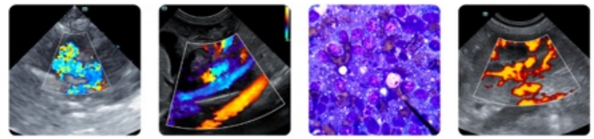


PATIENT

Luna Brown

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed female

AGE

4 years

WEIGHT

5.8 kg

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Goeres

HOSPITAL NAME

Kelowna VH

REFERRING VET

Dr. Forwood

INVOICE

68658

DATE

11/13/25

PRESENTING CLINICAL SIGNS

History: Chronic vomiting daily/EOD past 3 months, BW unremarkable, Grade III heart murmur normal proBNP no rads performed
Abnormal PE/Chem/CBC/UA Results: obese, possible mid to cranial abdominal mass palpable. no heart murmur auscultated today. currently on maropitant PO

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** is empty with a normal thickness and smooth appearance of the wall. A small urolith measuring 0.2 cm in size present.

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 right kidney measured 3.8 cm. The left kidney measured 3.6 cm.

Adrenal Glands

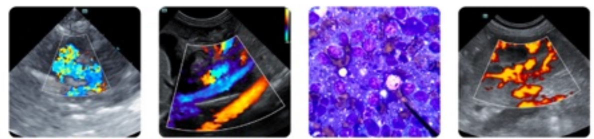
Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient.

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.

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 with slight disruption of the normal 1:3 muscularis/mucosal ratio. The pylorus was free of evident pathology. The intestinal submucosa was slightly irregular, thickened and hyperechoic suggestive of low grade, chronic disease. The transverse colon was slightly thickened and measured 0.6 cm. Regional lymph nodes were enlarged and reactive measuring up to 1.5 x 0.5 cm.

Pancreas

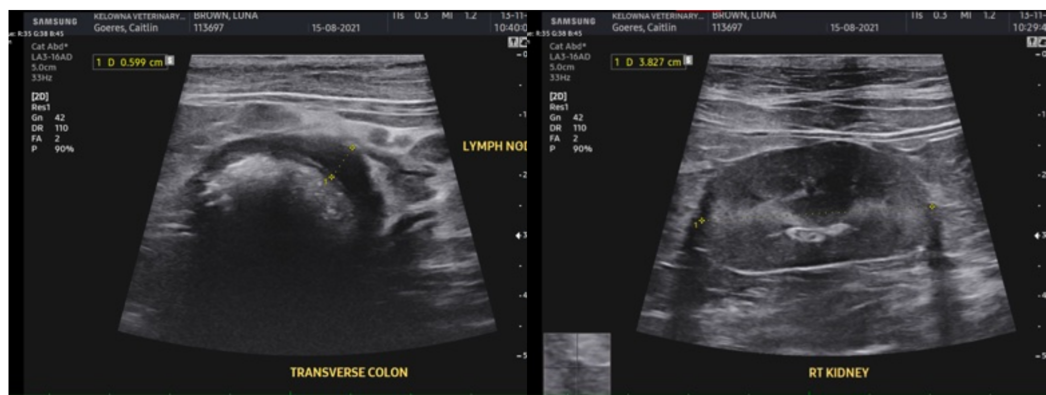
The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

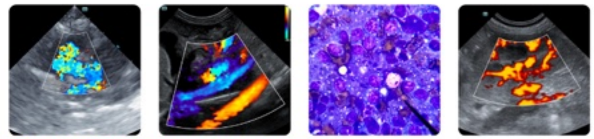
ULTRASONOGRAPHIC FINDINGS

- IBD GI with colonic wall thickening.
- Lymph node enlargement.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is concern for emerging colonic neoplasia. Ultrasound-guided FNA is indicated of the accessible lymph nodes and proximal colonic wall. Otherwise, full thickness biopsies may be necessary for a definitive diagnosis. Inflammatory bowel, lymphadenitis and colitis versus emerging round cell neoplasia. There is a remote potential for dry form FIP. Prognosis is guarded. Stool entrapment may be an issue in this patient.





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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