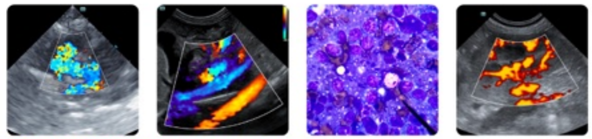


PATIENT
Mittens Hashagen

SPECIES
Feline

BREED
Domestic Longhair

SEX
Female

AGE
10 years

WEIGHT
8.2 lbs

INTERPRETED BY
Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY
Dr. Levy

HOSPITAL NAME
Court Street VH

REFERRING VET
Dr. Shonk

INVOICE
70288

DATE
1/19/26

PRESENTING CLINICAL SIGNS

Weight loss
Regurgitation of undigested food
Dental disease
Mild anemia (6.41 M/uL, RI: 6.5-11.56) Eosinophilia (2.087 K/uL, RI: 0.209-1.214) Thrombocytosis (495 K/uL, RI: 100-440) Elevated ALT (281 U/L, RI: 27-158) Elevated AST (71 U/L, RI: 16-67) Elevated ALP (79 U/L, RI: 12-59) USG 1.033, Creat 1.2, SDMA 10

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes was noted. Ureteral papillae were normal.

The **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The left kidney measured 3.8 cm. The right kidney measured 3.5 cm.

Adrenal Glands

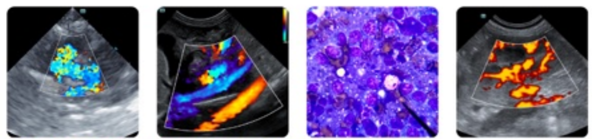
The regions of the **adrenal glands** were imaged with no evidence of pathology.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes was noted. The spleen measured 0.8 cm in width.

Liver

The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.



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Gastrointestinal

The **gastrointestinal** presentation revealed mild uniform prominence of the gastric mucosa as well as areas of "ropey" small intestinal wall. The muscularis layer was hypertrophied inverting the normal ratio (1:3). The intestinal submucosa was slightly irregular, thickened and hyperechoic suggestive of low grade, chronic inflammation. No evidence of obstruction was present. Chronic inflammatory bowel disease is probable with a low possibility of an early neoplastic event such as lymphoma or, less likely, dry form FIP can at times be found on biopsy of these presentations. Full thickness tissue biopsies via open laparotomy, ideally guided by intraoperative ultrasound in order to obtain the most representative mural sample, would be necessary to rule more significant disease than IBD.

Pancreas

The **pancreas** was heterogenous with parenchymal changes at the right base. Subxiphoid palpation is recommended. There were no overt masses noted.

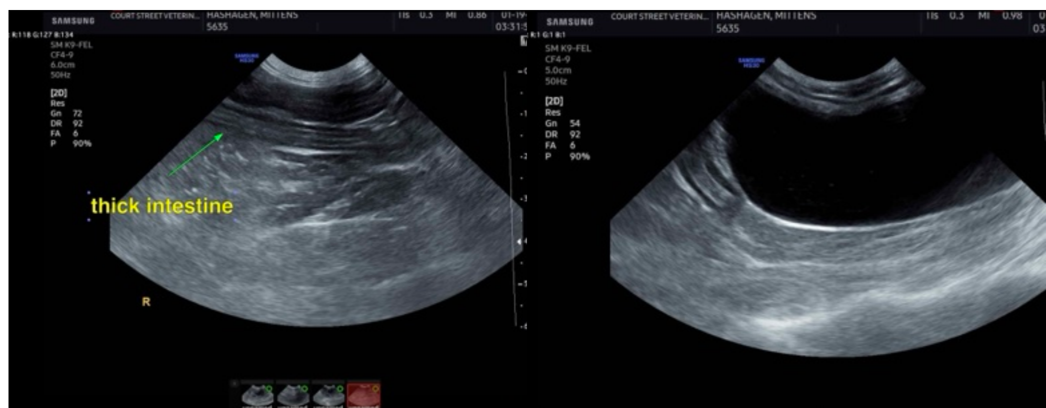
ULTRASONOGRAPHIC FINDINGS

Prominent pancreas.

Thickened intestine. Inflammatory bowel type presentation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Full thickness intestinal biopsies would be necessary for a definitive diagnosis. However, no overt neoplastic criteria is present at the time of the sonogram. Management for inflammatory bowel and potential low-grade pancreatitis is indicated or full thickness GI biopsies. CBC path review 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.

Eric Lindquist, DMV, DABVP (CFM), Cert. IVUSS, CEO of SonoPath.com

info@SonoPath.com