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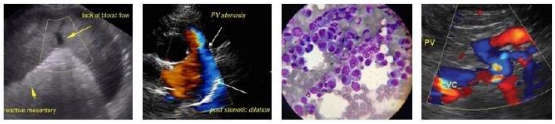

THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

**PATIENT**

Tino Stojanovic

**SPECIES**

Feline

**BREED**

DSH

**SEX**

MN

**AGE**

21 yr

**WEIGHT**

3.09 kg

**INTERPRETED BY**

R. McKenzie Daniel, DVM, DABVP

**IMAGING PERFORMED BY**

Crystal HIll

**HOSPITAL NAME**

Sixteen Mile VC

**REFERRING VET**

Dr. Gibbs

**INVOICE**

14880

**DATE**

9-15-22

## PRESENTING CLINICAL SIGNS

Investigate suspected abdominal mass. No meds currently.
Abnormal PE/Chem/CBC/UA Results: Mild non-regenerative anemia, mild hypoalbuminemia otherwise WNL.

## 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. Marked loss of corticomedullary distinction was also present. The renal medullary volume was subjectively reduced. Minor bilateral pyelectasia was present. Pinpoint medullary mineral was also noted in both kidneys. Intermittent small cortical cysts were noted in both the left and right kidneys. The left kidney was contained within a large anechoic cyst-like cavity. The cyst-like cavity surrounding the left kidney measured 7.5 cm length. The left kidney was mildly subnormal in size compared to the right measuring 3.1 cm in length. The right kidney measured 3.8 cm in length.

### *Adrenal Glands*

The left adrenal gland was not definitively visualized. A possible small nonhomogeneous mass was present in the area of the right adrenal gland measuring 1.9 cm in diameter.

### *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 0.6 cm width at the level of the hilus.

### *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 to potential several spherical, well-demarcated, nonhomogeneous, echogenic to cystic intraparenchymal nodules were noted with an example measuring 2.6 cm in diameter. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

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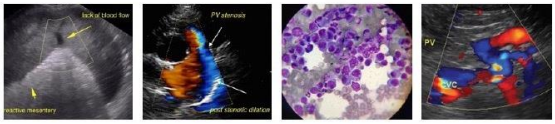

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### *Gastrointestinal*

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild to moderate ingesta exhibiting mild progressive distal acoustic shadowing likely consistent with food with potential for hairball density if a clinical history of hairballs. No evidence of mechanical pyloric outflow obstruction was noted.

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*

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia. This is likely consistent with age-related pancreatic changes and incidental.

### *Free Abdomen*

No significant lymphadenopathy was present. Intermittent small pockets of scant peritoneal free fluid were noted. No evidence of omental masses was noted.

Nonspecific subjective subcutaneous lesion was present in the right craniolateral abdomen to caudolateral thorax. The subjective subcutaneous mass lesion appeared to be mildly vascular on power doppler with potential for echogenic fluid component. The lesion measured approximately 5.0-6.0 cm in diameter.

## ULTRASONOGRAPHIC FINDINGS

- Left kidney perinephric pseudocyst, likely chronic interstitial nephritis
- Right kidney marked chronic degenerative renal changes - suspect chronic interstitial nephritis
- Hepatic parenchymal remodeling with probable benign cystic biliary adenoma / adenomas
- Possible indistinct nonhomogeneous small mass in the area of the right adrenal gland
- Ill-defined subjective subcutaneous mass right abdomen / caudal thorax - cellulitis, potential for suppurative cellulitis, neoplasia, or other

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Aside from the perinephric pseudocyst and probable benign hepatic cystic biliary adenomas, no overt evidence of large intraabdominal masses.

Screening blood pressure to assess for evidence of hypertension, given possible yet not definitive small nonhomogeneous mass lesion in the area of the right adrenal gland, is recommended.
Percutaneous drainage of the left perinephric pseudocyst could be considered. Monitoring of renal parameters going forward is advised. Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.

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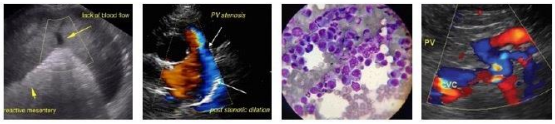

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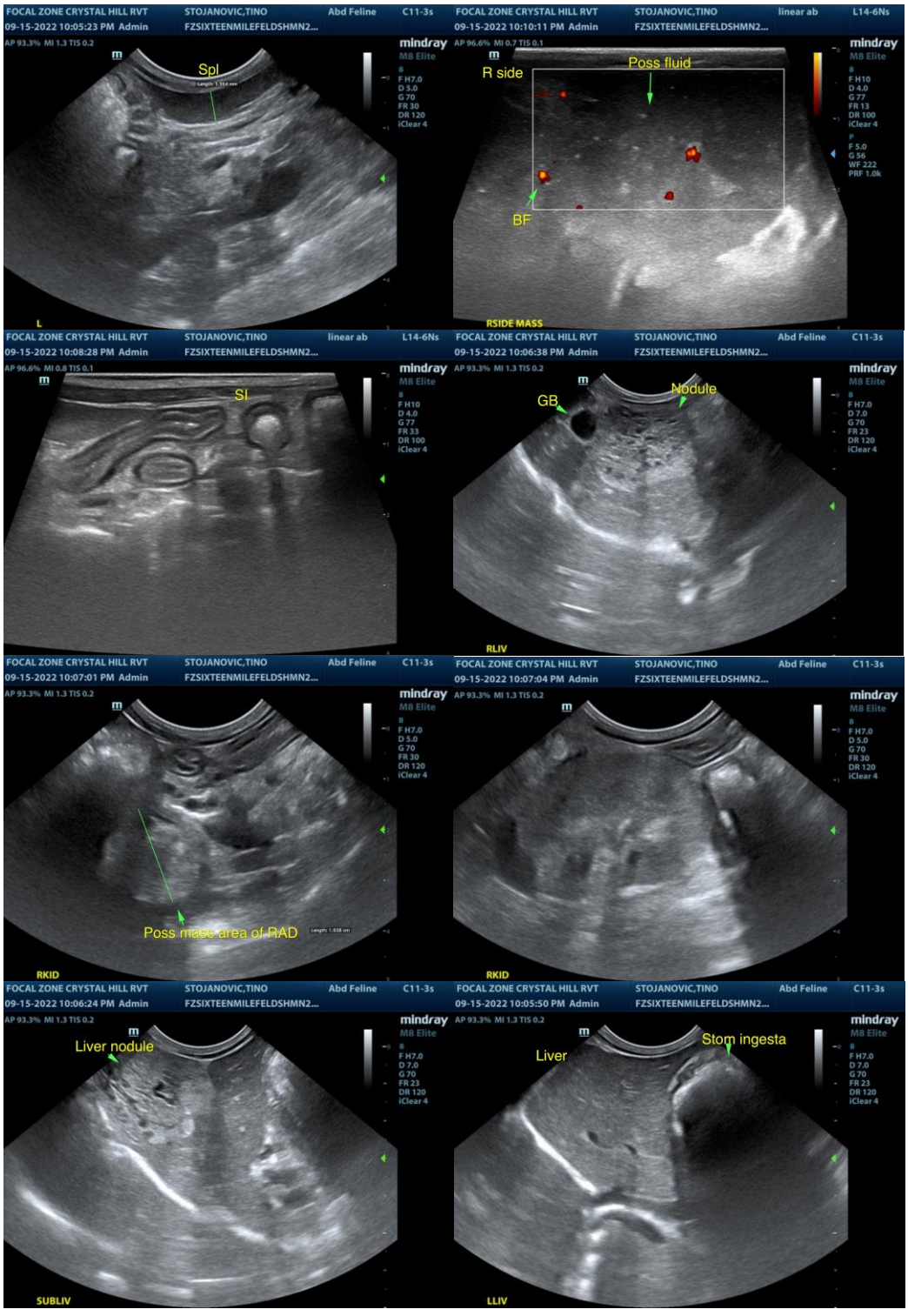
FNA of the nonspecific subjective subcutaneous right abdominal to caudal thoracic lesion for cytology +/- C/S, if evidence of inflammatory cells, may be considered.



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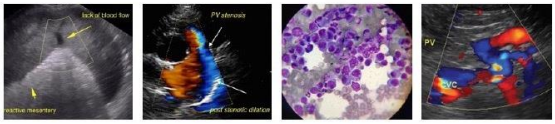

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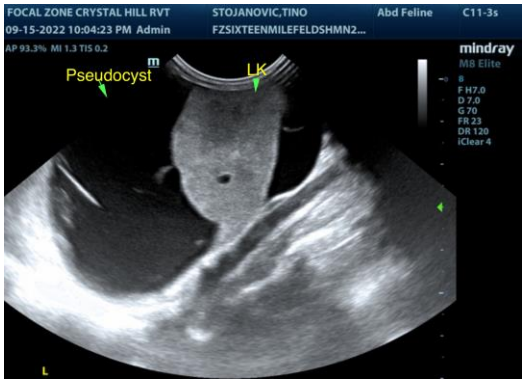


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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**