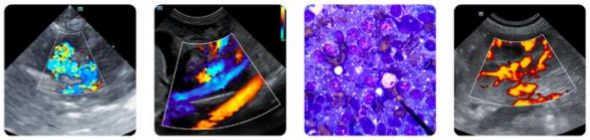


PATIENT

Shadow Foley

SPECIES

Feline

BREED

DMH

SEX

Neutered Male

AGE

12 Years

WEIGHT

8.74 pounds

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP

IMAGING PERFORMED BY

Dr. Ashley Gambon

HOSPITAL NAME

Lanier Animal Hospital

REFERRING VET

Dr. Ashley Gambon

INVOICE

13150

DATE

01/13/26

PRESENTING CLINICAL SIGNS

Shadow, a cat, presented with a history of vomiting for one to two months prior to a recent move from Kansas. The vomiting has since stopped. A mass on his neck has been growing. In the past week, he disappeared for two days, was found lethargic and discombobulated, and has been hiding in the shower. He is eating minimal wet food and barely drinking water. The patient's eyes have been gunky for the past week. He has experienced weight loss in the last two weeks. He has not been defecating or urinating regularly. Urine was noted to be brown, and blood was found in the shower. He is confused, quiet, and sneezing. He received trazodone earlier today.

Abnormal PE/Chem/CBC/UA Results: BW 1/13/26: CBC: regenerative anemia (HCT 20.9, reticulocytes 575.5), MCV 86.7 and MCH 22, leukocytosis (WBC 24.96) characterized by a neutrophilia 19.61 with suspected bands, monocytosis 1.31, eosinopenia 0.06, thrombocytopenia 9, and PCT 0.02 Chemistry: mild hyperglycemia 181 (suspect stress), SDMA 14, creatinine 0.7, ALT elevated at 260, ALKP low at 12 TT4 1.9 UA: SG over 1.050, pH 6, protein 500 mg/dl, negative glucose, negative ketones, 4 mg/dl UBG, 1 mg/dl BIL, 250 ery/ul

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Nondependent particulate mild sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

No evidence of medial iliac or sublumbar lymphadenopathy or masses. No evidence of distal aortic thrombus.

Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Mild loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. The left kidney measured 4.3 cm in length. The right kidney measured 4.3 cm in length.

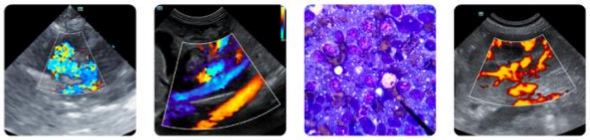
Adrenal Glands

The bilateral adrenal glands were normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.57 cm width. The right adrenal gland measured 0.52 cm width.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted. The spleen measured 1.0 cm width level of the mid spleen.

Liver & Gallbladder



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The liver presented with subjective normal size and vascular volume with no obvious hepatic congestive criteria. The liver exhibited lobar heterogeneous parenchyma with potential ill-defined liver mass measuring approximately 3.5 cm in diameter.

Transdiaphragmatic view revealed mild comet tail lung pattern, which is echogenic sound wave interface with microconsolidations within the caudal lung field. The lung field should not be visualized by sonogram unless pathology is present. Chest radiographs are recommended to rule out alveolar/lung disease such as neoplasia, thromboembolic disease, chronic inflammatory disease with microconsolidation.

The gallbladder was non-distended in size with mildly thickened hyperechoic nonedematous wall containing anechoic bile. The common bile duct was not visualized.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained variably echogenic, nonshadowing ingesta without signs of obstruction or foreign material.

The intestinal walls demonstrated intact wall layers with diffusely thickened walls and altered 1:3 muscularis / mucosa ratio primarily consisting of muscularis hypertrophy. The small intestine wall measured 0.30 cm wall width.

Normal visible colon wall layers were present with formed fecal matter in lumen.

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

A moderate to significant volume of mildly echogenic peritoneal effusion and generalized nonhomogenous mildly hyperechoic omentum.

ULTRASONOGRAPHIC FINDINGS

- Generalized intact thickened small intestine with nonshadowing gastric ingesta.
- Heterogeneous lobar hepatic parenchyma with ill-defined nonhomogenous hepatic mass.
- Mildly echogenic peritoneal effusion with generalized nonhomogenous omentum.
- Bilateral chronic renal changes.
- Urinary bladder sediment.
- Mild transdiaphragmatic comet tail artifact.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Without overt evidence of hepatic congestion or reported subnormal albumin levels, primary concern for multicentric neoplasia i.e. carcinomatosis, lymphomatosis or similar is warranted.

Further assessments may include (assuming normal clotting status) effusion analysis cytology +/- culture and sensitivity if inflammatory component and screening hepatic FNA cytology using 25-gauge needle. Technically, FIP is a potential and FIP titers/PCR on effusion could be considered if clinically indicated. However, FIP is considered less likely given patient's age.

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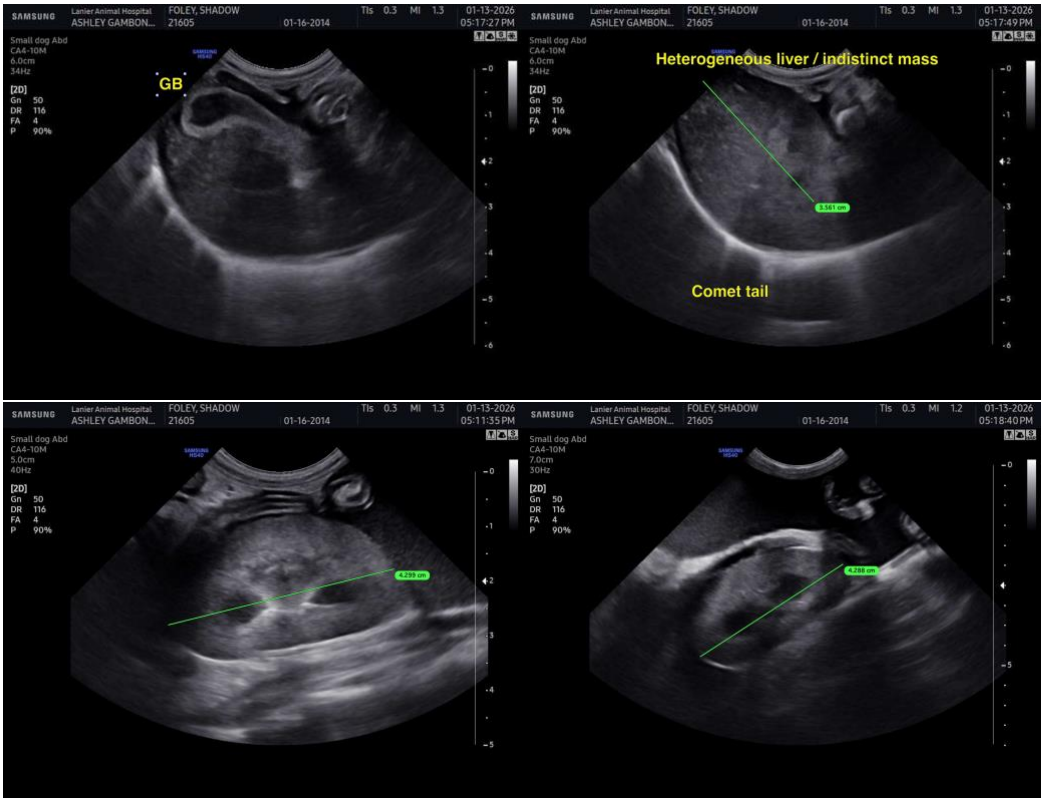
Three view chest radiographs are suggested if not done. Carcinomatosis, lymphomatosis or similar are primary differentials until proven otherwise.



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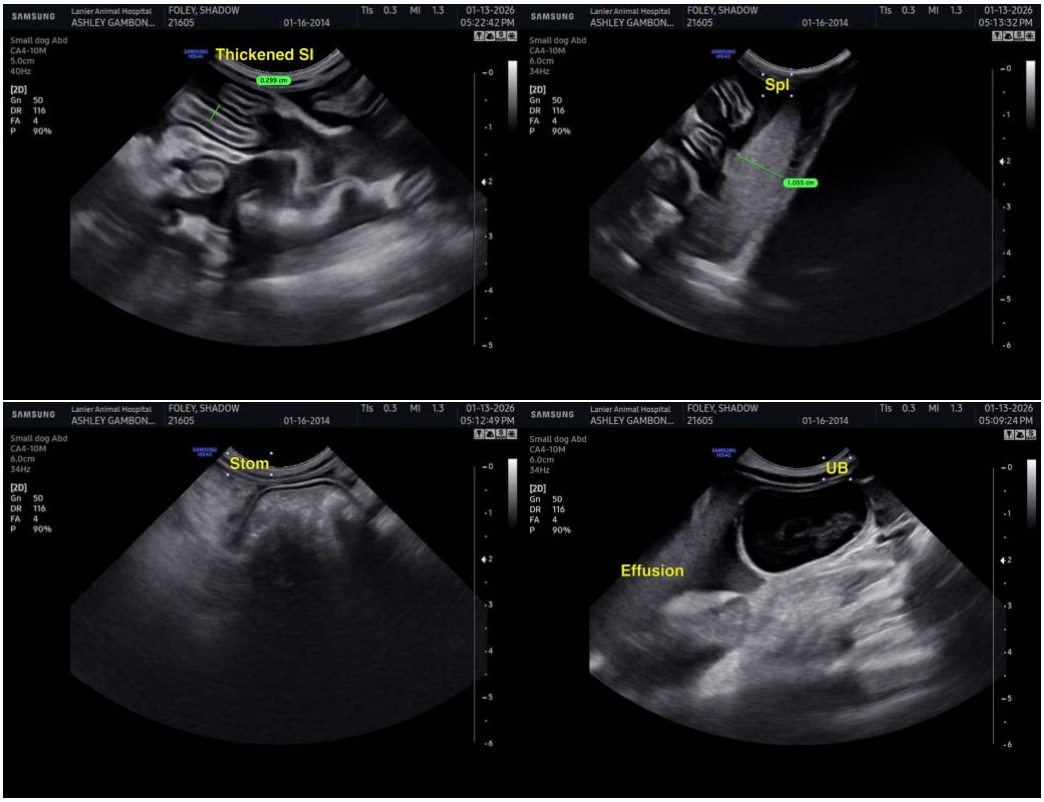

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

info@SonoPath.com