

## PATIENT

Willow Waters

## SPECIES

Feline

## BREED

Siamese

## SEX

Spayed Female

## AGE

13 Years 4 Months

## WEIGHT

7.5 lbs

## INTERPRETED BY

Tam Mengine, DVM,  
DABVP (canine/feline  
practice)

## IMAGING PERFORMED BY

Dr. Michael  
Wasserman

## HOSPITAL NAME

Highlands Animal  
Hospital

## REFERRING VET

Dr. Cindy Wasserman

## INVOICE

72115

## DATE

1/11/26

## PRESENTING CLINICAL SIGNS

Sedated with 0.1ml butorphanol 10mg/ml 1/2 IV first, then 1/2 IM. Adequate sedation for imaging. Initial complaint was head twitching yesterday. Firm "long" irregular abdominal mass palpated on right side of abdomen on exam. Treatment initiated 1/10/26 with clavamox, B12 injection, famotidine injection, 100ml LRS SC once

Abnormal PE/Chem/CBC/UA Results: HCT: 31% calculated, HGB 10.6, PLT 98k, Creat 2.8, BUN 44, UR SG 1.020 WBC 2 per hpf, 14rbc per hpf, BP 120 mmhg average,

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder is moderately distended with anechoic urine, and luminal sediment is not present. The bladder wall is focally thickened, and there is a 1.0 cm x 6.4 mm wide based mass arising from the apex. There is evidence of blood flow on doppler interrogation. The ureteral papillae, trigone and pelvic urethra are of normal appearance, and the ureters are not visible (normal). No calculi are noted. Urethra visualized to 3.0 cm.

The right kidney is hyperechoic, and exhibits mildly decreased cortico-medullary differentiation. There is no evidence of nephrolithiasis, mineralization, pyelectasia or hydronephrosis. The proximal ureters are not visible (normal).

There is a 3.1 cm x 3.0 cm cystic structure arising from a fluid-filled tube that has the architecture typical of a hydronephrotic kidney. Based on the location, this structure is suspected to represent the left kidney. There is no visible cause for ureteral obstruction seen within the clips provided.

### Adrenal Glands

The adrenal glands are both identified in their normal locations. They are normal in size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. Left measures 4.9 mm. Right measures 4.5 mm.

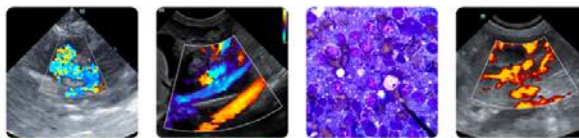
### Spleen

The spleen is of appropriate size (6.5 mm) and has a normal, homogenous parenchyma with a smooth, continuous capsular surface. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal. Thickness at the splenic hilus is normal.

### Liver

The liver is of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.



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## Gastrointestinal

The stomach is empty. The gastric wall is subjectively normal in thickness, and exhibits appropriate wall layering, but cannot be accurately measured due to normal deviations of the rugal folds. The pylorus is of normal appearance.

The visualized portions of the duodenum, jejunum, and ileum are of normal thickness with intact wall layering that exhibits the appropriate 1:3 muscularis to mucosa ratio. Intestinal motility appears normal.

The visible portions of the colon are of normal thickness with intact wall layering. The ileocecal junction is not seen.

## Pancreas

The pancreas is not distinctly visualized, but there is hyperechoic omental fat observed in the region of both limbs of the pancreas.

## Free Abdomen

There is no free fluid noted within the abdomen. There is hyperechoic, inflamed omental fat noted in the region of the cranial abdomen. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

## PRIMARY FINDINGS

- Cystic mass arising from a fluid-filled tubular structure, that has the architecture of a hydronephrotic kidney (left kidney suspected) - see attached picture
- Apical bladder mass, which may represent an inflammatory polyp or a neoplastic lesion
- Marked steatitis in the cranial abdomen, particularly in the region of the pancreas, which partially obscured assessment of some viscera - suspect severe, acute pancreatitis

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

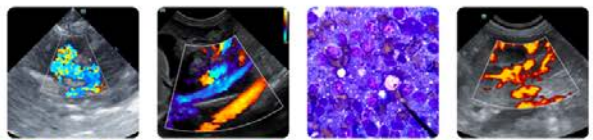
While not definitive, the architecture and location of the cystic mass is suspicious for a hydronephrotic left kidney. While the bladder mass is apical, it is possible that there is microscopic involvement in the region of the left ureter, leading to obstruction - or, there may be a clot or ureterolith present. Tracing the suspected ureter, with Doppler to help differentiate it from blood vessels, would be suggested, to determine whether it can be traced back to the bladder, or to an obstructive lesion.

Definitive diagnosis for the bladder lesion can be challenging - fine needle aspiration carries the risk of tumor seeding if it is indeed a malignancy. Surgical biopsy could be considered for definitive diagnosis, and could also be used to further evaluate (and potentially remove) the cystic mass.

The marked steatitis in the region of the pancreas suggests concurrent pancreatitis, or possibly pancreatic neoplasia. A serum pancreatic marker would be recommended, as well as fine needle aspiration of the pancreas if this can be achieved (or potentially a biopsy if surgical exploratory is pursued).

## ADDENDUM TO REPORT 1/12/26

37 additional images were sent, predominantly of the left kidney, left ureter, and urinary bladder, as well as several images of the cranial abdomen.



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While the liver is well visualized, the adjacent structures continue to be obscured by a large amount of hyperechoic omental fat, consistent with steatitis.

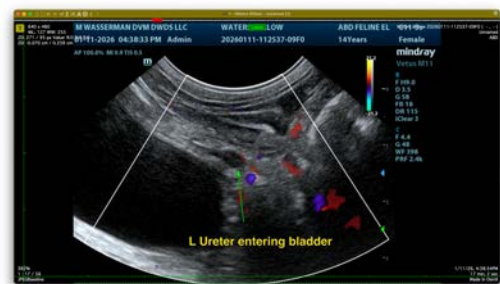
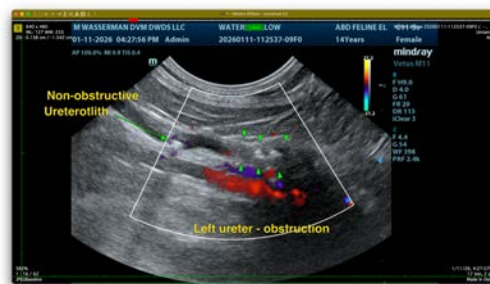
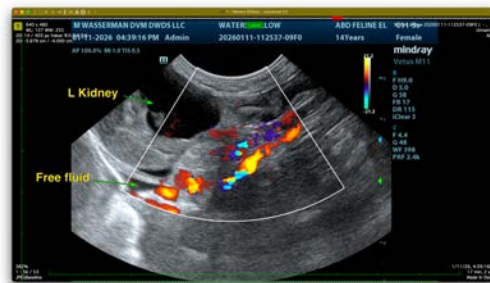
The hydronephrotic left kidney is identified and now has free fluid around it. The left ureter is traced from the kidney to the bladder, and multiple non-obstructive ureteroliths are identified. There is also what appears to be a small cluster of multiple ureteroliths as well as soft tissue such as cells or mucus, and this appears to be causing an obstruction. The mildly dilated ureter can also be seen entering the bladder, but there is no visible obstruction noted at that level.

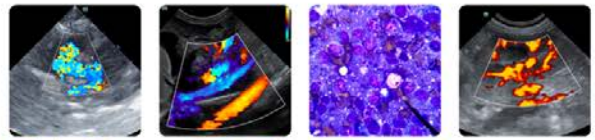
**ADDITIONAL FINDINGS**

- Ureteral obstruction with multiple ureteroliths.
- Large amount of steatitis in the cranial abdomen, likely secondary to pancreatitis.
- Free fluid around the nephrotic left kidney that was not visible on the initial set of images, suggesting active inflammation associated with the renal pathology.

**ADDITIONAL RECOMMENDATIONS**

Aggressive diuresis could be considered as a means to resolve the hydronephrosis. However, if the patient is not responding to this therapy, then nephrectomy or ureteral stenting may be necessary. The concurrent steatitis in the cranial abdomen appears to support pancreatitis. If not already performed, a serum pancreatic marker would be recommended to further investigate this. Pancreatic neoplasia would also be a possibility. Of note, the additional images of the bladder do not demonstrate the mass effect that was observed in the initial image set. The bladder is not scanned in its entirety, so it may be that these lesions simply were not visible in the additional clips, but it is also possible that there were blood clots that have since resolved, and that the doppler visible on them in the initial image set was in fact a motion artifact and not due to blood supply. Given that there are multiple ureteroliths clearly visible, this could be a reason for blood clot formation within the bladder.





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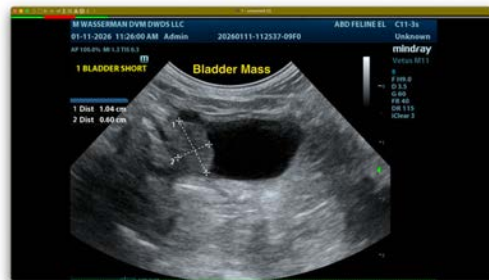
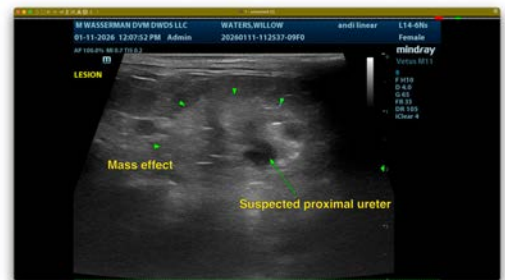
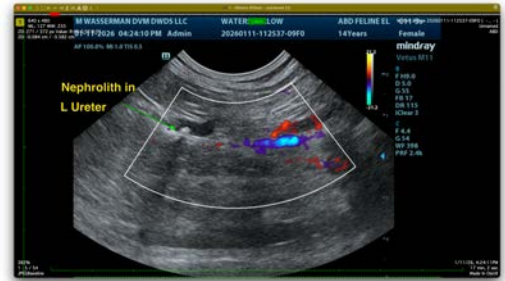
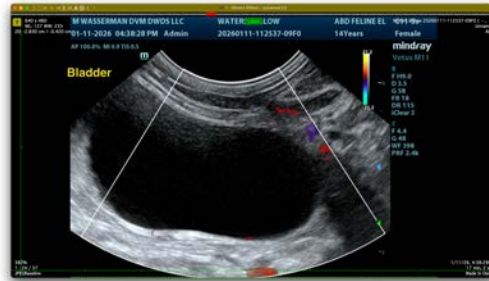
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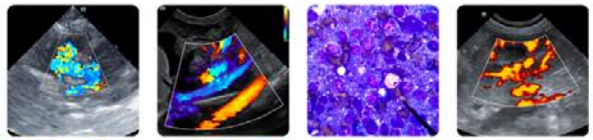
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**Tam Mengine, DVM, DABVP (canine/feline practice)**

info@SonoPath.com