



PATIENT

Morris Kraiter

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

15 Years

WEIGHT

9 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Saum Hadi

HOSPITAL NAME

Nimbus PH

REFERRING VET

Dr. Saum Hadi

INVOICE

35605

DATE

11/22/25

PRESENTING CLINICAL SIGNS

History: P presents for acute, progressive lethargy, hyporexia. Hx of hematochezia, mostly resolved after discontinuing chronic meloxicam for Mild azotemia with low USG, NSF on rest. Mildly elevated TT4 on labs. Hx of heart murmur, BNP normal. History of eating foreign objects.

Abnormal PE/Chem/CBC/UA Results: Mildly elevated TT4 Mild SDMA increase, isosthenuria. NSF on rest.

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 moderate 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 right kidney measured 3.15 cm.

Adrenal Glands

The regions of the **adrenal glands** revealed no evident pathology.

Spleen

The **spleen** revealed multifocal hyperechoic nodules (up to 0.8 cm), consistent with lipid plaques, however, FNA is warranted to ensure more significant disease is not present.

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.

Gastrointestinal

The **stomach** was overdistended with fluid and chyme. The small intestine revealed transit of chyme and was structurally unremarkable. The colon was unremarkable. This change is most consistent with a postprandial presentation; however, delayed outflow cannot be ruled out. This should be paired with the clinical history.

Pancreas



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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.

Other

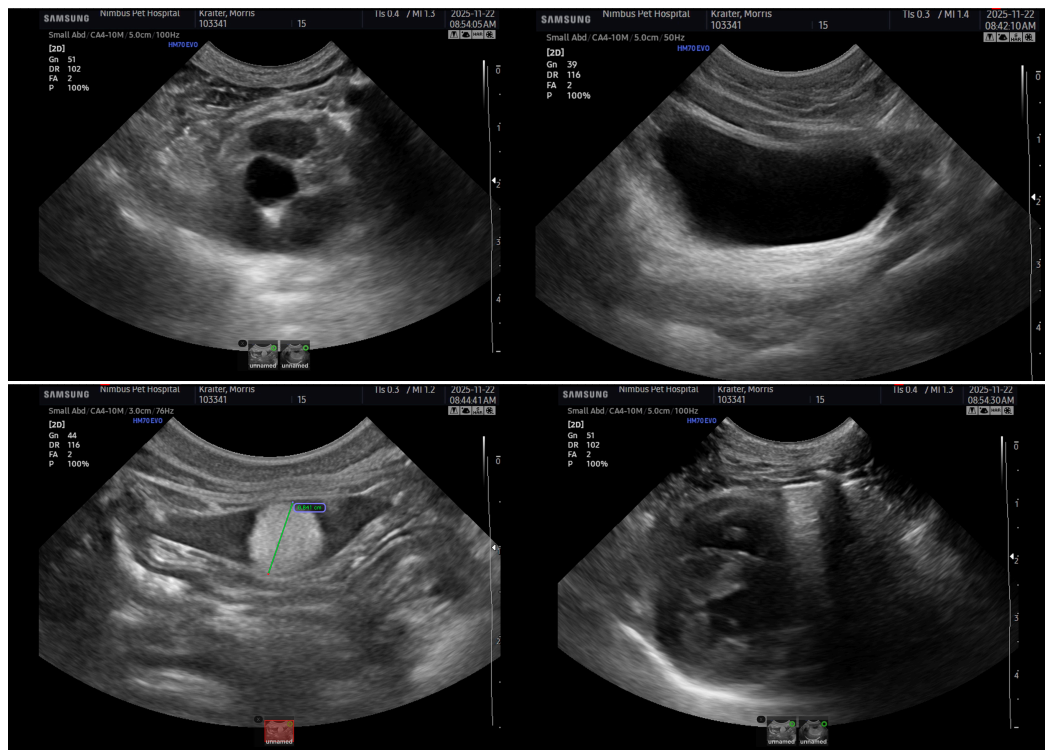
A rapid view of the **heart** revealed no evident pathology with subjective normal contractility and volumes. However, the heart was tachycardic.

ULTRASONOGRAPHIC FINDINGS

- Concern for delayed outflow gastric pattern or postprandial presentation.
- Splenic nodules
- Tachycardiac heart

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

FNA of the splenic nodules is indicated to ensure benign changes. There is concern for delayed outflow gastric pattern. No evidence of functional obstruction was noted, however, the echogenic material in the gastric lumen could represent foreign matter, but it would be more consistent with partially digested dry food/kibble.





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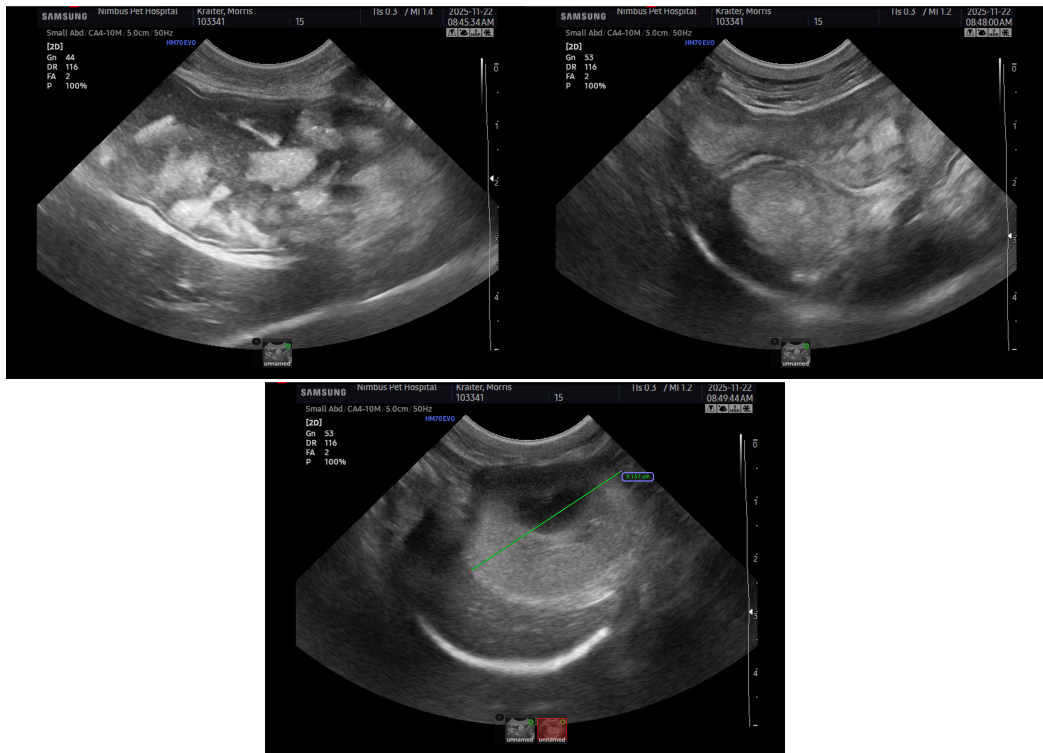
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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