



**PATIENT**

Patty Masterson

**SPECIES**

Feline

**BREED**

DLH

**SEX**

FS

**AGE**

13 years

**WEIGHT**

6.04 lbs.

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Jenna Walsh, CVT

**HOSPITAL NAME**

West Salem AC

**REFERRING VET**

Dr. Sirianni

**INVOICE**

15292

**DATE**

10/27/22

**PRESENTING CLINICAL SIGNS**

Grade II/VI parasternal systolic murmur SSP's; Normal respiratory effort. Palpation reveals a slightly distended but non-painful abdomen. There is a soft tissue mass present in the cranial aspect. Kidney palpation was not possible due the mild abdominal distension. Possible Seizures Abdominal Effusion Anemia Abdominal Mass Heart Murmur Lung mass Fleas Dental Disease Radiographic Findings - Abdomen: lateral view reveals moderate hepatomegaly and a moderate overall loss of detail due to abdominal effusion. -Thorax: the previously noted mass in the cranial thoracic cavity is still present and subjectively appears larger. No evidence of pulmonary/pleural edema or metastatic disease. Primary Question/Differential to Be Answered in This Exam 2. Abdominal mass r/o: liver, lymph node, open

Abnormal PE/Chem/CBC/UA Results: Blood work results reveal significant anemia now with a mild progression of her azotemia. BUN 52.4 CREA 2.9 Sodium 162 HCT 18.4 HGB 6.0 RBC 3.72 PLT 92

**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.

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 corticomodullary distinction was also present. The renal medullary volume was subjectively reduced. Mild left kidney pyelectasia was noted. Minor right kidney pyelectasia and lateral cortical cyst were noted. The left kidney was normal in size and measured 3.8 cm in length. The right kidney was mildly subnormal in size compared to the right and measured 3.1 cm in length.

**Adrenal Glands**

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.42 cm width. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.22 cm width.

**Spleen**

The spleen exhibited generalized enlargement yet maintained symmetrical capsule contour with finely textured homogeneous parenchyma. The spleen measured 1.2-1.3 cm width at the level of the hilus. No splenic masses or nodules were noted.



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***Liver/ Gallbladder***

The liver presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without overt evidence of hepatic congestion. Subjective normal volume cranial abdominal caudal vena cava was noted at the level of the liver and diaphragm. The gallbladder was non-distended in size with primarily anechoic luminal content. The cystic and common bile ducts were normal.

***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 0.28 cm.

The 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 small intestinal wall width measured 0.25 cm.

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

***Pancreas***

Moderate asymmetrical enlargement of the pancreas base and right pancreatic limb with nonhomogeneous nodular parenchyma and evidence of pancreatic duct dilation were present. An example of a pancreatic nodule measured 2.2 cm in diameter.

***Free Abdomen***

Multiple, variably sized, hypoechoic mesenteric lymph nodes were present. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. An example of lymph node size was 1.0 cm in diameter. Generalized mild nonuniform hyperechoic mesentery was present. Moderate volume peritoneal free fluid was noted.

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**ULTRASONOGRAPHIC FINDINGS**

***Primary Findings***

- Splenomegaly exhibiting uniform parenchyma
- Non congestive hepatomegaly
- Enlarged nonhomogeneous to nodular pancreas
- Multiple variably sized hypoechoic mesenteric lymphadenopathy



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- Bicavitory effusion - subjectively noncardiogenic

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**Secondary Findings**

**SPECIES**

- Bilateral chronic interstitial nephrosis renal pattern with minor bilateral pyelectasia and small right kidney cortical cyst

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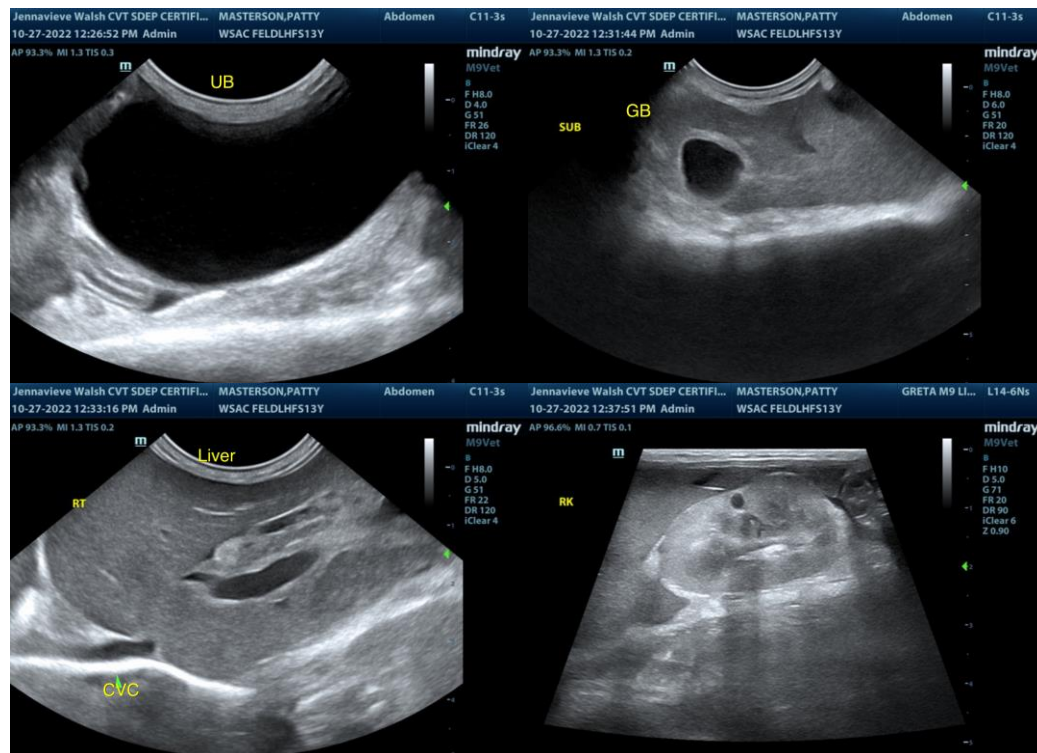
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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Assuming no subnormal albumin levels that would diminish oncotic pressure to the point of causing free fluid, no overt evidence of passive hepatic congestion or significant diffuse hepatic disease, as well as no obvious evidence of gastrointestinal mural pathology that may be responsible for bicavitory effusion. Lymphatic obstruction owing to underlying neoplastic etiology such as carcinomatosis, lymphomatosis, or similar, is of primary concern.

Further assessment may include, assuming normal clotting status and using a 25-gauge needle, hepatosplenic FNA cytology, as well as effusion analysis cytology +/- C/S if clinically indicated. Unfortunately, a likely unfavorable prognosis is indicated.





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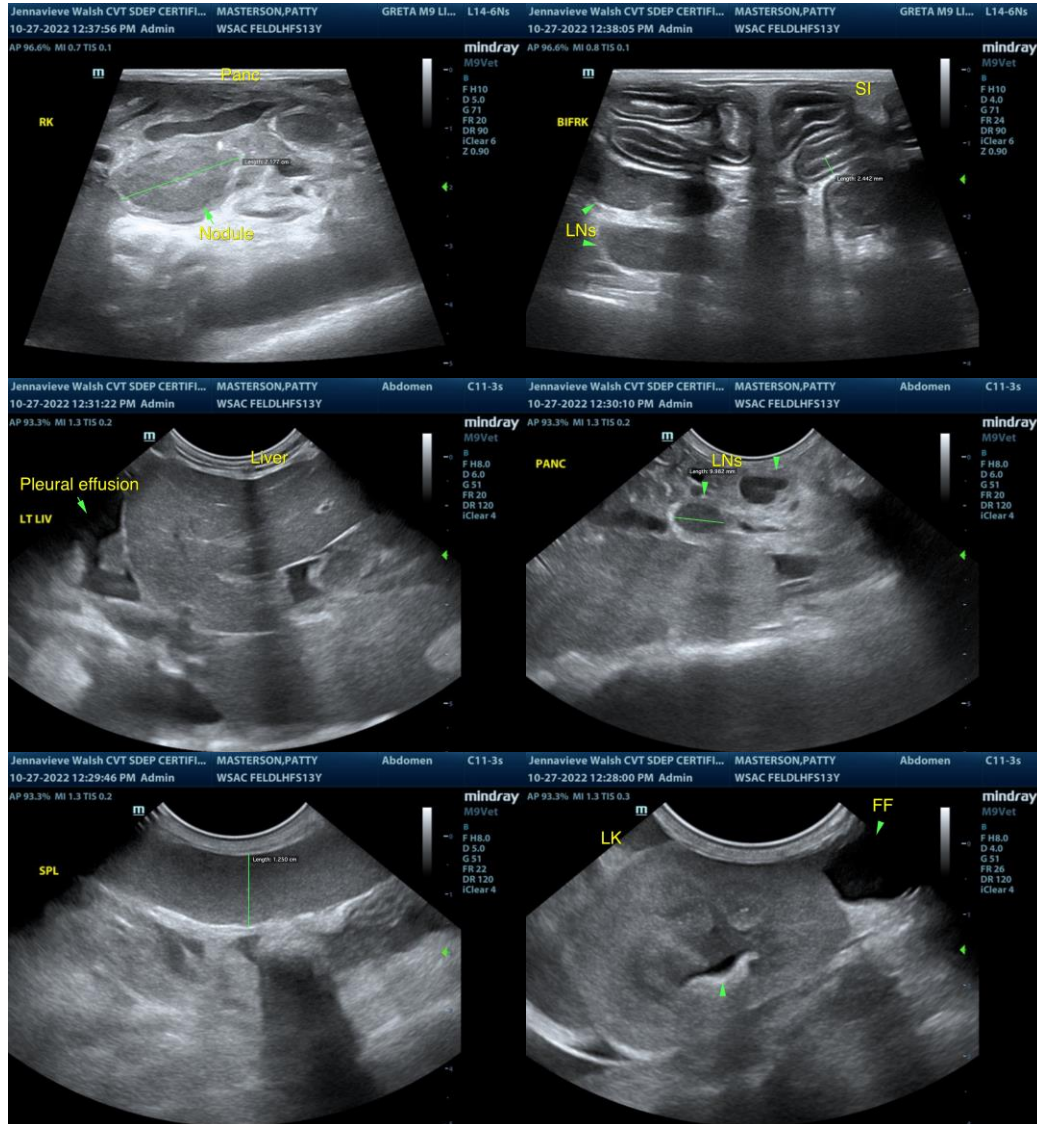
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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