



**PATIENT**

Madder Wall

**SPECIES**

Feline

**BREED**

Domestic Longhair

**SEX**

Spayed Female

**AGE**

15 years

**WEIGHT**

8.4 lbs

**INTERPRETED BY**

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

**IMAGING PERFORMED BY**

Dr. Ebersole

**HOSPITAL NAME**

Scanvet

**REFERRING VET**

Dr. Goodman

**INVOICE**

92210

**DATE**

10/6/21

**PRESENTING CLINICAL SIGNS**

History: Not eating, diarrhea and weight loss. History of seasonal asthma, on Prednisolone 2.5mg PO SID for last few weeks. Hasn't eaten well for awhile, has lost 3lbs. On Mirtazapine, Metronidazole, Cerenia, and received Convenia inj and SQ fluids on Friday.  
PE: BCS 2-3/9, muscle wasting. BW wnl

**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 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 this age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The left kidney measured 3.87 cm. The right kidney measured 3.86 cm. A cortical infarct was noted in the dorsal cortex of the left kidney.

**Adrenal Glands**

Both **adrenal glands** were 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. The right adrenal gland measured 0.47 cm.

**Spleen**

The **spleen** was mildly enlarged 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. The spleen measured 0.93 cm and was at the upper limits of normal.

**Liver**

The **liver** presented heterogenous parenchyma with increased portal markings and coarse architecture. Slight undulating capsular contour was noted. The gallbladder and common bile duct were unremarkable. This is consistent with chronic inflammatory hepatopathy.

**Gastrointestinal**

The **gastric** wall was relatively normal in thickness and measured 0.5 cm with increased submucosal echogenicity and thickness. Variable areas of the small intestine revealed early mural detail loss and



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nebulous submucosal changes with hypertrophied muscularis. Regional lymphadenopathy was noted. The mesenteric lymph nodes were rounded, hypoechoic and measured up to 0.7 cm.

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**Pancreas**

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The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Some parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxiphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

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**ULTRASONOGRAPHIC FINDINGS**

Spayed Female

Variable gastrointestinal thickening with regional lymphadenopathy.

**AGE**

Left renal infarct.

15 years

Mild to moderate degenerative renal changes.

Subacute on chronic inflammatory bowel.

**WEIGHT**

8.4 lbs

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

**INTERPRETED BY**

Intraoperative ultrasound and gastrointestinal biopsies would be ideal in this patient as some intramural pathology would not be visible from a surgical eye. The majority of the gastrointestinal tract is most consistent with inflammatory bowel; however, I am concerned for emerging round cell neoplasia. Screening FNA of the spleen can be considered and accessible lymph nodes with cytology +/- PCR evaluation if lymphoma is a potential, yet not definitive. Emerging intestinal lymphoma, dry form FIP, mast cell disease are all potentials. The Prednisolone may be suppressing a more significant presentation. Guarded prognosis.

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

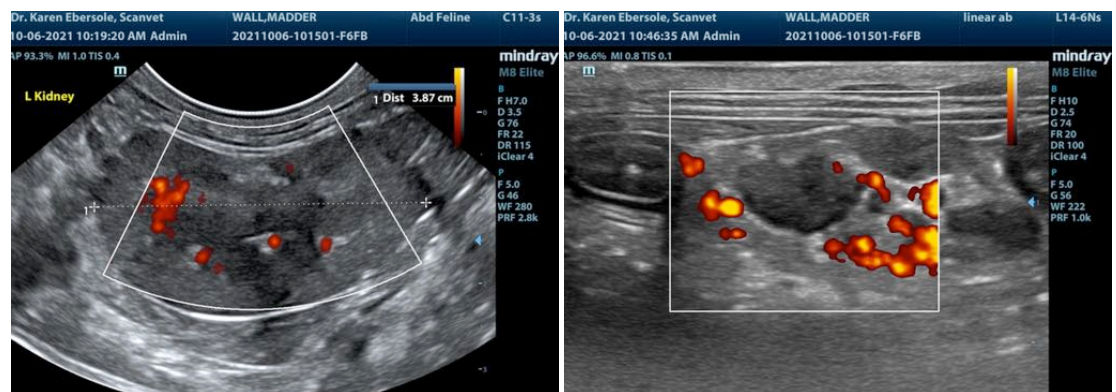
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Maldigestion panel, three view chest radiographs and full CNS examination is recommended to examine for occult disease that could be responsible for the weight loss. Evaluation for competitive eating environments should also be considered.

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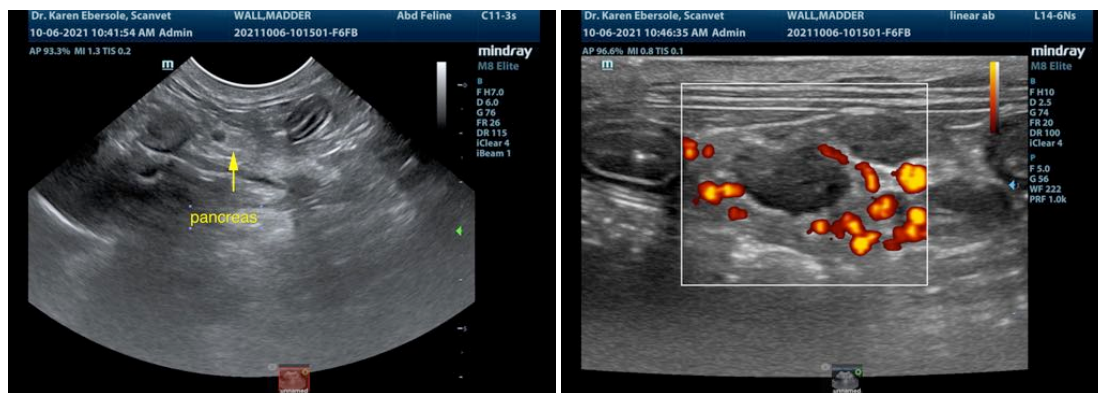
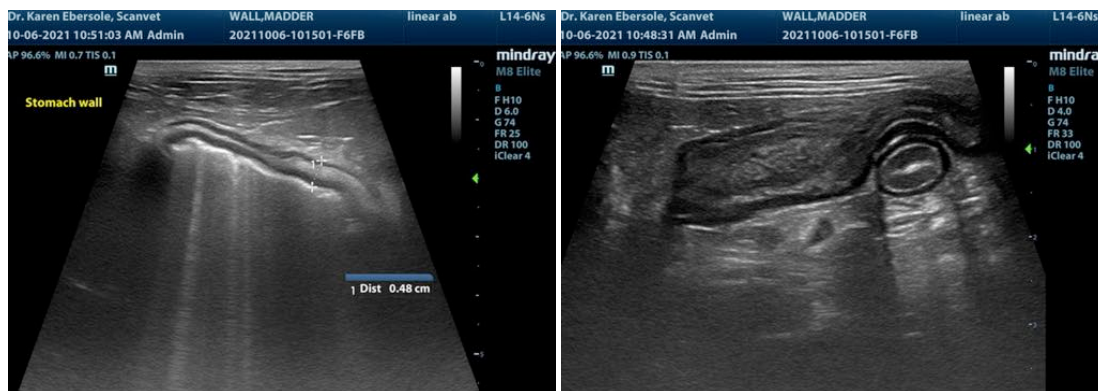
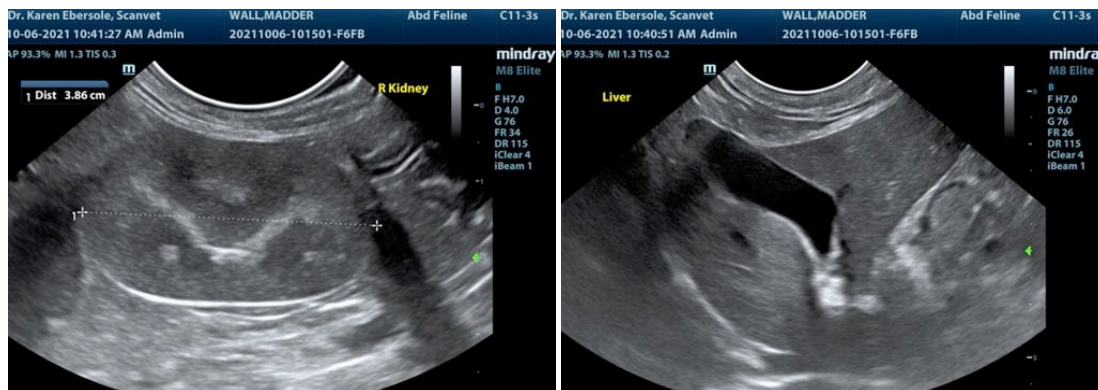
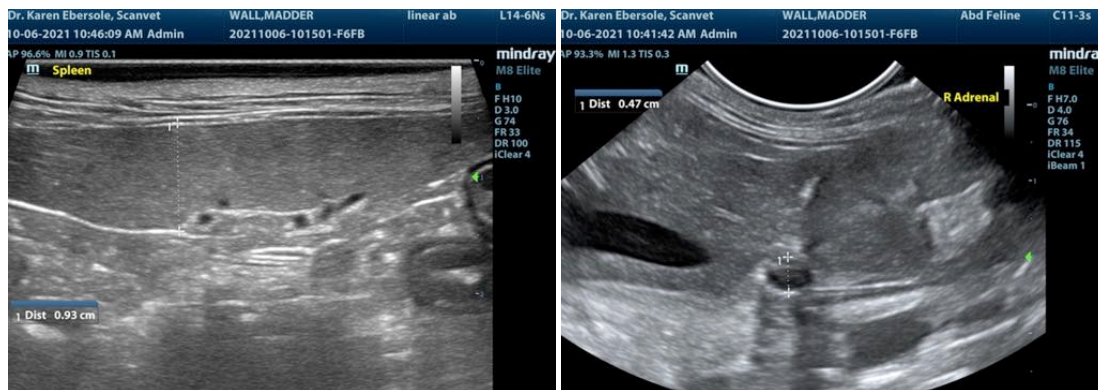
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, Cert. IVUSS, CEO of SonoPath.com  
info@SonoPath.com