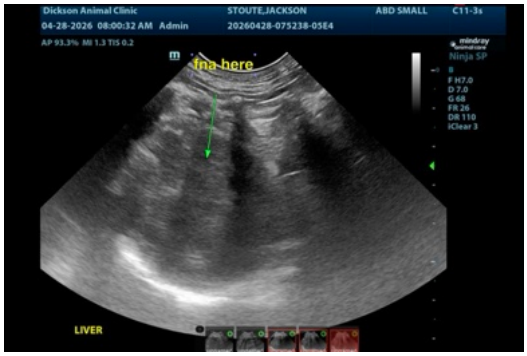

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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 of SonoPath.com

info@SonoPath.com