

**DATE**

5/2/22

PRESENTING CLINICAL SIGNS

Has been having "soft serve" stools for months and a constant sensation to urinate and defecate. Grade 3/6 systolic murmur on the right side of the chest upon exam. Lost .8lbs since October 2021.

Current Medications: None.

Lab Results: CBC/Chem/FPL and T4 all WNL.

Date of Previous IntraPet Ultrasound: 11/19/21, 1/27/2021 (echo), 2/14/20, and 1/25/2019. See attached.

Sedation: Declined.

Stat Report: Not requested.

Imaging Performed By:

PATIENT

Martini Karnegis

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Neutered male

AGE

12/23/10

WEIGHT

8 lbs

INTERPRETED BYEric Lindquist, DMV
DABVP, Cert. IVUSS**HOSPITAL NAME**

Parkville AH

REFERRING VET

Dr. Mangini

INVOICE

30079

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The **urinary bladder** and visible pelvic urethra were unremarkable for the level of repletion presented. The urine, however, did present some mildly echogenic debris consistent with mucous, exfoliated cells from renal or bladder origin, and/or blood clots as these echogenic changes can all present similarly. This is often related to urinary tract infection but may represent simple evidence of exfoliated debris or sterile inflammation. Cystocentesis, urinalysis, +/- culture would be recommended to rule out and define any UTI.

The **kidneys** had similar changes to the prior sonogram with an interstitial nephrosis pattern and cortical infarcts. The left kidney revealed mild pyelectasia that measured 0.26 cm. The left kidney measured 3.53 cm. The right kidney measured 3.68 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. The left adrenal gland measured 0.54 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 right-sided **liver** nodule has now expanded into a larger, coalescing cystic structure that measured 4.3 x 2.0 cm and deviated the gallbladder caudally. The left cranial liver revealed persistent cystadenoma type nodule that measured 2.0 cm. Mild hepatic remodeling was noted elsewhere. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident.

Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Variable areas of small intestine were slightly thickened, yet no overt neoplastic criteria was present. Slight mesenteric lymphadenopathy was noted and the largest node measured 1.0 x 0.5 cm.

Pancreas

The pancreas revealed heterogenous parenchymal changes with a dilated duct that measured 0.24 cm. The right limb measured 0.91 cm.

ULTRASONOGRAPHIC FINDINGS

Progressive cystadenoma type right cranial liver nodule, now a mass, possibility of biliary carcinoma. Stable left cranial liver nodule.

Other, hyperechoic, nodular changes were noted in the liver. This is consistent with cystadenomas.

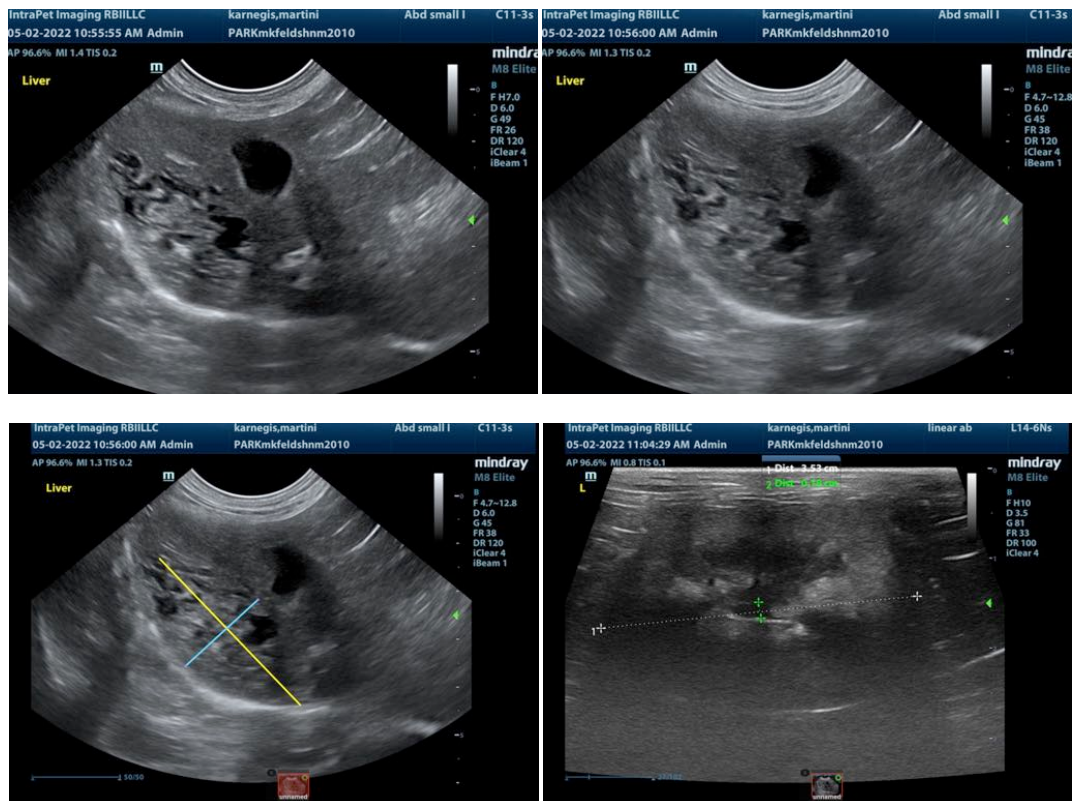
Chronic renal changes with infarcts and remodeling, similar to the prior sonogram.

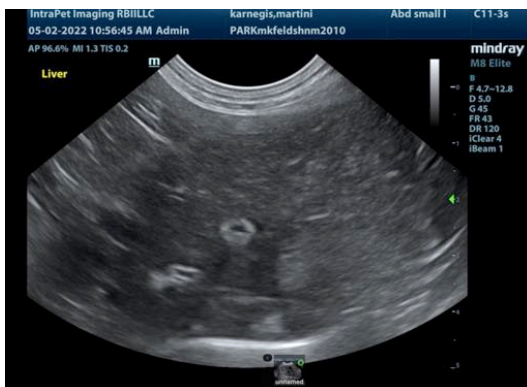
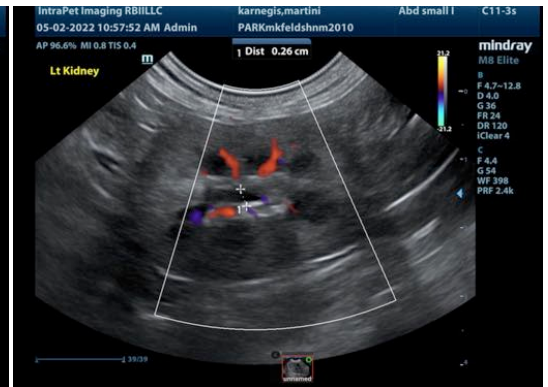
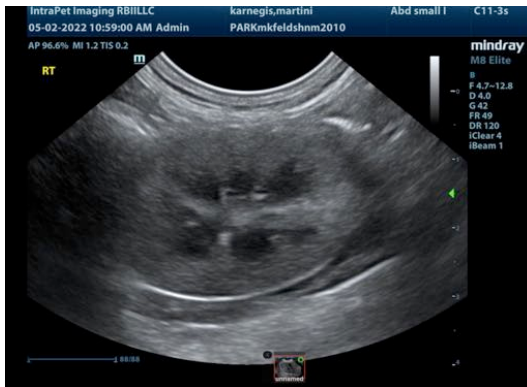
Age related pancreatic changes, appear stable.

Variable intestinal thickening and mild mesenteric lymphadenopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The larger right cranial liver cystic mass is not resectable, yet still likely benign or possibility of biliary carcinoma, low grade. The cause of GI signs is not evident. Malassimilation/maldigestion should be considered. No obvious neoplastic criteria, however, given the patient's history, emerging lymphoma is possible, yet inflammatory bowel with reactive lymph nodes is likely. Full thickness biopsies would be necessary for further definition.







The information and recommendations provided are based on the images presented by the referring veterinarian. 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.

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