



PATIENT

Mokey Swanston

SPECIES

Feline

BREED

Domestic Shorthair

SEX

Spayed Female

AGE

13 years

WEIGHT

3.76 kg

INTERPRETED BY

Eric Lindquist, DMV
DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Yogo

HOSPITAL NAME

Balmy Beach PH

REFERRING VET

Dr. Singh

INVOICE

92927

DATE

11/5/21

PRESENTING CLINICAL SIGNS

History: Appetite decreasing and energy down for a few weeks. Vomited yesterday and today. Presented icteric.

Abnormal PE/Chem/CBC/UA Results: ALT 589 (12-130) ALKP 164 (14-111) GGT 9 (0-4) TBIL 53 (0-15) CBC NAF snap fPL normal UNA Color: amber SG: 1.037 pH 6.5 Protein + UBG ++++ BIL +++ BLD ++ Bacteria: Suspected presence Epithelial cells: Squamous 1-2 Non-squamous 3-5

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 3.0 cm. The right kidney measured 3.0 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** 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 1.0 cm.

Liver

The **liver** revealed coarse architecture and increased portal markings with a minor amount of gallbladder debris. This is consistent with cholangitis. No overt masses were noted. Mild, swollen, irregular contour was noted with lobar biliary mineralization. The common bile duct measured 0.2 cm. There was no evidence of post hepatic obstruction.



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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. Soft shadowing material was noted in the stomach. I suspect hair accumulation. 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.

Pancreas

The **pancreas** was hypoechoic, mildly irregular and heterogenous. The pancreas was enlarged and measured 1.2 cm.

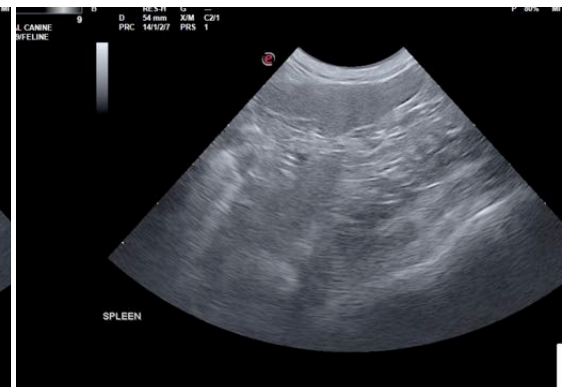
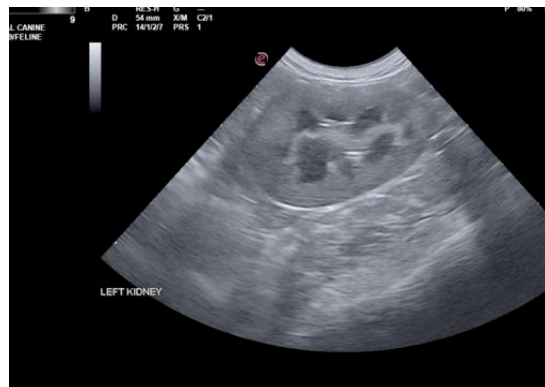
ULTRASONOGRAPHIC FINDINGS

Cholangitis liver pattern and splenic enlargement.

Chronic pancreatic changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a potential of emerging round cell neoplasia, likely hairball accumulation in the stomach. Ultrasound-guided FNA of the spleen and liver are warranted. I recommend assessment for Toxoplasmosis and Bartonella is warranted if there is no neoplasia found upon FNA. The patient may have passed a biliary calculus as well. However, no obstructive pattern was noted at the time of the sonogram.





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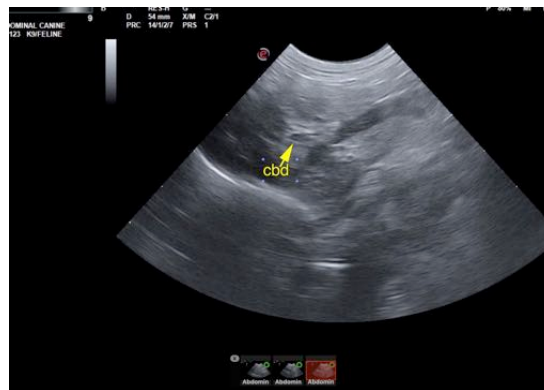
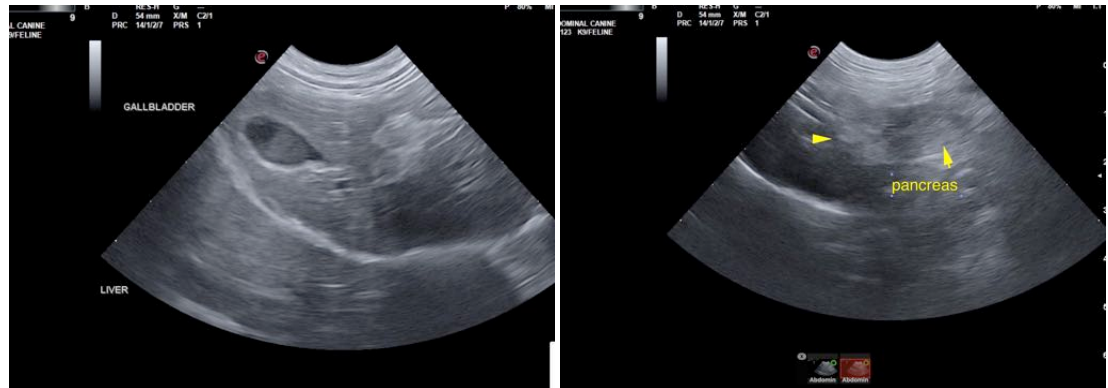
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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