



**PATIENT**

Tiger Dooley

**SPECIES**

Feline

**BREED**

DSH

**SEX**

Neutered Male

**AGE**

15 Years

**WEIGHT**

10.8 lbs

**INTERPRETED BY**

Eric Lindquist, DMV,  
DABVP (CFM), Cert.  
IVUSS

**IMAGING PERFORMED BY**

Eric Lindquist, DMV,  
DABVP (CFM), Cert.  
IVUSS

**HOSPITAL NAME**

Franklin Lakes Animal  
Hospital

**REFERRING VET**

Dr. Hudson

**INVOICE**

72236

**DATE**

1/15/26

**PRESENTING CLINICAL SIGNS**

ADR, weight loss, hx of mild azotemia, hyporexia. New heart murmur.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The **urinary bladder** revealed a small calculus measuring 0.67 cm, non-obstructive. The bladder was structurally unremarkable. The pelvic urethra was imaged 2.0 cm beyond the cystourethral junction.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for his age patient. Medullary structure differed distinctly from that of the cortex. Left kidney measured 3.0 cm with slight pyelectasia. Right kidney measured 4.36 cm with mineralization noted.

**Adrenal Glands**

The **left adrenal gland** was visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. Left measured 0.30 cm.

The region of the **right adrenal gland** was unremarkable.

**Spleen**

The **spleen** was mildly enlarged (1.24 cm) with uniform, but subtly micronodular parenchyma, and undulating capsular contour. This is consistent with reactive spleen owing to immune stimulus or early infiltrative disease such as mast cell disease or lymphoma. 25-gauge FNA would be ideal if weight loss is an issue to differentiate early round cell neoplasia versus splenitis or reactive spleen all of which can present in this manner.

**Liver**

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some age-related parenchymal remodeling was noted but likely not clinically significant at this time. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable.

**Gastrointestinal**

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.



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**Pancreas**

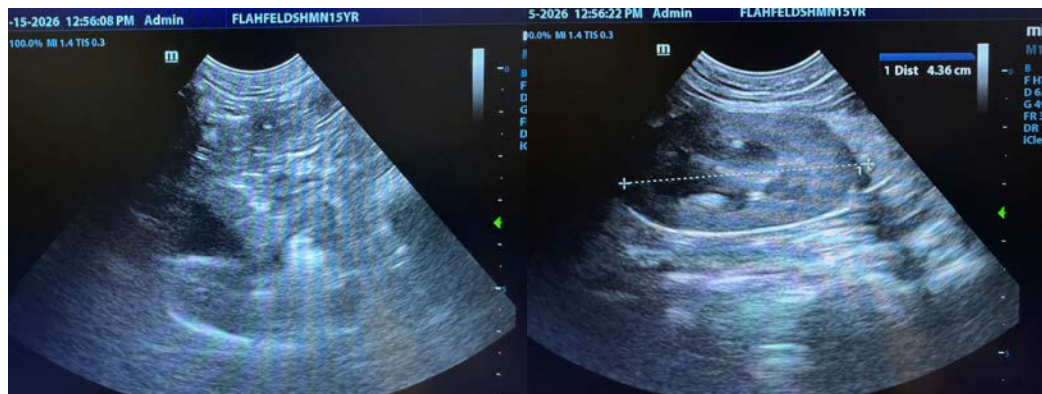
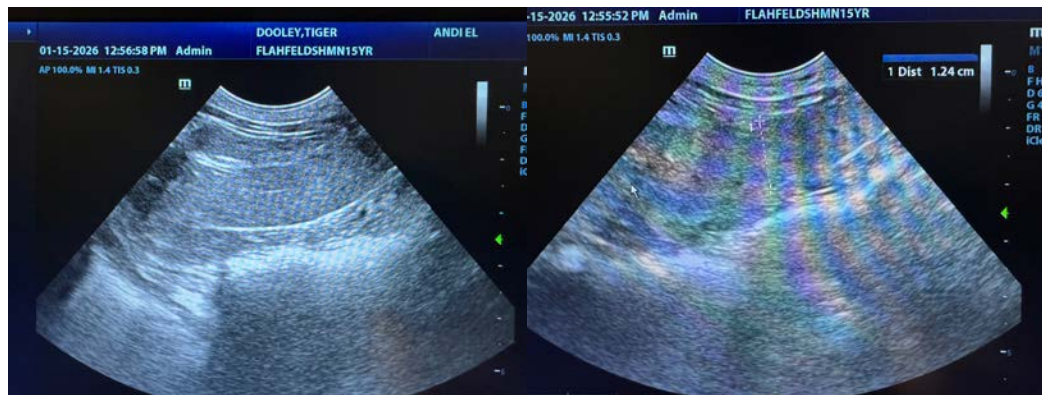
The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

**ULTRASONOGRAPHIC FINDINGS**

- Mild splenic enlargement – reactive spleen, round cell neoplasia or splenitis all possible.
- Mild degenerative renal disease on the right and moderate on the left.
- Urinary bladder calculus.
- Age related hepatic changes.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

FNA of the spleen would be indicated, given patient history.





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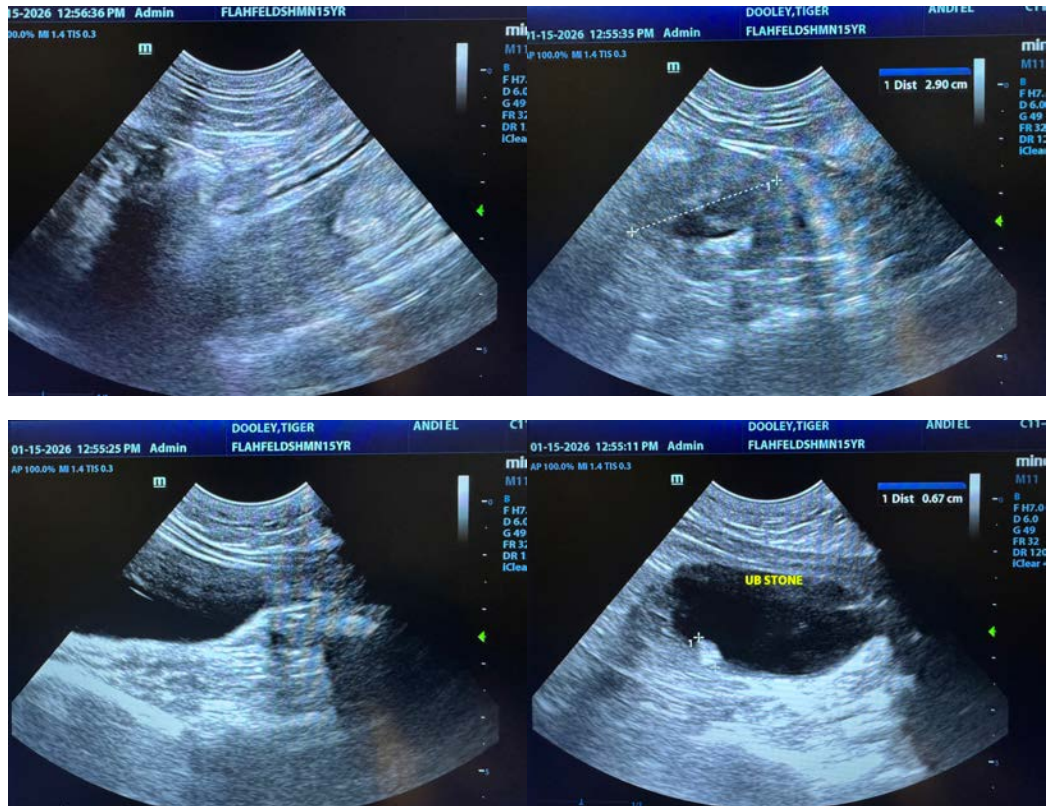
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**Eric Lindquist, DMV, DABVP(CFM), Cert. IVUSS,**  
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