



**PATIENT**

Jazmine Walker

**SPECIES**

Feline

**BREED**

DMH

**SEX**

FS

**AGE**

18 years

**WEIGHT**

6 lbs.

**INTERPRETED BY**

R. McKenzie Daniel,  
DVM, DABVP  
(Canine and Feline)

**IMAGING PERFORMED BY**

Dr. Mavis  
McCormick-Rantze

**HOSPITAL NAME**

Lanier AH

**REFERRING VET**

Dr. Mavis  
McCormick-Rantze

**INVOICE**

12451

**DATE**

10/23/21

**PRESENTING CLINICAL SIGNS**

Presented 6/22 with a history of vomiting for 2 days and constipation on/off for about a month. October 18, 2021 presented with a "swollen abdomen" and swollen left rear leg. Owner had just noticed the foot with in the last day. Also recently the patient had started drinking excessive amounts of water.

Abnormal PE/Chem/CBC/UA Results: On PE 10/18/21 - BCS 3/9, extreme muscle wasting; abdomen pendulous, unsure abdominal wall could be palpated well/worried that it has a rent/hernia; LR leg swollen but it was edematous, actually oozing fluid so wet; also on abdomen could see an area of skin that was superficially ripped/thin; also bruising on the lower abdomen BW on 10/18: cbc: sl anemic chem: lipase 5400 BUN 45 TP 5.7 albumin 2.2 T4 wnl UA: UTI present, cocci chains ++ Radiology report: 1. Normal thorax 2. Poor abdominal serosal detail - differential diagnosis includes abdominal masses, lack of muscle tone and secondary flaccidity or body wall rent/tear 3. Severe left pelvic limb swelling - attributed to reported edema (e.g. lymphedema) 4. Degenerative intervertebral disc disease, L4-S1

**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. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

The area of the aortic trifurcation was free of pathology. No overt evidence of medial iliac or sublumbar lymphadenopathy was noted.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Pinpoint areas of nonobstructive medullary mineral were present. No evidence of pelvic dilation was present. The left kidney measured 3.7 cm in length. The right kidney measured 3.9 cm in length.

**Adrenal Glands**

The left and right adrenal glands were not definitively visualized owing to periadrenal fluid and omental artifact.

**Spleen**

The visualized spleen was sonographically unremarkable, measuring 0.62 cm in width, with normal overall splenic size, contour, and parenchyma echogenicity.

**Liver/ Gallbladder**

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. A solitary, mid to deep parenchymal, mildly expansive cystic parenchymal mass measuring 2.4 cm in diameter, was present. The hepatic and portal vasculature were



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normal in appearance without signs of congestion. The gallbladder was non-distended in size. The common bile duct exhibited subjective moderate distention extending caudally to the approximate level of the duodenal papilla. The common bile duct and gallbladder contained anechoic fluid without evidence of mucus or calculi, as well as no overt evidence of obstructive duodenal papilla pathology. The common bile duct measured 0.52 cm in diameter.

***Gastrointestinal***

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction, or foreign material. The gastric body wall width measured 0.25 cm.

The visualized small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction, or foreign material. The jejunum wall width measured 0.25 cm. The ileocolic wall width measured 0.39 cm.

Normal visible colon wall layers were present with apparent formed feces in lumen.

***Pancreas***

The pancreas was not definitively visualized owing to peripancreatic artifact and cystic peritoneal mass.

***Free Abdomen***

A large, complex to cystic structure occupying the majority of the peritoneal cavity was present. Concurrent mild to moderate peritoneal free fluid was noted. Intermittent, variably sized, primarily homogeneous isoechoic mesenteric lymph nodes. An example of a mesenteric lymph node measured 1.6 cm x 0.78 cm. The lymph nodes exhibited borderline abnormal width to length ratio (approximately 0.5).

**ULTRASONOGRAPHIC FINDINGS**

***Primary Findings***

- A large, unspecified to complex cystic structure occupying the majority of the peritoneal cavity with concurrent peritoneal free fluid
- Mid to deep hepatic parenchymal cystic mass - benign cystic biliary adenoma vs. potential for cystic biliary adenocarcinoma suspected
- Nondistended gallbladder with variable common bile duct dilation approaching duodenal papilla - nonspecific, not overtly consistent with post hepatic obstruction given lack of reported hepatic enzyme elevations or Icterus
- Bilateral chronic renal changes with focal medullary mineral
- Intermittent mesenteric lymphadenopathy - lymphoid hyperplasia, reactive lymphadenitis, or early neoplastic lymphadenopathy possible

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Given the presence of mid to deep liver parenchymal cystic mass, the unspecified complex cystic structure occupying the majority of the peritoneal cavity may be hepatic in origin, although potential



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for non-hepatic origins such as omental or pancreatic origin or similar cannot be excluded. Benign vs. malignant etiologies for the peritoneal cystic structure are possible. It is suspected that given the size of the peritoneal cystic structure, lymphatic obstruction is suspected resulting in lymphatic obstruction given the severe left rear limb lymphedema.

Abdominal CT is likely ideal for further assessment in this case, yet subjectively the large peritoneal cystic structure does not appear amendable to complete surgical resection.





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**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.

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