



**PATIENT**

Baby Gotchy

**SPECIES**

Feline

**BREED**

Domestic Shorthair

**SEX**

Neutered male

**AGE**

10 years

**WEIGHT**

6.38 lbs

**INTERPRETED BY**

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

**IMAGING PERFORMED BY**

Dorris

**HOSPITAL NAME**

Rockport VC

**REFERRING VET**

Dr. Miller

**INVOICE**

46764

**DATE**

8/24/23

**PRESENTING CLINICAL SIGNS**

History: Patient presents for ADR/Not eating well. O describes vague ADR symptoms (not himself, used to be the alpha cat and isn't anymore, etc. No specific symptoms like vomiting, diarrhea, coughing, etc) He did say he thinks the cat drinks a lot. Physical exam findings normal except for thin BCS. Pet has lost about 2 lbs since we saw it 3 years ago but unclear whether this was rapid recent weight loss or gradual. O agreed to pursue some diagnostics. Bloodwork showed anemia of chronic dz, elevated liver enzymes. Rads show hepatomegaly. O agreed to ultrasound to get a more specific diagnosis. Will start tx w/ Denamarin and Abs in the meantime. UTI also identified on U/A so abs will cover this as well.

**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. The left kidney measured 3.4 cm. The right kidney measured 4.0 cm.

**Adrenal Glands**

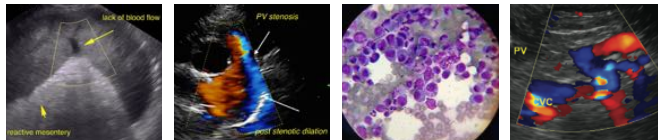
The **adrenal glands** were not visualized.

**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** in this patient revealed multi-focal, coalescing masses with ill-defined margins. Impingement upon the diaphragm with diaphragmatic deviation was noted. The gallbladder was deviated caudally. Portions of the mass appeared to be cavitated with cysts and necrosis.



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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. However, deviation of the stomach was noted owing to the hepatic mass effects. 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. Some parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxiphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

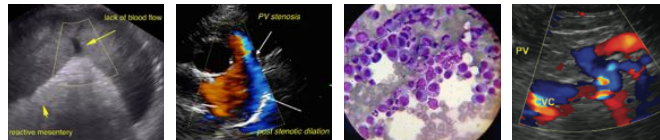
## ULTRASONOGRAPHIC FINDINGS

Coalescing expansive, non-resectable hepatic masses.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Carcinoma is suspected. 25-gauge FNA of the parenchymal portion of the mass is recommended. Bile acid profile is warranted. I recommend focusing on the liver for further diagnostics, yet the protognosis is poor.





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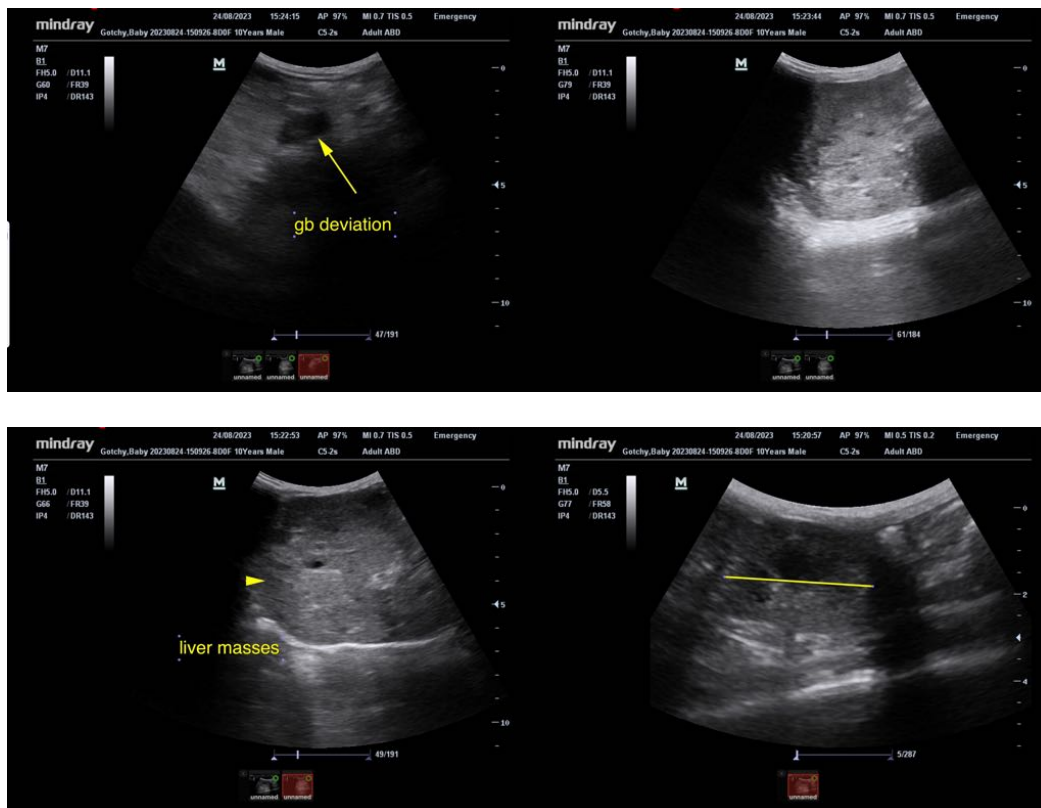
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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