



PATIENT

Tiny Morris

SPECIES

Feline

BREED

Japanese Bobtail Cat

SEX

Neutered Male

AGE

15 Years

WEIGHT

16.1

INTERPRETED BY

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

IMAGING PERFORMED BY

JK

HOSPITAL NAME

Hamburg Veterinary
Clinic

REFERRING VET

Dr. Martens

INVOICE

71696

DATE

11/11/25

PRESENTING CLINICAL SIGNS

Weight loss, hyper thyroid, in treatment
Abnormal PE/Chem/CBC/UA Results: Thyroid 4.0

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 were noted. Ureteral papillae were normal. The pelvic urethra was imaged 1.0 cm beyond the cystourethral junction.

The **kidneys** presented a relatively uniform cortical hyperechogenicity when compared to the renal medulla, spleen and liver. No overt masses were noted. Corticomedullary definition was nebulous and the ratio favored the cortex slightly. The ureters were not visible and assumed to be normal. These changes are most consistent with chronic interstitial nephritis yet infiltrative disease could not be entirely ruled out without biopsy though neoplasia is not suspected. The right kidney measured 3.5 cm with pinpoint mineralizations noted. The left kidney was mildly enlarged at 4.8 cm.

Adrenal Glands

The regions of the **adrenal glands** were unremarkable.

Spleen

The **spleen** was mildly enlarged (1.1 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

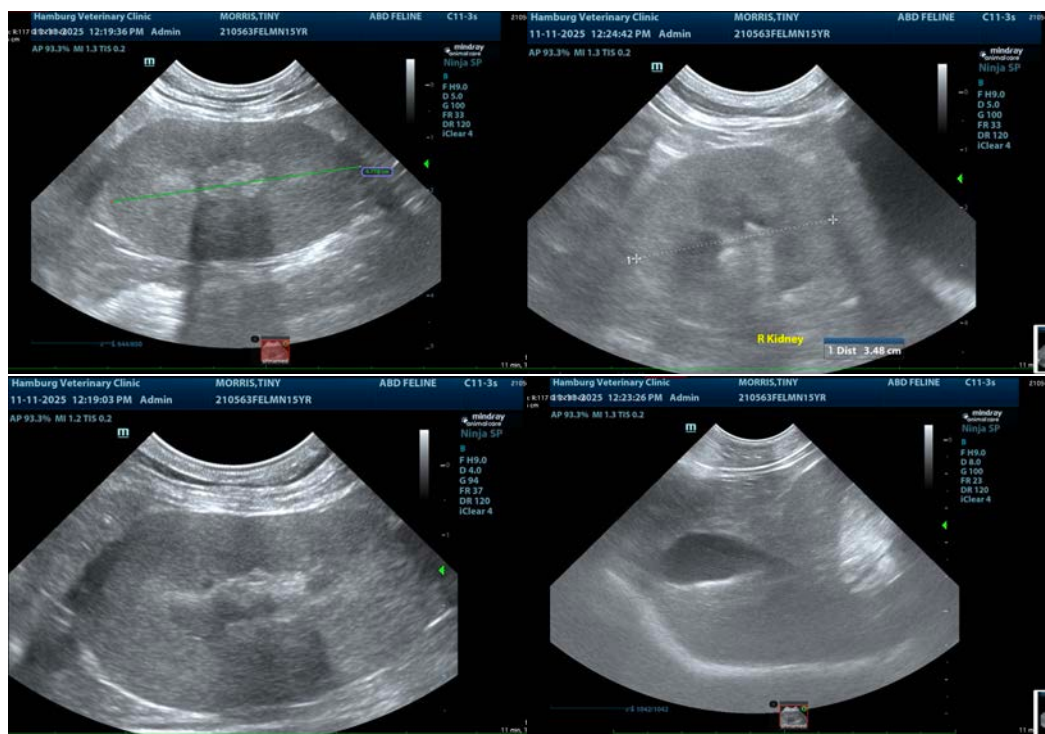
The region of the **pancreas** revealed an irregular cystic structure in a region of approximately 2.0 cm x 3.0 cm.

ULTRASONOGRAPHIC FINDINGS

- Heterogeneous area in the pancreas - Differentials include nodular hyperplasia versus carcinoma, possibility of abscessation or pseudocyst.
- Mild splenic enlargement.
- Interstitial nephrosis renal pattern.
- Age related hepatic changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further imaging of the pancreatic cystic structure would be appropriate with power doppler assessment +/- FNA of the region. FNA of the spleen also ideal to ensure reactive state as opposed to emerging round cell neoplasia.





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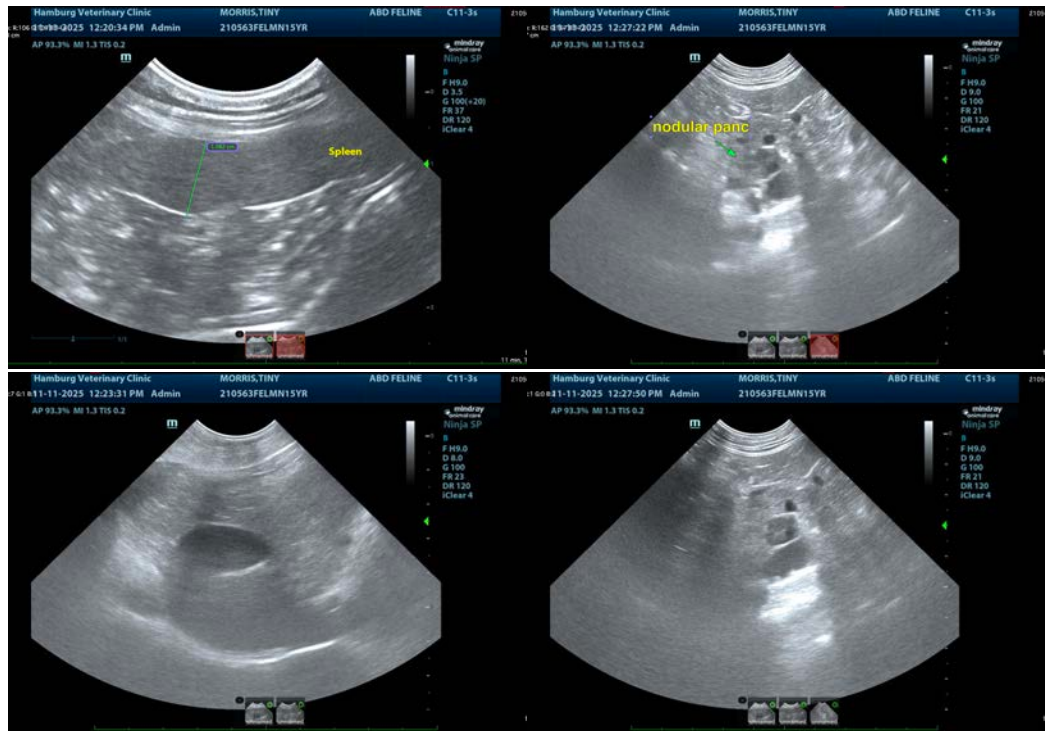
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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