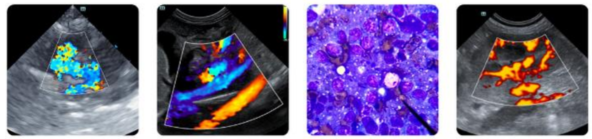


PATIENT

Willow Stewart

SPECIES

Feline

BREED

Persian

SEX

FS

AGE

15.5 y

WEIGHT

9.9 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Karla Schultz

HOSPITAL NAME

Northshore VH

REFERRING VET

Karla Schultz

INVOICE

10672

DATE

3/12/26

PRESENTING CLINICAL SIGNS

History:

- asymptomatic at home; has history of intermittent vomiting but o reports that this has been reduced in frequency for past several months
- mass palpated incidentally at dental procedure last week
- I took FNA samples from the mass today and submitted for cytologic evaluation; several US videos were taken after sampling to confirm no active bleeding (labeled)

Abnormal PE/Chem/CBC/UA Results: -abnormal PE results: 2/6 left parasternal systolic murmur, ~4 cm firm abdominal mass palpated in mid-cranial ventral abdomen, when on her back it is left of midline, 1.3# weight loss from 4/2025-3/2026 -CBC/chem/T4 end of Feb 2026: mild monocytosis (0.6K); mild azotemia (SDMA 19, creat 1.8, BUN 22) -mass cytology- submitted, pending -full body rads- submitted, pending. Initial impression- quiet lungs, no mineralization of mass

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 were noted.

No evidence of pathology in the area of the aortic trifurcation.

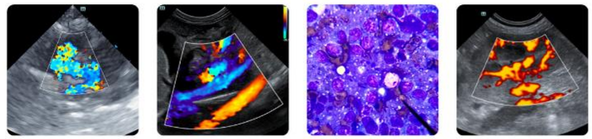
Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. A mild hyperechoic corticomedullary band, consistent with a medullary rim sign, was present. This is a nonspecific finding seen in both normal and abnormal kidneys. It may be associated interstitial renal disease, hypercalcemia, tubular necrosis, lymphoma, and FIP. However, it is a nonspecific finding. The left kidney measured 3.1 cm in length. The right kidney measured 3.2 cm in length.

Adrenal Glands

No obvious pathology was noted in the area of the left or right adrenal glands.

Spleen

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. A solitary, cranial medial, non-capsule deforming, hyperechoic nodule was present, measuring 0.62 cm in diameter. The spleen was overall normal in size with a mild asymmetrical medial capsule contour. Within the area of the caudal spleen, a well-demarcated, primarily spherical, homogenous hyperechoic mass appearing to derive from the caudal spleen was present, measuring ~4.5 cm in diameter. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory or neoplastic changes were not noted. The echogenic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas. The spleen measured 0.8 cm width at the level of the mid-spleen.



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Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. Normal hepatic vascular volume was present. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size containing primarily anechoic content with minor gallbladder debris. 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 was empty without evidence of retained ingesta, fluid, or foreign material.

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. Mild duodenal corrugation was noted. There is no evidence of mechanical / metabolic ileus to the level of the colon. The duodenum wall measured 0.24 cm width. The jejunum wall measured 0.23 cm width.

Normal visible colon wall layers were present with formed feces 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

No significant omental lymphadenopathy was visualized. No evidence of peritoneal effusion was present.

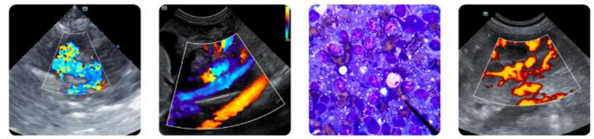
ULTRASONOGRAPHIC FINDINGS

- Hyperechoic spherical mass area of cranial spleen – most consistent with hyperechoic splenic mass
- Non-capsule deforming, similar appearing hyperechoic splenic nodule
- Normal gastrointestinal tract with mild duodenal corrugation – possible mild duodenitis
- Bilateral nonspecific renal medullary rim sign

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The splenic mass and nodule are nonspecific with considerations including nodular hyperplasia, expansive caudal splenic and focal cranial splenic myelolipomas, granuloma, or neoplasia. A non-splenic hyperechoic mass, i.e., omental mass or other unspecified mass impinging upon the spleen is thought less likely. Correlation with pending cytology is recommended.

A GI panel to include PLI/TLI/Cobalamin/Folate to assess for nonstructural intestinal disease or mild pancreatitis as a contributing factor to the mild weight loss may be considered. As-needed GI support is recommended. Urinary workup including urinalysis +/- urine C/S or UPC level for renal staging is recommended. Pending cytology, laparotomy with expectation towards splenectomy with perioperative renal support and monitoring could be considered.



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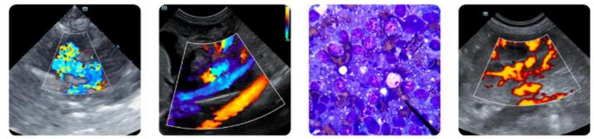

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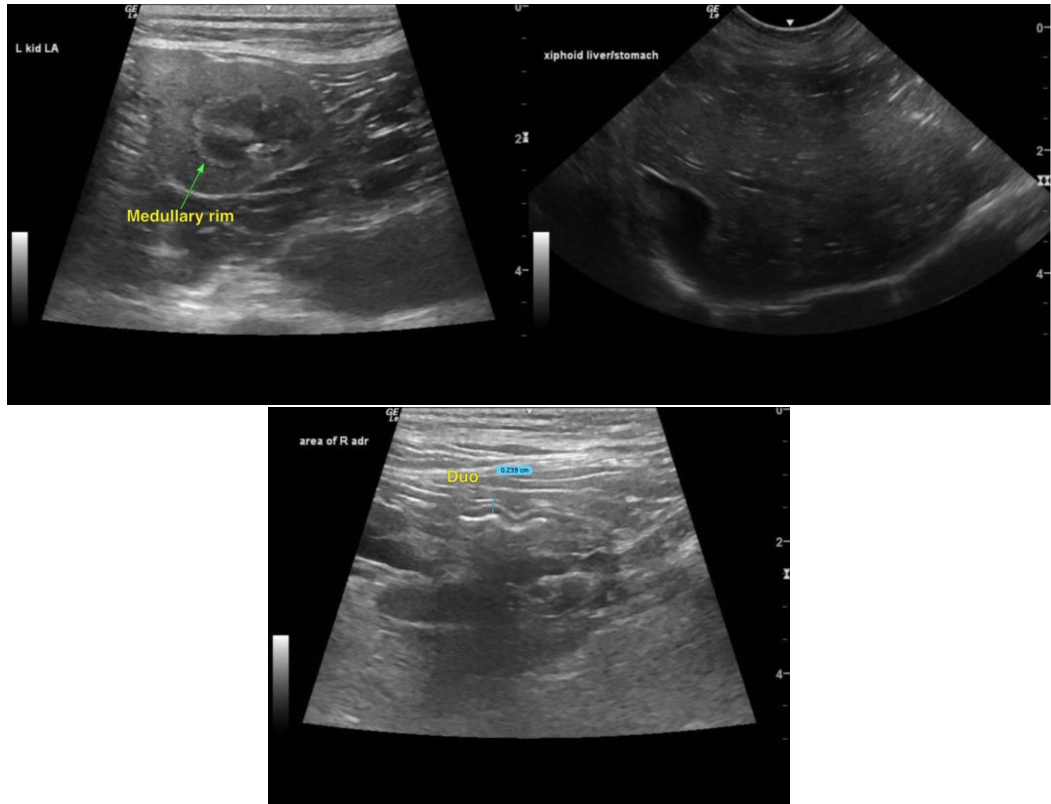

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
info@sonopath.com