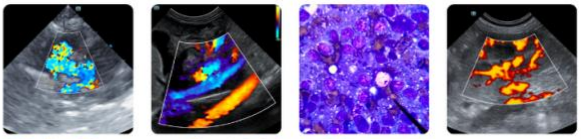

PATIENT

Crush Otero

SPECIES

Feline

BREED

DLH

SEX

Male

AGE

13 Years

WEIGHT

10 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Julissa Díaz LVT

HOSPITAL NAME

Centro Veterinario del Norte

REFERRING VET

Joanne Fernandez López, DVM

INVOICE

15194

DATE

04/17/26

PRESENTING CLINICAL SIGNS

Crush presented for abdominal ultrasound and re-evaluation. Pet has been lethargic and showing anorexia due to mass in abdomen and ascites. After abdominocentesis of approximately 1,000 mls last week, started to eat a bit. ultrasound to help us guide treatment plan and level of involvement with other organs.

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 change were noted.

The area of the aortic trifurcation was free of pathology.

Normal size and margination was 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 mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 3.6 cm in length. The right kidney measured 4.3 cm in length.

Adrenal Glands

The left and right adrenal glands were not definitively visualized.

Spleen

The spleen was mildly subnormal in size (suggestive of volume contraction) and 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.

Liver & Gallbladder

The liver presented enlarged in size. An intraparenchymal mass was present in the mid to cranial liver exhibiting nonhomogenous echogenicity measuring approximately 4.0 cm in diameter. A nonhomogenous cystic appearing mass was present occupying a majority of the mid to cranial abdomen and appearing to efface or connect to the liver measuring approximately 9.0 cm in diameter.

The gallbladder was non-distended in size containing mild bile sediment. The common bile duct was not visualized.

Gastrointestinal

The stomach was not definitively visualized likely secondary to gastric displacement, secondary to the abdominal mass.

The visualized segments of small intestine presented intact wall layering with empty lumen and subjective mildly prominent muscularis layer yet without evidence of intestinal wall thickening. The small intestine wall measured 0.23 cm wall width.

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

Pancreas

The pancreas was not definitively visualized owing to abdominal mass.

Free Abdomen

No obvious visualized significant or swollen mesenteric lymphadenopathy was present. A mild volume of peritoneal effusion was present. Normal to mildly hypoechoic omental echogenicity.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Probable large to caudally expansive liver mass with concurrent mid to cranial intraparenchymal liver mass.
- Mild volume of effusion.

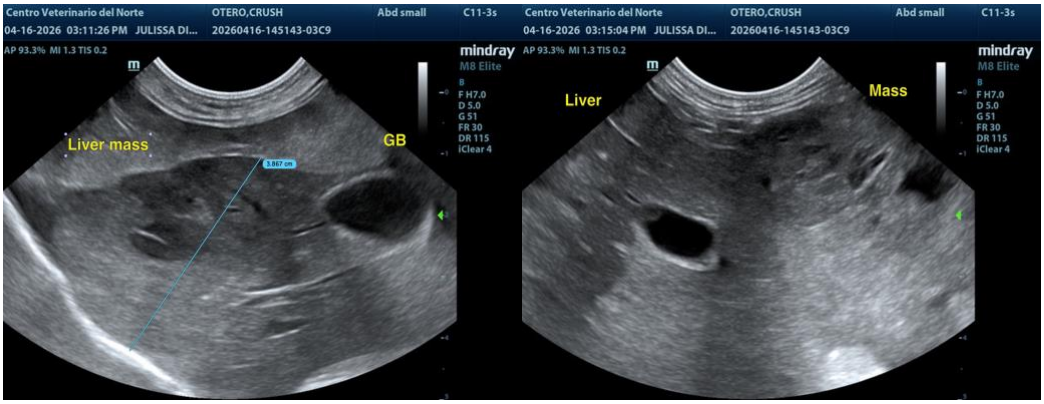
Secondary Findings

- Nondistended gallbladder with mild bile sediment.
- Mild chronic renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Non-hepatic origin for the primary abdominal mass with caudal hepatic effacement and concurrent hepatic intra-parenchymal primary or metastatic mass is thought less likely yet not yet technically not excluded.

Assuming normal clotting status, mass FNA cytology could be considered for further clarification. Extensive neoplastic criteria with potential for carcinomatosis or similar or effusion secondary to portal hypertension given albumin level is possible. Concurrent correlation with abdominal effusion +/- cytospin cytology could be considered. Gastrointestinal support is indicated.



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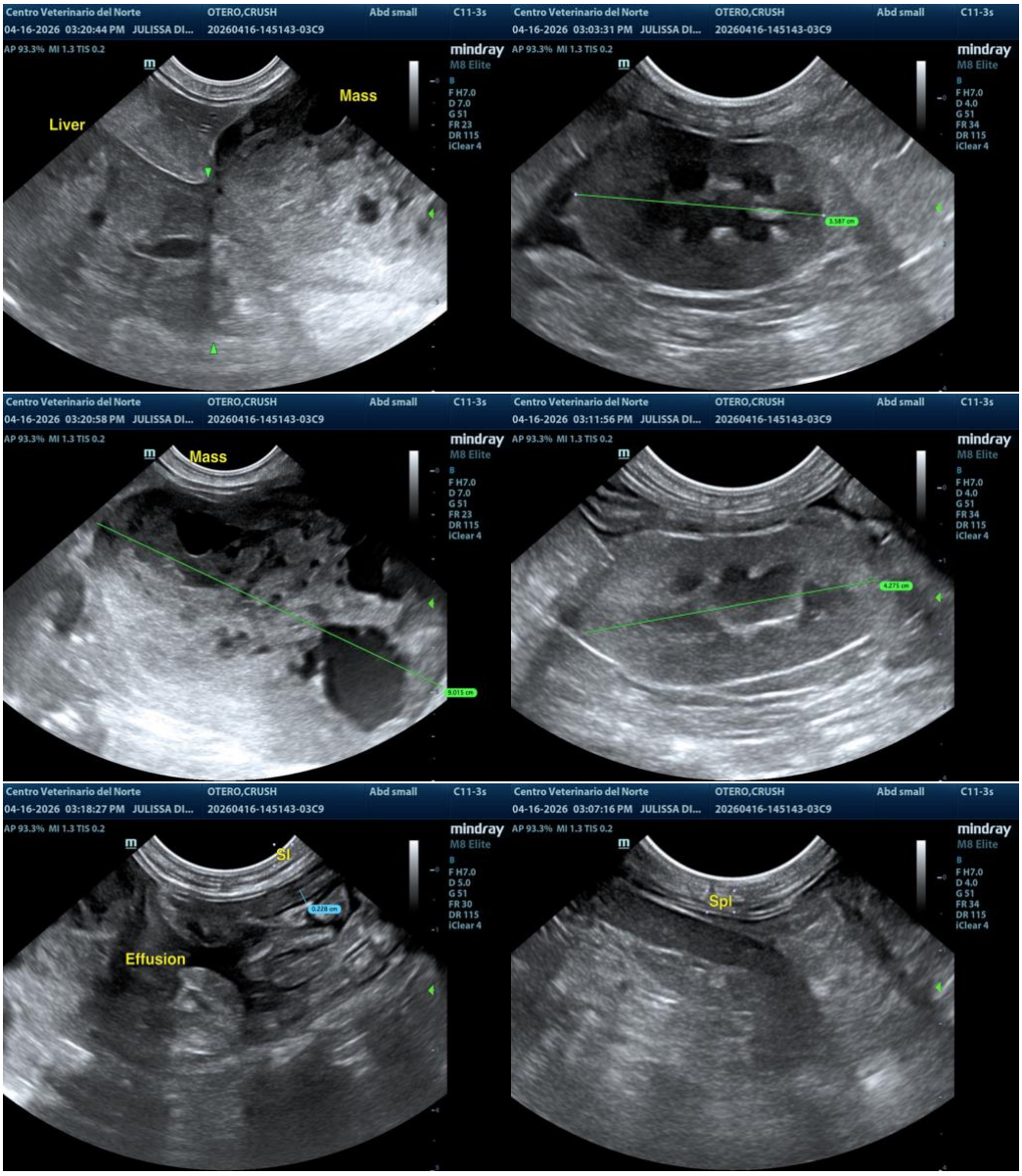

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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